FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

David S. Hodge, M.D.
At-large

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D.
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

Jeff Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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DATE: October 11, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

Please find the agenda and supporting documents enclosed for the upcoming Commission meeting on:

Thursday, October 17, 2024
1:30 pm to 3:30 pm

Where to attend:

1) CalViva Health
7625 N. Palm Ave., #109
Fresno, CA

2) Woodward Park Regional Library
WDWD Large Study Room
944 E Perrin Avenue
Fresno, CA 93720

Meeting materials have been emailed to you.

Currently, there are **11** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
October 17, 2024
1:30pm - 3:30pm

Meeting Locations:

1) CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

2) Woodward Park Regional Library
WDWD Large Study Room
944 E Perrin Avenue
Fresno, CA 93720

Item	Attachment #	Topic of Discussion	Presenter
1.		**Call to Order**	D. Hodge, MD, Chair
2.		**Roll Call**	C. Hurley, Clerk
3. Action	Attachment 3.A " " " Attachment 3.B " " " " " Attachment 3.C	**Consent Agenda:** • Commission Minutes dated 9/19/2024 • Finance Committee Minutes dated 7/18/2024 • QI/UM Committee Minutes dated 7/18/2024 • Public Policy Committee Minutes dated 6/5/24 • Commission Calendar • Finance Committee Calendar • QIUM Committee Calendar • Credentialing Sub-Committee Calendar • Peer Review Sub-Committee Calendar • Public Policy Committee Calendar • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4. **Action**		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** A. Conference with Legal Counsel - Existing Litigation, pursuant to Government Code section 54596.9 • Fresno County Superior Court Case No. 24CECG02996	
5. Action	Attachment 5.A	**Financial Audit Report for Fiscal Year 2024** • Moss Adams Board Presentation of Audit *Action: Approve Audit Report*	Moss Adams Representatives: R. Suico and E. Garibaldi

6. Action	Attachment 6.A Attachment 6.B	**2024 Heath Equity** • Executive Summary • Work Plan Mid-Year Evaluation *Action: Approve 2024 Health Equity Executive Summary and Work Plan Mid-Year Evaluation*	S. Xiong-Lopez, EqO
7. Action	Attachment 7.A	**2024 Quality Improvement Health Equity Transformation Program** *Action: Approve 2024 QI Health Equity Transformation Program*	P. Marabella, MD, CMO
8. Action		**Standing Reports**	
	Attachment 8.A	**Finance** • Financials as of August 31, 2024	D. Maychen, CFO
	Attachment 8.B Attachment 8.C Attachment 8.D	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • QIUM Quarterly Report	P. Marabella, MD, CMO
	No attachment	**Equity** • Equity Update	Sia Xiong-Lopez, EqO
	Attachment 8.E	**Executive** • Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	
9.		**Final Comments from Commission Members and Staff**	
10.		**Announcements**	
11.		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
12.		**Adjourn**	D. Hodge, MD, Chair

Supporting documents will be posted on our website 72 hours prior to the meeting.
If you have any questions, please notify the Clerk to the Commission at: Churley@calvivahealth.org

If special accommodations are needed to participate in this meeting, please contact Cheryl Hurley at 559-540-7842 during regular business hours (M-F 8:00 a.m. – 5:00 p.m.)

Next Meeting scheduled for November 21, 2024 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

“To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners.”

Item #3
Attachment 3.A-C

Consent Agenda

3.A.1 Commission Minutes 9/19/24
3.A.2 Finance Minutes 7/18/24
3.A.3 QIUM Minutes 7/18/24
3.A.4 PPC Minutes 6/5/24

3.B.1 2025 Commission Calendar
3.B.2 2025 Finance Calendar
3.B.3 2025 QIUM Calendar
3.B.4 2025 Credentialing Calendar
3.B.5 2025 Peer Review Calendar
3.B.6 2025 Public Policy Calendar

3.C Compliance Report

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
September 10, 2024

Meeting Location:
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

	Commission Members		
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health	✓	**David Luchini**, Director, Fresno County Dept. of Public Health
✓	**David Cardona**, M.D., Fresno County At-large Appointee	✓	**Aftab Naz,** M.D., Madera County At-large Appointee
	Aldo De La Torre, Community Medical Center Representative	✓	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
✓	**Joyce Fields-Keene,** Fresno County At-large Appointee	✓	**Lisa Lewis**, Ph.D., Kings County At-large Appointee
✓	**John Frye**, Commission At-large Appointee, Fresno	✓	**Sal Quintero**, Fresno County Board of Supervisor
	Soyla Griffin, Fresno County At-large Appointee	✓	**Rose Mary Rahn**, Director, Kings County Dept. of Public Health
✓	**David Hodge**, M.D., Chair, Fresno County At-large Appointee	✓	**David Rogers**, Madera County Board of Supervisors
	Kerry Hydash, Commission At-large Appointee, Kings County	✓	**Jennifer Armendariz**, Valley Children's Hospital Appointee
		✓	**Paulo Soares**, Commission At-large Appointee, Madera County
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Amy Schneider**, R.N., Senior Director of Medical Management
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Cheryl Hurley**, Commission Clerk, Director Office/HR
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Sia Xiong-Lopez**, Equity Officer
✓	**Mary Lourdes Leone**, Chief Compliance Officer		
	General Counsel and Consultants		
✓*	**Jason Epperson**, General Counsel		
✓= Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
● = Attended via Teleconference			

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#1 Call to Order	The meeting was called to order at 1:31 pm. A quorum was present.		
#2 Roll Call	A roll call was taken for the current Commission Members.		*A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Cheryl Hurley, Clerk to the Commission			
#3 Consent Agenda • *Commission Minutes dated 7/18/24* • *Finance Committee Minutes dated 5/16/24* • *QI/UM Committee Minutes dated 5/16/24* • *Public Policy Committee Minutes dated 6/5/24* Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *14 – 0 – 0 – 3* *(Neves / Soares)*
#4 Public Policy Committee Charter Revision **Information** Courtney Shapiro, Director of Community Relations & Marketing	The revised Public Policy Committee Charter was presented for approval.		***Motion**: Approve revised PPC Charter.* *14 – 0 – 0 – 3* *(Neves / Rahn)*
#5 Closed Session	Jason Epperson, General Counsel, reported out of closed session. The Commission discussed in closed session Item 5.A, specifically Conference Report Involving Trade Secret – Discussion of service, program, or facility, estimated date of public disclosure is July 1, 2025, pursuant to Government Code Section 54954.5. That item was discussed in closed session, general direction was given to staff. There Commission recessed at 1:50 pm and took no other reportable action.		
#6 2024 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation • Executive Summary	Dr. Marabella presented the 2024 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation. Planned Initiatives and Quality Improvement Focus for 2024 include: • Behavioral Health		***See #7 for Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• Work Plan Evaluation Action P. Marabella, MD, CMO	• Chronic Conditions • Pharmacy & Related Measures • Member Engagement & Experience • Hospital Quality & Patient Safety • Pediatric/Perinatal/Dental • Preventive Health • Provider Engagement/Communication There was a total of 84 measurable objectives: • 66 objectives completed at mid-year. • 36 out of 66 objectives were met. • 30 out of 66 objectives were not met. • 18 additional objectives scheduled for Q3-Q4 & on track at mid-year. Programs that did not meet their objectives were Behavioral Health, Pediatric/Perinatal/ Dental, Pharmacy, and Provider Engagement/Communication. Ongoing activities continue. There was a total of 123 planned activities for the year: • 31 out of 35 activities were completed. • 4 activities under Chronic Conditions and Provider. Engagement/Communication off-track and not completed. • 88 activities planned for July to December. The 88 activities planned for July to December, and the four (4) activities that are off track are on track for completion by the end of year. Within Access to Care, there are two surveys: 1. Provider Appointment Availability Survey (PAAS): a. PCP Urgent & Non-Urgent exceeded 70% threshold. b. Specialist Urgent & Non-Urgent improved but did not meet the 70% threshold. c. Ancillary non-urgent exceeded the 70% threshold. 2. Provider After Hours Access Survey (PAHAS): a. Appropriate Emergency Instructions exceeded the 90% goal but Contacting On-Call MD did not (85.9%).		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Access – Actions to be taken: • All non-compliant providers will receive Corrective Action Plans in August. • 10 Mandatory Provider Training Webinars will be conducted in July to December. Member Satisfaction - Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey conducted by the state in 2024: • The report for this survey will be available in November. • Quarterly Root Cause Analyses of A & G Data is being performed. • Sullivan Luallin Webinar Trainings for Providers will be offered. Reporting Year 2024 HEDIS® Results: All three counties, Fresno, Kings and Madera, fell below the Minimum Performance Level (MPL) in the following areas: • Follow-Up After ED Visit for Mental Health Illness-30 days (FUM) • Follow-Up After ED Visit for Substance Abuse-30 (FUA) Fresno and Kings Counties fell below the MPL in the following areas: • Asthma Medication Ration (AMR). • Childhood Immunizations – Combo 10 (CIS-10). • Lead Screening in Children (LSC). • Well-Child Visits in the First 15 Months of Life- Six or more Well-Child Visits (W30-15); and • Well-Child Visits for age 15 Months to 30 Months – Two or more Well-Child Visits (W30-30) All three counties met, or exceeded, the MPL in the following categories: • Breast Cancer Screening • Cervical Cancer Screening • Chlamydia Screening • Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control • Controlling High Blood Pressure • Prenatal Care • Postpartum Care	*Rose Mary Rahn asked why most of the projects are in Fresno and Madera counties?* *Dr. Marabella responded that current projects address MY2022 data and today we are presenting*	

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	The two Performance Improvement Projects (PIPs) selected by the State are: 1. Clinical - Well Child Visits in First 30 Months of Life in the African American population in Fresno County. Annual Submission 9/11/2024 2. Non-Clinical – Improve Provider Notifications after ED Visit for SUD/MH Fresno & Madera Counties. Annual Submission 09/25/2024 Additional projects include: • IHI Well Child Visit Collaborative • IHI Behavioral Health Collaborative • DHCS Lean Project Madera County (BH Domain) • DHCS Lean Project Kings County (Child Domain) • DHCS Comprehensive Project Fresno County (BH & Child Domain) Health Education ongoing activities and actions include: • Continuing Member Incentive Strategy. • Promote Digital Resources including QR Codes & Links. • Member Services to inform Members of programs and materials that are available. • Review & Update materials following DHCS Guidelines. • Complete ED analysis for 2023 Central California Asthma Collaborative asthma project. • Continue partnership and promotion of BCS & CCS screenings at *Every Woman Counts event.* ▪ Continue promotion of *Kick It California* tobacco cessation program. • Obtain DHCS approval of the Diabetes Prevention Program with new Provider. o Develop & launch two (2) Member Outreach campaigns to promote the new *Diabetes Prevention Program.* o Develop & launch one (1) Provider Outreach campaign to promote the new *Diabetes Prevention Program*	*MY2023 data. Kings County performance declined in MY2023. Kings County is the focus of the Kings County Lean Project to improve Well Child Visits. Additionally, projects mandated by the state are based upon the four (4) domains (Childhood Preventive measures, Behavioral Health, Chronic Conditions, and Reproductive & Cancer measures) and in MY2022 Kings County was non-compliant in only one domain (missed all six (6) Pediatric Preventive measures) so only one project was required. This year (MY2023) Kings County is still non-compliant for the Pediatric Domain and now also the Behavioral Health Domain. Our PIP topics are targeted and were selected by the DHCS.* *Dr. Lewis asked for the non-clinical PIP and the follow-up after ED Visits, is the requirement provider notification or is the*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		requirement follow-up behavioral health visit? *Dr. Marabella responded the HEDIS® specification is for a follow-up assessment/visit within seven (7) days with a Provider, which is almost impossible in most settings. The PIP topic was selected by the state and is focused on provider notification, which is the first step in the process, in order for that assessment/visit to occur, a provider must be notified. What was discovered in Kings County is that members seen in the ED for MH/SUD were being seen that same day by a Social Worker (LCSW) conducting an assessment and appropriate referrals, which counts for the HEDIS® hit. The challenge has been to correctly document this encounter which was done correctly in Kings County last year. In Fresno County, at CRMC, they're doing a similar process, but they don't*	

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		know how to account for it. The Plan is trying to teach them how to document it correctly. The HEDIS® specification is the follow-up assessment/visit, but our PIP Project is provider notifications. *Dr. Lewis responded Kings County is dealing with the exact same people in the ED at Adventist. Follow-up appointments are required but also, there is a 40% shortage of mental health Providers in the central valley.* *Dr. Marabella stated the State has already heard about the challenges with this measure from most of the health plan medical directors but the problem with the FUA FUM is the ability to get information from the counties. The problem is not just in the central valley, it's everywhere. The State said, for this year, the Plans won't be penalized*	

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		(sanctioned), but next year we will. *Sara Bosse asked if it's possible to get the survey data on access to care for the different counties to be able to see what the actual percentages are (i.e. provider appointment, and the after-hours access).* *Dr. Marabella indicated that there is a Provider Update.* *Mary Lourdes Leone added that the Provider Update still needs to be reviewed and approved. Once the final data is available, we will finalize and distribute the Provider Update.*	
#7 2024 Utilization Management Care Management Work Plan Mid-Year Evaluation • Executive Summary • Work Plan Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2024 Utilization Management Care Management Work Plan Mid-Year Evaluation. The Five Area of Focus Activities in 2024 include: • Compliance with Regulatory & Accreditation Requirements. • Monitoring the UM Process. • Monitoring Utilization Metrics. • Monitoring Coordination with Other Programs. • Monitoring Activities for Special Populations.		***Motion**: 2024 QIUM and 2024 UM Work Plan Evaluations* *14 – 0 – 0 – 3* *(Neves / Frye)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Utilization Management processes have remained consistent. Case Management and Disease Management continue to monitor the effectiveness of programs to better serve our members. <u>Compliance with Regulatory & Accreditation Requirements</u> All Compliance Activities on target for Mid-Year. • Separation of Medical Decisions from Fiscal Considerations – Q1 2024 CalViva conducted UMCM Oversight Audit and requested evidence of attestations regarding Affirmative Statement regarding Incentives. 73% Compliance. o CAP issued and resolved in Q2. o A job aid was updated to assign Attestations as an element of annual training. <u>Monitoring the Utilization Management Process</u> All Activities related to Monitoring the UM Process are on Target at the Mid-Year. • All Turn-around Times (TAT) met or exceeded the threshold for action of 95%. • All cases that didn't meet TAT were addressed. <u>Monitoring Utilization Metrics</u> All Monitoring Utilization Metrics are on target at the Mid-Year except 3.3 PPG Profile. • Acute inpatient on target to meet goals for 2% reduction in avg length of stay and readmissions 8-30 days. • 3.3 PPG Profile: o Specialty Access continues to be a challenge: Collaboration with PPG, FQHC, and the Plan o Extension Letter Accuracy: CAP issued o TAT on Denials: CAP issued <u>Monitoring Coordination with Other Programs</u> All Activities related to Monitoring Coordination with other programs are on track. Some Barriers Being Addressed: • Care Management Program – noted fewer than expected member satisfaction surveys. Obtaining member preferred contact method and encouraging completion.		

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	• Behavioral Health Care Management – referrals reduced due to some cases going to Transitional Care Services Team. Outreaching using other sources. <u>Monitoring Activities for Special Populations</u> All Monitoring Activities for Special Populations on target at the Mid-Year. No Barriers Identified.		
#8 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of Fiscal Year End 2024:</u> As of June 30, 2024, total current assets recorded were approximately $480M; total current liabilities were approximately $328.1M. Current ratio is approximately 1.46. Total net equity as of the end of June 2024 was approximately $161.7M, which is approximately 736% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $8.5M, which is approximately $4.9M more than budgeted due to rates being higher than projected. Premium capitation income actual recorded was approximately $2B which is approximately $316.3M more than budgeted due to MCO taxes that DHCS paid the Plan relating to FY 2023 in FY 2024 which amounted to approximately $125.5M and the remaining increase is due to rates and enrollment being higher than projected. Total cost of Medical Care expense was approximately $1.31B which is approximately $180.6M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $57.6M, which is approximately $6.2M more than budgeted due to enrollment being higher than projected. Dues and Subscriptions expense actual recorded was approximately $238K which is $4K more than budged due to trade associations increasing dues as they hire additional staff to be able to better represent the local health plans. All other expense line items are in line or below what was budgeted. MCO taxes actual recorded was approximately $658.3M,		***Motion**: Standing Reports Approved* *14 – 0 – 0 – 3* *(Neves / Rogers)*

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• **Compliance** M.L. Leone, CCO	which is approximately $125.5M more than budgeted due to DHCS paying the Plan MCO taxes related to the prior fiscal year (FY 2023), in FY 2024. Net income for Fiscal Year End 2024 actual recorded was approximately $20.3M, which is approximately $11.5M more than budgeted primarily due to interest income being higher than projected by $4.9M, and rates and enrollment being higher than projected. **Compliance** <u>Compliance Report</u> Year to date there have been 272 Administrative & Operational regulatory filings for 2024; 35 Member Materials filed for approval; 94 Provider Materials reviewed and distributed, and 83 DMHC filings. There have been 20 potential Privacy & Security breach cases reported year to date, with zero being high risk. Since the 7/18/2024 Compliance Regulatory Report to the Commission, there were 3 new MC609 cases filed, with a year to date total of 15. There are 23 cases that remain open and under investigation. The 3 new cases involved: 1) A participating DME provider billing for services not rendered, upcoding of wheelchairs and excessive billing of TENS unit supplies; 2) A participating provider specializing in podiatry for alleged fraudulent billing of services; and 3) A participating provider specializing in pediatrics for billing a high volume of a non-medically necessary services per health plan policy and frequently billing high level of E/M services despite previous education. The Annual Oversight Audits currently in progress since last reported include UMCM, Claims/PDR, FWA, Call Center, Health Education, and Privacy & Security. The high number of audits is a result of the NCQA requirement and having everyone on the same cycle. In addition, there was an annual internal Compliance		

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	Audit of staff, Board Members, and Committee members completed with no CAP issued. Audits completed were Marketing, no CAP issued, and Member Rights, no CAP issued. On 9/3/2024 DHCS issued a formal response to the Plan's responses and rebuttals to each of the nine findings for the 2023 Focused Audit for Behavioral Health and Transportation. DHCS stated that the Plan's responses did not contain sufficient information to affect the preliminary findings. On 9/6/2024 the Plan received DHCS Focus Audit CAP Request. The Plan's initial response is due by October 6, 2024. On 9/12/24, the Plan received the DHCS 2024 Preliminary Audit Report related to the 2024 Medical Audit. There were two findings. The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. And, the Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. The audit Exit Conference was conducted on 9/16/2024. DHCS has issued its Transitional Rent Concept Paper for public comment in reference to CalAIM. DHCS is seeking to provide coverage of rent/temporary housing to members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria. California seeks to begin providing coverage of rent/temporary housing as a Medi-Cal service—to be known as "Transitional Rent" on January 1, 2025. And Coverage of Transitional Rent will be optional for Medi-Cal managed care health plans (MCPs) beginning on January 1, 2025, and required for MCPs on January 1, 2026. On 7/24/2024 the Plan received DHCS approval on Phase II Network Readiness deliverables related to executing contracts, in relation to Long Term Care Carve-In Deliverable List – Phase II. In reference to the 2023 Subnetwork Certification (SNC), as required by the DHCS, the Plan continues to follow-up with PPGs on the status of all CAPS the Plan		

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	previously issued for not meeting time and distance standards in their networks. The next quarterly update submission is due by 10/1/2024. In reference to the 2023 Annual Network Certification (ANC), the Plan had requested several alternate access standard (AAS) requests to the DHCS. The Plan received a response to the AAS on 9/5/2024. DHCS denied 44 zip code requests from across the Plan's service area. The Plan is reviewing the DHCS findings and will need to make any revisions to the AAS request by 9/19/2024. Regarding the RY 2023 MY 2022, DMHC issued a Network Findings Report with two findings related to Geographic Access (i.e., time and distance) and Data Accuracy (i.e., 11 addresses for a single physician). The Plan acknowledged the Departments T&D findings and reanalyzed the data for 2024. The reanalysis indicated all time and distance standards are being met. The Plan disagreed with the data quality issue stating that we followed MY 2022 instructions to report all the physical practice addresses where the specialists delivered in-person services on an outpatient basis. The Plan is awaiting the Department's response. The Plan received NCQA Accreditation on 7/19/24 in compliance with the 2024 DHCS Contract. The Plan has begun to review NCQA Health Equity standards and prepare for the 3/11/2025 Health Equity submission. Three of the twenty-one MOUs have been fully executed and posted to the CalViva Health website. Those include the Fresno County Department of Behavioral Health (DMC-ODS), Fresno Economic Opportunity Commission (EOC), United Center (UHC), and Clinica Sierra Vista (CSV), and Kings County Department of Behavioral Health (Specialty mental Health). The Public Policy Committee meeting was held on September 4, 2024. The following reports were presented: Health Education Semi-Annual Member Incentive Programs, Appeals and Grievance Report, and Population Health Management Collaboration Update. Dr. Marabella gave an overview of the Q2 2024 A&G Dashboard, noting certain types of grievances reported. The revised PPC Charter was approved to be submitted to the Commission for board approval.	*Sara Bosse asked, in reference to the alternate access standards, how many does the plan have?* *Mary Lourdes Leone responded, they are posted to the CVH website and also on the DHCS website. They infrequently change because the DMHC and DHCS have changed their methodology for how they analyze it and how CVH had analyzed it. They have now standardized the population point methodology and things should be in sync. From the ANC that the Plan just submitted there were six.* *Sara Bosse responded that in the change of the analysis, the count went from 44 to 6 which might suggest the analysis is manipulating things to make it look better than it actually is; (i.e. the State changing the*	

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	Mary Lourdes Leone presented an overview of SB 1019 regarding required member outreach for Non-Specialty Mental Health Services, and the PPC members provided suggestions/recommendations on how best to conduct the outreach. The next Public Policy Committee meeting will be held December 4, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	*methodology; not local Plan)?* *Mary Lourdes Leone responded that was for the 2023 ANC. It's at that point in time. However, now if reanalyzed, which was done, it turns out those Providers that were initially "out of standard" right now are actually within the standard.* *Dr. Lewis stated in reference to the transitional rent issue, the idea of fund Is one thing, which is something DHCS came up with and CBHDA, the Directors Association for specialty mental health has been pushing back on very strongly because the percentage of our MHSA funds that would be used in that is typically encumbered in services so is 30% that is supposed to be used for housing, but we're using it largely for housing right now for things like act teams or similar who we can get somebody into services*	

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		and housed very quickly and we use those funds for that, which is a big challenge and we don't know what is going to happen as far as the fund. The other issue is that the way they have it conceptualized right now is the managed care plans are going to have to expend the funds on the transitional rent prior to the ability for the specialty mental health folks to go in with the BH funding for housing for instance an act team, etc. If the State leaves it that way and it doesn't change it's going to put a tremendous amount of pressure on the managed care plans because they're going to have to act really quickly to expend those funds when somebody needs them so that BH can then come in after them and do what BH normally does. It's a big issue that CBHDA is pushing. *Mary Lourdes replied stated the Plan would get*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		the money and it would be separate form the other money the Plan normally receives, like capitation for the medical services, and then there's another entity which is a flex pool that the Plan would have to contract with that would be the central contracting entity that would work with the Providers of the housing and paying them. Then there is the local county departments as well as the nonprofits which there's different funding sources. The answer for how all that will work out is unknown at this time but there is a lot of feedback that has gone back, and this is still out for public comment because it's extremely complex.	
• **Medical Management** P. Marabella, MD, CMO	**Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through July 31, 2024.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN

	• The total number of grievances through July 2024 has increased compared to 2023 counts. The Quality-of-Service category represents the highest volume of total grievances.
	• For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Administrative, Balanced Billing, and Interpersonal. Transportation – Access has improved.
	• The volume of Quality of Care (QOC) cases remains consistent when compared to last year.
	• The volume of Exempt Grievances also remains consistent.
	• Total Appeals volume has increased from previous months, with the majority being Advanced Imaging, and Other (SNF-Long Term Care related). Uphold and overturn rates remain consistent.
	
	<u>Key Indicator Report</u>
	
	Dr. Marabella presented the Key Indicator Report (KIR) through July 31, 2024.
	
	A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through July 2024.
	• Membership has had a slight increase and leveled off and utilization has remained consistent or increased slightly over the previous months. SPD utilization remains low.
	• Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for TANF, MCE, and SPDs remain consistent with recent months with the following exceptions:
	  ○ For Bed Days (adjusted PTMPY), SPDs show steady decline month over month.
	  ○ Acute Length of Stay (adjusted PTMPY) decreased in July in all four categories.
	• Turn-around time compliance remains at 100%.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Case Management (CM) and engagement rates are up, and all areas have improved. <u>Credentialing Sub-Committee Quarterly Report</u> The Credentialing Sub-Committee met on July 18, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering the first quarter for 2024 were reviewed for delegated entities and second quarter 2024 for Health Net and HN Behavioral Health. Credentialing Adverse Actions report for Q2 for CalViva from Health Net Credentialing Committee was presented. There was one (1) case presented for discussion. The case remains open in pending status, awaiting the Medical Board of California decision. The Adverse Events Q1 2024 report was reviewed. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period. Credentialing submitted one (1) case to the Credentialing Committee in the second quarter of 2024. It was not a behavioral health case. There were no (0) reconsiderations or fair hearings during the second quarter of 2024. There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the second quarter of 2024. There were zero cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in the second quarter of 2024. The Access & Availability Substantial Harm Report Q2 2024 was presented and reviewed. The purpose of this report is to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issue (PQI) cases identified related to appointment availability and the cases are ranked by severity level. After a thorough review of all second quarter 2024 PQI/QOC cases, the Credentialing Department identified zero new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The 2024 Credentialing Oversight Audit Corrective Action Plan. The Oversight Audit results of the Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function for January to December 2023 were presented at the May 2024 Credentialing Sub-Committee Meeting. Two (2) issues were identified during the audit that required corrective action, 1) Timeliness of attestations in the Recredentialing files for one PPG, and 2) Timeliness of Re-Credentialing within thirty-six months for HealthNet. A corrective action plan was submitted by HealthNet and approved. Re-monitoring will occur with the next annual Oversight Audit. <u>Peer Review Sub-Committee Quarterly Report</u> The Peer Review Sub-Committee met on July 18, 2024. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2024 were reviewed for approval. There were no significant cases to report. The Q2 2024 Adverse Events Report was presented. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period. There were ten (10) cases identified in Q2 that met the criteria and were reported to the Peer Review Committee. Six (6) cases involved a practitioner, and four (4) cases involved organizational providers (facilities). Of the ten (10) cases, two (2) were tabled, one (1) was tabled with a letter of concern, one (1) was placed on monitoring, two (2) were closed to track and trend with a letter of concern, and four (4) were closed to track and trend. Nine (9) cases were quality of care grievances, one (1) was a potential quality issue, zero (0) were lower-level cases, and zero (0) were track and trend. Three (3) cases involved seniors and persons with disabilities (SPDs). Zero (0) cases involved behavioral health. There were no incidents (0) involving appointment availability issues resulting in substantial harm to a member or members in Q2 2024. There was one (1) case identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. There were thirty-six (36) cases identified that required further outreach. Outreach can include but is not limited to an		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. The Access & Availability Substantial Harm Report for Q2 2024 was also presented. The purpose of this report is to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability issues and they are ranked by severity level. Fifteen (15) cases were submitted to the Peer Review Committee in Q2 2024. There was one (1) incident found involving appointment availability issues without significant harm to a member. Three (3) cases were determined to be related to significant harm without appointment availability issues. No cases (0) were related to behavioral health issues. There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2024. The Q2 2024 Peer Count Report was presented and discussed with the committee. There was a total of fifteen (15) cases reviewed. There were eight (8) cases closed and cleared. No (0) cases were closed/terminated. There were two (2) cases with Corrective Action Plan (CAP) outstanding. There were three (3) cases tabled pending further information and two (2) pending closure for CAP compliance. The Sub-Committee members were in agreement with the recommendations. Ongoing monitoring and reporting will continue.		
• **Health Equity Report** S. Xiong-Lopez, Equity Officer	**Health Equity Report** <u>Health Disparities Report</u> CalViva Health is committed to supporting the health of our members and reducing health disparities across our membership. Health equity is incorporated throughout our organization, reflecting CalViva Health's commitment to transforming the health of our communities.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Health literacy, cultural competency, language services, health disparity reduction, and social drivers of health are integrated into programs to serve our diverse membership. The Plan designs programs to decrease barriers and increase quality care for our members by focusing on needs at the member, provider, and community levels. Key to the Health Equity model process is obtaining input from stakeholders (members, community, and providers), researching disparity root causes, and developing informed tailored interventions. To understand the population, capturing valid and reliable data is critical to the Health Disparity Improvement process. Data systems and interfaces designed to accurately collect, capture, and code member demographic data are used. Demographic data that includes race, ethnicity, language, sexual orientation, and gender identity and that is accurate and reliable is a priority. In 2021 the Disparities Dashboard was created to identify disparities and HEDIS® quality measurement. An interactive table of HEDIS® measure compliance rates, 95% confidence interval of compliance rates, and national 50% benchmarks, by measures, products, and segments; visualization of compliance rates by measures, products, or segments; and an interactive map of non-complaint members. The Plan's Annual Disparity Analysis consists of all three service counties: Fresno, Kings and Madera. The analysis looks at race, ethnicity, language, and gender. Statistically significant differences are identified by the HEDIS® measures such as: Pediatric Measures; Perinatal Measures; Colorectal Cancer Screening; Chronic Conditions; and Behavioral Health. Two high priority Health Disparity Projects were established from the Annual Analysis: • Through the Disparity Leadership Program (DLP), sponsored by Massachusetts General Hospital, a team engaged in a project to improve HbA1c for members who have not completed a test or are at risk of becoming diabetic.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• The California Department of Health Care Services (DHCS) is requiring CalViva to focus on improving infant well care visits in the Black or African American population for the 2023 to 2026 clinical performance improvement project (PIP). Barriers identified within the Diabetes Project include: • Fresno Census tract analysis identified major food deserts with low-income individuals. • Literature review confirmed that although members understand that diet and exercise contribute to control of their diabetes, they don't understand how to implement that into their lives. An intervention for the Diabetes Project consisted of Cooking Matters where members enroll into a 6-sesssion healthy cooking class. The project provides free resources to access free to low-cost fresh produce delivery. A $50 gift card for members completing 4 of 6 classes. And at the end of each class session each member received a box of food. The evaluation and/or impact of the Diabetes Project was to: • Compare HbA1c levels before and after the class. • 30 members attended at least one (1) class • 21 members attended 4 of 6 classes The lessons learned and future plans for the Diabetes Project consist of: • Separate classrooms into English and Spanish. Both languages and cultures in the same room were difficult. • Ensure culturally tailored menus. • Avoid obtaining HbA1c results in December. May have impacted results. For the Well Child Visit Project focused on black infant health. Barriers identified include: • Lack of Black/AA providers • Transportation • Inability to take time off work		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Communication challenges • Mistrust • Social Determinants of Health - Housing and food insecurity Intervention strategy includes: • Work with Black Infant Health (BIH) to address key barriers through Case Management. • Share list of members non-compliant with WCV, CIS-10 with BIH monthly to outreach to members. • Work with providers to encourage birthing parent engagement with BIH. The evaluation results of the Health Disparities Report are currently pending and expected receipt is September 2024. <u>DEI Survey Findings and Opportunities</u> The purpose of the DEI Survey is to meet the NCQA accreditation requirements, find opportunities and, if necessary, improve areas of diversity, equity, and inclusion amongst Staff, Leadership, Committees, and Governing Bodies. The survey was 100% anonymous. Thirty surveys were sent out to Governance bodies including, but were not limited to, the organization's board of directors, and committee members, who were identified as individuals, internal or external, to the organization appointed for specific functions. Eighteen surveys were sent out to CalViva staff members. Surveys were split into two categories, Leadership-individuals with managerial authority and executive positions, such as manager, director, vice president, or chief officer, and staff. For the Board and Committee members, 18 out of 30 responded and there were no concerns as it relates to DEI, or Bias. The inquiries from that group included: 1. More in depth conversation about transportation accessibility and activities being done to address that.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	2. Request for further discussion about member barriers and why they do not meet certain benchmarks as it relates to Medi-Cal and cultural barriers to healthcare. 3. Request for focus on women's health specifically, perimenopause and menopause treatment and preventative care. For Staff and Leadership, 93% of staff/leadership agreed that CalViva does not celebrate/ acknowledge various celebrated cultures such as New Year Celebrations, Dia de Los Muertos, Juneteenth, Awareness months (Pride month, Black History, etc.). 11.1% of staff members 1) did not feel comfortable sharing their opinion; 2) Did not feel comfortable sharing their concerns with their direct supervisor; 3) Did not feel they were encouraged to share their opinion; and 4) Did not feel that there is work life balance. The "wants" of the staff include 1) Team/Interpersonal relationship building inside/outside of work with the possibility if including their families; 2) Learn about their peers' own cultural backgrounds. The ultimate response was that they want it all surrounded by cultural food, potluck style. The action plan for staff as a result of the survey includes the following: • Adjust settings of staff meetings. • Implement Ice Breaker activities to promote conversation and build more interpersonal relationships. • 2X a year HR will poll staff for cultural activities with the purpose of learning about a different culture of the majority choice. (Potluck Style) The action plan for Board/ Committee Members is to further discuss/investigate Perimenopausal and menopause. <u>Equity Update</u> Current equity projects consist of:		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	• Mobile Health Clinic and scheduling for accommodating members. • The WIC pilot program: goal is to increase enrollment. • Central Valley Fresno Foundation with the possibility in bringing all DEI personnel together at a round table to discuss equity and what that looks like, not only in health care, but the schools and the community. **Executive Report** <u>Executive Dashboard</u> Enrollment has increased to approximately 437,027. Market share increased in May, June and July. Regarding Information Technology, the Cybersecurity Assessment is scheduled for Calendar Year 2024. The average age of workstations is decreasing as older workstations are being updated. Regarding the Call Center and Website, Q2 2024 numbers are available. All areas met performance and goal. Efforts remain ongoing to allow members a self-service option to gain access to their Member ID Card through the CalViva Health Website. In reference to Provider Network Activities, management is awaiting an update from our Plan Administrator on Behavioral Health Reporting for Network Adequacy and Network Availability. Management is tracking new metrics performed by the Provider Relations Department. Regarding Claims Processing, and Provider Disputes, Q2 2024 numbers are not yet available. As stated during the Compliance presentation, CalViva Health received its NCQA Health Plan Accreditation. CalViva is now up and active on Instagram.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding Community Reinvestment, DHCS released a draft APL for public feedback. Medi-Cal Plans are reviewing the draft APL to assess its impact. Based on the draft, it most likely will have impacts on FKM RHA's Community Supports Program. Updates will be provided as appropriate. Regarding Proposition 35, related to the MCO tax, State Law prohibits public employees from participating in ballot measure campaigns during compensated work hours or from expending public resources for campaign purposes. With that said the Commission was presented that if there is an "ask" from the Board, or they feel strongly that CVH or FKM RHA should take an official position this is the time and place to have that discussion. Commissioner John Frye asked for a summary of Prop 35. If Prop 35 was to pass, it would increase funding to pay for Medi-Cal Health Care Services. It prohibits revenues from being used to replace existing Medi-Cal funding. It would make the MCO tax permanent from a State perspective, even though it needs federal approval every five years.		
#9 Final Comments from Commission Members and Staff	None.		
#10 Announcements	None.		
#11 Public Comment	None.		
#12 Adjourn	The meeting adjourned at 3:21pm. The next Commission meeting is scheduled for October 17, 2024, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

Meeting Location
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

July 18, 2024

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
	Paulo Soares		
✓	Joe Neves		
✓	Supervisor Rogers		
	John Frye		
✓	Rose Mary Rahn		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am, a quorum was present.		
#2 Finance Committee Minutes dated May 16, 2024 Attachment 2.A Action, D. Maychen, Chair	The minutes from the May 16, 2024, Finance meeting were approved as read.		Motion: *Minutes were approved* *5 – 0 – 0 – 2* *(Neves / Rahn)*
#3 Financials – as of May 31, 2024 Action D. Maychen, Chair	Total current assets recorded were approximately $454.5M; total current liabilities were approximately $304.7M. Current ratio is approximately 1.49. Total net equity as of the end of May 2024 was approximately $159.7M, which is approximately 890% above the minimum DMHC required TNE amount.		Motion: *Financials as of May 31, 2024, were approved* *5 – 0 – 0 – 2* *(Rogers / Neves)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	Interest income actual earned was approximately $7.6M, which is approximately $4.3M more than budgeted due to rates being higher than projected. Premium capitation income actual recorded was approximately $1.92B which is approximately $328.4M more than budgeted due to MCO taxes that DHCS paid the Plan related to FY 2023 in FY 2024, which accounts for approximately $125.5M, the remaining is related to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $52.8, which is approximately $5.3M more than budgeted due to enrollment being higher than budgeted. Taxes actual recorded was approximately $611.3M, which is approximately $125.5M more than budgeted due DHCS paying the Plan MCO taxes related to the prior fiscal year (FY 2023), in FY 2024. All other expense line items are in line or below what was budgeted. Net income through May 31, 2024, actual recorded was approximately $18.3M, which is approximately $10.2M more than budgeted primarily due to interest income being higher than projected by $4.3M, and rates and enrollment being higher than projected.		
#4 Announcements	None.		
#5 Adjourn	Meeting was adjourned at 11:36 am		

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission

Dated: 9-19-2024

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 9/19/24

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
July 18th, 2024

CalViva Health
7625 North Palm Avenue; Suite #109
Fresno, CA 93711
Attachment A

Committee Members in Attendance			CalViva Health Staff in Attendance
✓	**Patrick Marabella, M.D.**, Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Senior Director of Medical Management Services
	David Cardona, M.D., Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**Christian Faulkenberry-Miranda, M.D.,** Pediatrics, University of California, San Francisco	✓	**Sia Xiong-Lopez,** Equity Officer
✓	**Ana-Liza Pascual, M.D.,** Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group	✓	**Maria Sanchez**, Senior Compliance Manager
	Carolina Quezada, M.D., Internal Medicine/Pediatrics, Family Health Care Network	✓	**Patricia Gomez,** Senior Compliance Analyst
	Joel Ramirez, M.D., Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Nicole Foss, RN**, Medical Management Services Manager
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Zaman Jennaty, RN**, Senior Medical Management Nurse Analyst
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA (**Alternate)**	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	Guests/Speakers		
	None were in attendance.		

✓ = in attendance
* = Arrived late/left early
** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D Chair	The meeting was called to order at 10:34 am. A quorum was present. Dr. Marabella introduced Sia Xiong-Lopez, CVH Equity Officer, and Nicole Foss, CVH Medical Management Services Manager.	
#2 **Approve Consent Agenda** Committee Minutes: May 16, 2024	The May 16th, 2024, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member.	**Motion**: *Approve* Consent Agenda (Pascual/Waugh)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Specialty Referrals Report- HN (Q1) - Standing Referrals Report (Q1) - Provider Preventable Conditions (Q1) - County Relations Quarterly Update (Q1) - Initial Health Appointment Quarterly Audit Report (Q4 2023) - Enhanced Care Management and Community Supports Performance Report (Q1) - MedZed Care Management Report (Q1) - Evolent Report (NIA) (Q1) - SPD HRA Outreach Report (Q1) - TurningPoint Musculoskeletal Utilization Review (Q1) - Pharmacy Provider Update (Attachments A-L) **Action** Patrick Marabella, M.D Chair	A link for Medi-Cal Rx Contract Drug List was available for reference.	4-0-0-3
#3 **QI Business** - A&G Dashboard & Turnaround Time Report (May) (Attachments M) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through May 2024 were presented. Dr. Marabella explained how Members and providers submit grievances via phone, fax, email, or online, and each of these is categorized and reported on the dashboard and in other narrative reports. Each monthly Excel file includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. There was a total of 202 grievances received this month, an increase from 2023. • For May, most grievances (183) were Quality of Service (QOS) related: Twenty-nine (29) Access-Other mostly Prior Authorization delays, thirty-four (34) Administrative for prior	**Motion**: *Approve* - A&G Dashboard & Turnaround Time Report (May) (Pascual/Waugh) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	authorizations; and thirty-three (33) related to Balanced Billing. Fourteen (14) were Transportation Access with nine (9) provider no-shows, and there is a CAP in place with the transportation subcontractors to improve services. There were thirty-six (36) Quality of Care (QOC) grievances with thirteen (13) in the PCP Care category. QOC grievances are all reviewed by Dr. Marabella and scored based upon severity. Trends are monitored through the dashboard on a monthly basis. • Exempt Grievances are resolved over the phone within one (1) business day. They decreased in May compared to last month, except for Balanced Billing which increased. • For May, there were zero (0) Transportation Provider No-Shows reported under QOS and zero (0) late arrivals showing an improvement over Q1. • Forty-three (43) Total Standard Appeals for May with fourteen (14) cases related to Advanced Imaging (MRI, PET scans, cardiac imaging, etc.). • A new trend is noted this month for appeals associated with providers discontinuing contracted services with the members' assigned PPG and the attempt by the member to remain with that provider. This is associated with two PPGs in particular. • The ratio of upholds to overturns for May was 50% to 45% respectively. • Two (2) cases were out of compliance for turnaround time, both were Acknowledgement Letters for grievances in May.	
#3 **QI Business** - Behavioral Health Performance Indicator Report (Q1) (Attachment N) **Action** Patrick Marabella, M.D Chair	The **Behavioral Health Performance Indicator Report Q1** provides a summary of an array of indicators to evaluate the behavioral health services provided to CalViva members. The behavioral health potential quality issues, provider disputes, and network availability and adequacy metrics were previously included in this report but are now included in other reports as part of an organizational change that resulted in the integration of behavioral health into the Plan effective 01/01/2024: • Potential quality issues involving behavioral health are now included in the QI/UM#52 & ACCESS#17 reports • Behavioral health provider disputes are included in the MOM #4 Report • Behavioral health network availability, adequacy, and open practice performance are now included in various ACCESS reports prepared and presented by Provider Network Management, such as ACCESS#15. The QI/UM Committee currently receives these reports, or we receive reports from the Access	**Motion**: *Approve* - Behavioral Health Performance Indicator Report (Q1) (Waugh/Faulkenberry) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Workgroup on their content. In Q1 2024, 4 of the 5 metrics met or exceeded their targets. The non-ABA review timeliness metric that missed the 100% target at 97% exceeded the 95% threshold for corrective action. The target was missed due to one (1) non-ABA post-service review that missed the timeliness standard due to a Claims Department delay. This is the second quarter in a row that the non-ABA reviews compliance rate was above 95% but below 100%. • CalViva overall membership for Q1 was 436,836 (a 1.3 % increase from Q4 2023). • The Q1 2024 behavioral health utilization rate (# of unique members with at least one behavioral health claim) was 2% or approximately 8,700 members. (This metric has a 1-quarter lag.) • There were zero (0) Life-Threatening Emergent cases. • There were zero (0) Non-Life-Threatening Emergent cases. • There were two (2) Urgent cases.	
#3 **QI Business** - Facility Site & Medical Records and PARS Review Report (Q3-Q4 2023) (Attachment O) **Action** Patrick Marabella, M.D Chair	The **Facility Site & Medical Records and PARS Reviews (Q3-Q4 2022)** report displays completed activity and results of the DHCS-required PCP Facility Site (FSR) and Medical Record Reviews (MRR) in all CalViva counties using the New FSR/MRR tools and standards. The results of Physical Accessibility Review Survey (PARS) assessments of providers are also provided. The results are analyzed for monitoring and improving the performance of PCPs against DHCS and CalViva Health standards. • 18 FSRs and 18 MRRs were completed during the 3rd and 4th Quarters of 2023. o The FSR mean rate for Q3-Q4 2023 was 96%. o The MRR mean rate for Q3-Q4 2023 was 92%. ▪ The Adult Preventive Care mean score over all counties for Q3 & Q4 was 86%. ▪ The Pediatric Preventive Care mean score over all counties for Q3 & Q4 was 87%. • Interim Review is a DHCS-required monitoring activity to evaluate the PCP site between the 3-year periodic FSR cycle. In Q3 and Q4 2023, 19 interim reviews were completed in the three (3) CalViva counties. • There was one (1) "dirty office" complaint received which triggered a site visit. • Seven (7) PARS were completed with 3 of the 7 PARS having Basic level access. • CalViva completed the backlog of audits created by the public health emergency by the December 2023 DHCS deadline. Backlog completion has been reviewed and approved by	**Motion**: *Approve* - Facility Site & Medical Records and PARS Reviews (Q3-Q4 2023) (Faulkenberry/ Pascual) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	DHCS.	
#3 **QI Business** - Lead Screening Quarterly Report (Q4 2023) (Attachment P) **Action** Patrick Marabella, M.D Chair	The **Lead Screening Quarterly Report (Q4 2023)** is a Quarterly Assessment of Blood Lead Screening in Children compliance to ensure that CalViva members receive blood lead level testing and follow-up when indicated and that parents/caregivers receive anticipatory guidance related to blood lead poisoning prevention from providers. The Q4 2023 report provides CalViva Health's performance on blood lead level screenings and the provision of anticipatory guidance from Q1 2023 – Q4 2023. • In Q4 2023 the compliance for CPT Code 83655 (lead screening only) demonstrates a variation of approximately 4% compared to the Q3 2023 rates. The highest compliance increase is with the 6–17-month age group. The next steps include identifying high-volume, low-performing providers who are not conducting POC blood lead level screenings. • In Q4 2023 Anticipatory Guidance Code rates demonstrate slight variation but no significant improvement is noted. The next steps include working with Provider Engagement to educate targeted providers on the preferred method of documenting anticipatory guidance. • In Q3 2023, the Plan also began funding LeadCare II analyzers and test kits for providers who submitted a QI EDGE funding request. In 2023, a total of eight lead analyzers were funded. The next steps include establishing a process to order additional blood lead analyzers for providers who are high-volume and low-performing. • Barriers to improved compliance include: o Incorrect coding by providers. o Low point of care (POC) LSC testing in high-volume provider offices. o Members do not want to go to lab locations for services due to impeded processes and lacking transportation. o Members do not show up for scheduled appointments. o Providers need to establish workflow processes and obtain regulatory approval (waived testing) for capillary screening in their offices.	**Motion**: *Approve* - Lead Screening Quarterly Report (Q4 2023) (Faulkenberry/ Waugh) 4-0-0-3
#3 **QI Business** - CA Operations Oversight Audit of Call Center Inquiry Calls (Q1) (Attachment Q)	The **CA Operations Oversight Audit of Call Center Inquiry Calls (Q1)** report is conducted primarily to ensure all member expressions of dissatisfaction are properly identified and processed as grievances. The audit will focus on accurate grievance identification during inquiry calls and corrective action will be initiated when deficiencies are identified. This monthly audit will be conducted through a randomized sample of ten (10) inquiry call audio files evaluated against established criteria. If an individual audio file is not auditable or is otherwise unavailable, a	**Motion**: *Approve* - CA Operations Oversight Audit of Call Center Inquiry Calls (Q1)

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Action Patrick Marabella, M.D Chair	replacement sample will be selected for the audit. Both English and Spanish calls will be evaluated. • During Q1 2024, a total of thirty (30) cases were planned to be audited. However, ten (10) cases were identified as "incomplete" due to the caller interaction being conducted in Spanish and the auditor's inability to translate. These calls were not replaced. Going forward, bilingual auditors and selecting replacement cases will be utilized to ensure a complete sample of thirty (30) cases per quarter.	(Pascual/ Faulkenberry) 4-0-0-3
#4 **Key Presentations** - Care Management End-of-Year Evaluation & Executive Summary 2023 (Attachments R) **Action** Patrick Marabella, M.D Chair	The **Care Management Program Evaluation 2023 & Executive Summary** was presented and reviewed by the Committee. Care Management (CM) encompasses three main components: Physical Health (PH), Behavioral Health (BH), and Perinatal Wellness (PCM) with its purpose of achieving member wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. The goals of Care Management are to provide quality health care along a continuum, decrease fragmentation of care across settings, enhance the members' quality of life, and efficient utilization of patient care resources. <u>2023 Goals:</u> • Increase the number of cases managed. This goal was met with 3,571 cases in 2023 compared to 3,275 in 2022. Or 0.81% of the entire population managed in physical, behavioral, or perinatal case management. • Maintain Compliance of 90% for medical record documentation. This goal was also met with each program scoring 90% or greater on file reviews. • Graphic representation of case volumes by program demonstrated that PH and PCM cases increased in 2023, and BH cases decreased for all counties combined. <u>Audit Results:</u> • Quarterly results of Complex & Non-complex file reviews by program ranged from 90% - 100% for the following for PH, BH, and PCM: o Welcome letter sent to member and PCP o Calling PCP to discuss and request a plan of care from PCP o Sending PCP a copy of the care plan o Documentation of case closure discussed with the member & PCP/involved provider. <u>Outcomes Data:</u> • Readmission Rates declined for members enrolled in Care Management (90 days after enrollment) to 34.6% compared to 36.1% 90 days prior to enrollment. • ED Visit claims volume declined per 1000 members per year when 90 days after enrollment	**Motion**: *Approve* - Care Management End-of-Year Evaluation & Executive Summary 2023 (Pascual/Waugh) 4-0-0-3

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	was compared to 90 days prior to enrollment. • Inpatient and Outpatient Claims also decreased when evaluated pre and post-enrollment. However, Pharmacy Claims increased due to improved medication adherence with CM oversight, all reflecting improved patient outcomes. • High-risk OB members enrolled in CM saw a 5.1% increase in first prenatal visits in the 1st Trimester, a 4.5% decrease in Preterm deliveries, and a 3.7% increase in postpartum visits after delivery. • Of 31 responses to the 2023 Member Satisfaction Survey: o 90% positive response of Very satisfied/Satisfied. o 90% Satisfied with CM Program (met goal) o 96% Satisfied with the ability to reach their CM. o 92% Reported CM helped them to reach their health goals. o 96% Reported CM helped to organize care with MD and other caregivers. • The satisfaction survey response rate was noted to have declined in 2023 compared to 2022. Potential improvement strategies are under review. • Key Accomplishments 2023: o Successful coordination of CalAIM ECM member self-referrals o Successful CalAIM Community Supports referrals. o Enhanced Transitional Care Services (TCS) Program to Meet Population Health Management (PHM) Requirements including: ▪ Increased staffing ▪ Outreach to all high-risk inpatient members ▪ Created a TCS hotline for recent inpatient members with care coordination needs per DHCS requirements. • Goals for 2024 include: o Outreach to all Acute Inpatient Admissions o Increase member enrollment in the Transitional Care Services program: ▪ Utilize non-clinical staff on-site at hospitals to improve engagement. o Increase caseload per CM to 75 to align with goals. o Support CalAIM activities and prepare for additional Populations of Focus. o Support CalAIM Community Supports programs and increased offerings. o Manage more members across all CM Programs.	

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	There were no questions or comments from committee members.	
#4 **Key Presentations** - Health Disparities Analysis and Actions Report 2024 (Attachment S) **Action** Patrick Marabella, M.D Chair	The **Health Disparities Analysis and Actions Report 2024** presented demonstrates CalViva Health's commitment to supporting the health of our members and reducing health disparities across all membership. Health equity is incorporated throughout the organization, reflecting CalViva's commitment to transforming the health of the communities served. Health literacy, cultural competency, language services, health disparity reduction, and social drivers of health (SDoH) are integrated into programs to serve the diverse membership. The Health Equity Model designs programs to decrease barriers and increase quality care for our members by focusing on needs at the member, provider, and community levels: • Community o Prioritize, develop, and evaluate o SDoH interventions: Housing; Income; Nutrition; Care Coordination o Shared Funding Model o Community anchor o Targeted social marketing • Member o SDOH Data and integration o Training and toolkits o Incentives, outreach, and programs o Tailored Interventions o Enhance referrals and SDoH Discretionary funds o Member connections o Med management/LTSS • Provider o Process Mapping and Intervention Design o Provider dashboards o SDoH integration o SDoH data The Health Equity model process obtains input from stakeholders (members, community, and providers), researching disparity root causes, and developing informed tailored interventions: • Analyze Data o Use multiple data sources and Geo-mapping	Motion: *Approve* - Health Disparities Analysis and Actions Report 2024 (Pascual/ Faulkenberry) 4-0-0-3

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	○ Identify disparate populations, places, and providers • Research ○ Stakeholder interviews ○ Literature reviews ○ Best practices ○ Barrier analysis with SDoH Overlay • Design Initiatives ○ Use community and health plan coalitions ○ Target member, provider, and community levels for interventions • Implement and Evaluate ○ Establish programs/initiatives ○ Monitor progress ○ Evaluate goals and measures <u>CalViva (CVH) must first understand the population it serves by:</u> • Capturing valid and reliable data. • Designing Data systems and Interfaces to accurately collect, capture, and code member demographic data. • Ensuring accurate and reliable demographic data that includes race, ethnicity, language (REaL), sexual orientation, and gender identity (SOGI). • Using a Disparities Dashboard, that allows data to be segmented by gender, race, ethnicity, housing status, health conditions, and geography. The Disparities Dashboard is: ○ An interactive table of HEDIS®measure compliance rates, 95% confidence interval of compliance rates, and national 50% benchmarks, by measures, products, and segments. ○ Visualization of compliance rates by measures, products, or segments. ○ Interactive map of non-compliant members. ***Discussion:*** *Mary Lourdes Leone asked if the Dashboard uses CVH data.* *Dr. Marabella stated it is CVH data.* CVH Health Gap Disparity Analysis looks at Race/Ethnicity/Language and Gender data from Fresno, Kings, and Madera Counties. Statistically significant differences are identified by the following	

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	HEDIS® measures: Pediatric and Perinatal Measures, Colorectal Cancer Screening, Chronic Conditions, and Behavioral Health. <u>Two high priority Health Disparity Projects were established from the Annual Analysis:</u> 1. Through the **Disparity Leadership Program (DLP)**, sponsored by Massachusetts General Hospital, a team engaged in a project to **Improve HbA1c for members who have not completed a test or are at risk of becoming diabetic.** Barrier Analysis: o Fresno Census tract analysis identified major food deserts with low-income individuals. o Literature review confirmed that although members understand that diet and exercise contribute to control of their diabetes, they don't understand how to implement that into their lives. Intervention (Cooking Matters®): o Enroll members into a 6-session healthy cooking class. o Provide free resources to access free to low-cost fresh produce delivery o $50 gift card for completing 4 of 6 classes. o At the end of each class session each member received a box of food. Evaluation/Impact: o Compared HbA1c levels before and after the class. o 30 members attended at least one (1) class o 21 members attended 4 of 6 classes ▪ 15 class members had no change to HbA1c or were not part of the measure ▪ 6 class members had a statistical change in their HbA1c results. Lessons Learned/Future Plans: o Separate classrooms into English and Spanish. Both languages and cultures in the same room were difficult. o Ensure culturally tailored menus. o Avoid obtaining HbA1c results in December. Test timing may have impacted results. 2. The **California Department of Health Care Services (DHCS)** is requiring CalViva to focus on **Improving Infant Well-Care Visits in the Black or African American population** for the 2023 to 2026 Clinical Performance Improvement Project (PIP). Barrier Analysis focus Black/AA: o Lack of Black/AA providers	

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	○ Transportation ○ Inability to take time off work ○ Communication challenges ○ Mistrust ○ SDoH - Housing and food insecurity Intervention: ○ Work with Black Infant Health (BIH) to address key barriers through Case Management. ○ Share a list of members non-compliant with WCV, and CIS-10 with BIH monthly to outreach to members. ○ Work with providers to encourage birthing parent engagement with BIH. Evaluation/Impact: ○ Results pending. ○ Three-year project, the first evaluation of data will be Sept 2024.	
#4 **Key Presentations** - Continuity & Coordination of Medical Care Report 2024 (Attachments T) **Action** Patrick Marabella, M.D Chair	The **Continuity & Coordination of Medical Care Report 2024** was presented to provide strategies used to monitor aspects of continuity and coordination of medical care. The goal of these efforts is to reduce miscommunication and gaps in care coordination, which will help minimize errors, improve patient safety, and enhance continuity in the healthcare system. CalViva members will benefit from these actions initiated to enhance care coordination. • Measure #1 Timeliness of Postpartum Care (HEDIS® measure) met the goal of 77.37% (MPL-minimum performance level) in all three CVH counties. • Measure #2 Eye Exam for Patients with Diabetes (HEDIS® measure) met the goal of 51.09% (MPL) in all three CVH Counties. • Measure #3 Pharmacotherapy for Opioid Use Disorder (HEDIS® measure) did not meet the goal of 28.5% (MPL) in any CVH Counties. Barriers Include: ○ Lack of coordinated communication about opioid prescriptions among prescribers ○ Members don't fully understand the risks of over-using opioids Opportunity for Improvement: ○ Proactively identify high-use members and send provider/provider groups opioid high-utilization reports. ○ Educate members with pharmacy outreach calls.	Motion: *Approve* - Continuity & Coordination of Medical Care Report 2024 (Waugh/Faulkenberry) 4-0-0-3

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	○ Develop educational materials for members. ○ Distribute educational materials to providers to share with members. • Measure #4 Plan All-Cause Readmissions (HEDIS® measure) met the goal of 0.996% (MPL) in Fresno and Madera Counties. Kings County did not meet the goal. Barriers Include: ○ Lack of formal hand-off process between hospitals, providers, and Plans. ○ Member is discharged from an acute care facility and MD doesn't follow up to do medication reconciliation. Opportunity for Improvement: ○ Member/provider/specialist education regarding sharing of information and communication with the health plan. This allows the Plan to make early contact with members and connect them to resources and support after discharge. ○ Conduct post-discharge phone calls to assess patient condition and medication understanding. Reconcile medications on hospital discharge instructions with outpatient medications.	
#5 **UM/CM Business** - Key Indicator & TAT Report (May) - UM Report – Top 10 Inpatient Diagnoses MY2023 - Case Management & CCM Report (Q1) - Medical Policies (Q2) - Clinical Practice Guidelines (Attachments U-Y) **Action** Patrick Marabella, M.D Chair	The **Key Indicator Report and Turn Around Time Report** through May were presented. • Overall, Membership demonstrated a slight increase but has leveled off. Utilization has remained consistent or increased slightly over the previous months (TANF & MCE). SPD utilization remains low. • Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for TANF, MCE, and SPDs remain consistent in recent months with the following exceptions: ○ For Bed Days (adjusted PTMPY), SPDs show a steady decline month over month. • Case Management results remained robust in most categories. Behavioral Health referrals have nearly doubled for May. • The new First Year of Life program aims to transition members from the Perinatal program into the First Year Program after delivery, with an emphasis on Well-Child visits, immunizations, and other preventive health measures. However, both referrals and engagement declined in May. • Turnaround Times were not met for two (2) cases in May: ○ Pre-service Urgent – One out of fifty (50) cases did not meet the decision turnaround time. This case was related to case handling for holidays and weekends. Education provided for staff involved.	Motion: *Approve* - Key Indicator & TAT Report (May) - UM Report – Top 10 Inpatient Diagnoses MY2023 - Case Management & CCM Report (Q1) - Medical Policies (Q2) - Clinical Practice Guidelines (Pascual/ Faulkenberry) 4-0-0-3

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	○ Pre-service Routine Deferrals – One out of fifty (50) cases missed the deferral decision turnaround time. The case was canceled in error. The associate responsible for the incorrect processing is no longer with the organization. However, a reminder has been issued to the team to ensure a thorough review of PA forms in the future. The **UM Top 10 Diagnoses Report 2023** provides an annual evaluation of the hospital admissions per one thousand (Adm/k), bed days per one thousand (Days/k), and average length of stay (ALOS) for the top 10 diagnoses, among the TANF (Temporary Assistance for Needy Families), SPD (Seniors and Persons with Disabilities), and MCE (Medicaid Covered Expansion) populations (excluding pregnancy-related diagnoses). Identification of utilization trends provides a source from which to establish opportunities for collaboration and outcome improvement. Trends noted for CalViva Top 10 Diagnoses in 2022 compared to 2023 (Table 1) include: • Sepsis continued to rank as the number one non-pregnancy-related diagnosis in 2023. • COVID-19 moved from #3 in 2022 to rank #17 in 2023. • Asthma dropped from rank #9 in 2022 to rank #15 in 2023. • Cerebral infarction moved up to #8 in 2023 from rank #11 in 2022 and other fluid, electrolyte, and acid-base balance disorders moved up to #9 in 2023 compared to rank #14 in 2022. All CalViva Top Diagnoses Year Over Year (Table 2) • Other sepsis diagnoses and Type 2 diabetes mellitus remain the top 2 diagnoses respectively. • Cardiac-related diagnoses (hypertensive heart disease, hypertensive heart and chronic kidney disease, and cerebral infarction) increased in admissions and Bed days in 2023. • Respiratory diagnoses (respiratory failure, COVID-19, and asthma) decreased in admissions, days, and average length of stay (ALOS) in 2023. SPD • Pneumonia and Acute myocardial infarction were added to the top 10 in 2023 whereas COVID-19 and Respiratory failure fell out of the top 10 diagnoses from 2022. TANF • COVID-19 diagnoses fell out of the top 10 and metabolic disorders were added in 2023. The **Case Management and CCM Report** for Q1 was presented to provide an overview of Physical Health Care Management (PH CM), Transitional Care Services (TCS), Behavioral Health Care Management (BH CM), Perinatal (PCM), and First Year of Life activities. This includes referral	

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	volume, member engagement, and an evaluation of Program effectiveness. • From Q4 to Q1, Physical Health (PH CM) referral volume increased by 90% (407 to 777 respectively), TCS referrals increased by 2.4% to 702, Behavioral Health Care Management (BH CM) referral volume increased 131% to 241, Perinatal (PCM) referrals increased 51% to 683, and First Year of Life referrals increased by 47%. • Total Cases Managed also increased in PH CM, BH CM, PCM, and First Year of Life in Q1 2024. • Physical and BH Outcomes Post enrollment: o Readmissions decreased 1.5%. o ED claims per 1,000 members per year decreased by 738 (25.6% for the second half of 2023). • Perinatal Outcomes demonstrated increases in compliance rates for prenatal and postpartum visits and decreased pre-term deliveries for high-risk members. The **Medical Policies** (Q2) were presented to the committee. Dr. Marabella recommended that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback. Medical Policies are compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. Updated policies for April and May 2024 include but are not limited to: • CP.MP.176 – Cardiac Rehabilitation, Outpatient • CP.MP.145 – Electric Tumor Treatment Fields • CP.MP.106 – Endometrial Ablation • CP.MP.209 – Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing • CP.MP.121 – Homocysteine Testing • CP.MP.180 – Implantable Hypoglossal Nerve Stimulation • CP.MP.69 – Intensity Modulated Radiotherapy • CP.MP.57 – Lung Transplantation • CP.MP.246 – Pediatric Kidney Transplant • CP.MP.146 – Sclerotherapy and Chemical Endovenous Ablation for Varicose Veins • CP.MP.37 – Bariatric Surgery • CP.BH.201 – Deep Transcranial Magnetic Stimulation for Obsessive Compulsive Disorder	

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	• CP.MP.185 – Skin and Soft Tissue Substitutes for Chronic Wounds • CP.BH.200 – Transcranial Magnetic Stimulation for Treatment-Resistant Major Depression Clinical Practice Guidelines Updates can be referenced on the tables on pages 3-5 of the May Provider Update. Genetic Testing Policy Updates can be referenced on the tables on pages 5-6 of the May Provider Update. The **Clinical Practice Guidelines** were presented and reviewed by the Committee. HN adopts guidelines from Centene's National organization and then CalViva reviews, provides feedback, or asks questions about new guidelines or changes to existing guidelines. The links to each guideline are listed in the attachment and are also available on the provider portal. No concerns or questions were raised after review and the clinical practice guidelines were adopted for CalViva Health.	
#6 **Policy & Procedure Business** - Quality Improvement Policy & Procedure Annual Review (Attachments Z) **Action** Patrick Marabella, M.D Chair	The **Quality Improvement Policy & Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with no changes made: • QI-006 Annual HEDIS Production and Reporting • QI-010 Medical Records Documentation Standards The following policies were presented for annual review and were approved with the following changes: • QI-005 Medi-Cal Quality & Performance Improvement Program Requirements: Updated policy name. Updated Quality Monitoring Performance tiers and triggers. Revisions were made to be compliant with APL 24-004. The full policy with edits was provided to committee members for review. • QI-007 Health Equity Quality Review and Engagement Strategies: Updated authority. • QI-008 Data Collection and Disparity Analysis: Added SOGI definition and data collection procedure. • QI-011 Medi-Cal PCP Facility Site Medical Record Review: Updated definitions section. • QI-012 Physical Accessibility Review Survey: Added PARS reassessment timeline and updated reference.	Motion: *Approve* - Quality Improvement Policy & Procedure Annual Review (Waugh/Pascual) 4-0-0-3

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	• QI-013 Medical Record Confidentiality & Release of Information: Updated definitions and authority sections. • QI-014 Potential Quality Issues (PQI) Management Process: Added definitions for CQS and Behavioral Health Medical Director role. Updated Attachment A. • QI-017 Provider Preventable Conditions Program: Updated definitions section and PPC reporting form. • QI-018 Initial Health Appointment (IHA): Added provisions for members less than 21 years of age. Added information for Provider online report access to identify members with incomplete IHA. • QI-019 Childhood Blood Lead Screening: Updated reporting limits, authority, and requirements.	
#7 **Oversight Audits** - Continuity of Care 2023 - Emergency Services 2023 (Attachment AA-BB) **Action** Patrick Marabella, M.D Chair	The **Continuity of Care Oversight Audit 2023** of Health Net Community Solutions (HNCS) Continuity of Care functions for CalViva Health were presented and reviewed. The audit review period was Jan. 1, 2021, through Dec. 31, 2022. HNCS provided several policies and procedures, documents, and reports as evidence of compliance with established standards and regulations for both Health Net and MHN (behavioral health). Evidence was provided to demonstrate compliance with policies and procedures for Continuity of Care (COC) and Transition of Care (TOC) including call logs and monitoring and tracking reports for TOC, COC, and Out of Network services provided. Additionally, we reviewed a sample of COC and TOC cases from the audit period with 100% noted with audit criteria. • Continuity of Care (COC) 7/7 compliant (six (6) denials and one (1) approval from HealthNet and MHN) • Transitions of Care (TOC) 8/8 compliant (Sample of thirty (30) cases requested with 100% compliance in first eight (8) cases) Based upon review of these documents and communication with appropriate HNCS staff CalViva Health observed 100% compliance with this function. Potential enhancements: None at this time. The **Emergency Access to Services Oversight Audit 2023** of Health Net Community Solutions (HNCS) Emergency Services Access function. Policies and procedures, documents, and reports were reviewed as evidence of compliance with established standards and regulations. One way to assess the implementation of the post-stabilization policy and procedure is through a review of medical	Motion: *Approve* - Continuity of Care 2023 - Emergency Services 2023 (Faulkenberry/Waugh) 4-0-0-3

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	records. Per standard 2A-5, a log of post-stabilization denial cases was requested. However, HNCS was unable to provide this log since the post-stabilization process was on temporary hold due to the COVID-19 Public Health Emergency. There were no post-stabilization denials available for review due to this hold. Therefore, the updated policy and procedure were reviewed and determined to be consistent with the new All Plan Letter 22-011 published by DHCS in October 2022. File review will be performed during the next annual audit. Standard 3A relating to the Plan's policies and procedures specifying that providers are reimbursed for emergency services, the policy provided by Health Net met all standards except, "The Plan provides evidence that policy contains a statement regarding misdirected claims". This element was not addressed within the policy. For standard 4A-2, there were 56,224 medical screening exams identified with denial of payment for a variety of reasons during the audit period. An initial evaluation of this data, completed by Medical Management and Finance staff, showed none of the cases were identified via RA code to have been denied for medical necessity. A representative sample of seventeen (17) cases was selected to audit for Medical Screening Exam denials identified during this audit period to confirm the appropriateness of documentation. These cases were denied for appropriate reasons per CalViva Finance staff. For standard SA-2, which requires the plan to provide all necessary health plan-specific information to non-contracting hospitals to facilitate member transfers, it was noted that appropriate information was prepared in the form of a written notification for non-contracting facilities in California. However, a comparison of the list of hospitals that received the letter (72) with the total list of contracting and non-contracting hospitals in the state (235) revealed a discrepancy. Consequently, this element did not meet compliance standards. Based on the review of all documents and ongoing communication with HNCS staff, CVH observed 87.5% compliance with the assessable standards per policy and other documentation provided. In response to the DMHC 2022 audit findings, CalViva will implement corrective actions as directed and reassess compliance during the next annual oversight audit. A corrective action plan is required. <u>Potential Enhancements/Discretionary Recommendations:</u> Recommend that Medical Management staff ensure that a process to identify/track details of Post stabilization cases where the process was initiated by out-of-network hospitals is established to allow CalViva to assess compliance with	

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	all elements associated with the post-stabilization policy and procedure and state and federal regulations.	
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report Q2 (Attachments CC) Action Patrick Marabella, M.D Chair	The **Credentialing Sub-Committee Quarterly Report** was presented. The Credentialing Sub-Committee met on May 16, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. • Corrected versions of the Q1 to Q4 2023 Health Net Credentialing reports were reviewed and approved at the May meeting. A reporting error was discovered and corrected related to computer parameter settings that were incorrectly identifying practitioners for initial and recredentialing activities for these reports. • The **Credentialing Adverse Actions** report for Q1 for CalViva from HealthNet Credentialing Committee was presented. There were two (2) cases presented for discussion. Both cases remain open and are subject to semiannual monitoring to continue through the completion of probation. • The **Adverse Events Q1 2024** report was reviewed. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o Credentialing submitted zero (0) cases to the Credentialing Committee in the first quarter of 2024. o There were no (0) reconsiderations or fair hearings during the first quarter of 2024. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the first quarter of 2024. o There were zero cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in the first quarter of 2024. • The **Access & Availability Substantial Harm Report Q1 2024** was presented and reviewed. This report aims to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked on severity level. o After a thorough review of all first quarter 2024 PQI/QOC cases, the Credentialing Department identified zero new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).	Motion: *Approve* - Credentialing Subcommittee Report Q2 (Faulkenberry/Waugh) 4-0-0-3

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	• The **2024 Credentialing Oversight Audit Results** of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function were presented and reviewed. The audit review period was Jan. 1, 2023, through Dec. 31, 2023. The audit was conducted from Dec. 2023 through April 2024. o A total of one-hundred-and-seventy-four (174) practitioner & organizational provider files were reviewed for this audit. o Issues with timeliness were noted for attestations in the Recredentialing files for one PPG which will require corrective action. Additionally, the timeliness of the Re-Credentialing cycle to occur within thirty-six (36) months for all practitioners for HealthNet will also require corrective action. These two items must pass at 100% or corrective action is required. • The 2023 Credentialing Sub-committee Charter was reviewed for annual approval. There we no edits to the Charter.	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q2 (Attachment DD) Action Patrick Marabella, M.D Chair	**Peer Review Sub-Committee Quarterly Report** was presented. The Peer Review Sub-Committee met on May 16, 2024. • The county-specific **Peer Review Sub-Committee Summary Reports for Q1** were reviewed for approval. No significant cases to report. • The **Q1 2024 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o There were seven (7) cases identified in Q1 2024 that met the criteria and were reported to the Peer Review Committee. ▪ Three (3) cases involved a practitioner, and four (4) cases involved organizational providers (facilities). ▪ Of the seven (7) cases, three (3) were tabled, one (1) was closed with a letter of education, and three (3) were closed to track and trend. ▪ Six (6) cases were quality of care grievances, one was a potential quality issue, zero (0) were lower-level cases, and zero were track and trend. ▪ Two cases involved seniors and persons with disabilities (SPDs). o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2024. o There were two (2) cases identified outside of the ongoing monitoring process this	Motion: Approve - Peer Review Subcommittee Report Q2 (Faulkenberry/Waugh) 4-0-0-3

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	quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) o There were seventeen (17) cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. • The **Access & Availability Substantial Harm Report for Q1 2024** was also presented. This is a new report for the Peer Review Committee. This report aims to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability issues and they are ranked by severity level. o Thirteen (13) cases were submitted to the Peer Review Committee in Q1 2024. There were zero (0) incidents found involving appointment availability issues resulting in substantial harm to a member or members. Two (2) cases were determined to be related to significant harm without appointment availability issues. • The **Q1 Peer Count Report** was presented at the meeting with a total of thirteen (13) cases reviewed. Six (6) cases were closed and cleared. No (0) cases were closed/terminated. Four (4) cases are tabled for further information. There were two (2) cases with CAP outstanding and one (1) was pending closure for CAP compliance. • The 2024 Peer Review Sub-committee Charter was reviewed for annual approval. There we no edits to the Charter. Follow-up was initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue.	
#9 **Access Business** - Access Workgroup Minutes 03/26/2024 - Access Workgroup Quarterly Report (Q2) (Attachment EE-FF)	**Access Work Group Minutes from 03/26/2024** were presented and reviewed. The list of reports that the Access Work Group routinely reviews was presented and key reports were presented with additional detail to the QU/IM Committee in the **Access Work Group Quarterly Report (Q2).** The **Access Work Group Quarterly Report (Q2)** was presented and reviewed. This report is to provide the RHA Commission and QI/UM Committee with an update on the CalViva Health Access Workgroup activities in Quarter 2 2024. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions.	Motion: *Approve* - Access Workgroup Minutes 03/26/2024 - Access Workgroup Quarterly Report (Q2) (Pascual/Waugh)

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Action Patrick Marabella, M.D Chair	The following are some of the key standing reports/matters approved and discussed: • **Network Adequacy Report (Q4 2023)** - This report measures geographic distribution standards for member distance and drive times to PCPs / Specialists in accordance to DMHC and DHCS standards. The DMHC standard is 100% for PCPs and the internal standard of 90% for specialists is set by the Plan to meet "reasonable" access requirements by the DMHC. DHCS PCP analyses are separately assessed according to Adult and Pediatric specialties, and by "core specialties" by county. The DHCS standard is 100% for PCPs and defined core specialists. Alternative access is requested when the standard is not met. The Q4 2023 analysis indicated the following. **DMHC Analysis:** o PCP standard was not met in Fresno and Madera Counties. Alternative Access was previously requested through the 2023 DMHC Material Modification process [approved 12/20/23]. o Specialties by Combined Counties: All specialties in all counties met the internal standard of 90%. o Specialties by County: All specialties in Fresno and Madera Counties met the internal standard. However, Anesthesiology, Cardiovascular Surgery, Geneticists, HIV/AIDS, Maternal/Fetal Medicine, and Neonatology specialties are below the standard in Kings County. **DHCS Analysis:** o PCPS o Adult PCP: The DHCS standard was not met in Fresno and Madera Counties. Kings County met the standard. o Pediatric PCP: The DHCS standard was not met in Fresno and Madera Counties. Kings County met the standards. o Pediatric Specialties: o Fresno: All pediatric specialties did not meet the access standard. o Kings: Fourteen pediatric specialties met standard. Two pediatric specialties of HIV/AIDS Spec/Infectious Disease and Ophthalmology did not meet the standard. o Madera: All pediatric specialties except for Psychiatry in Madera County met	4-0-0-3

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	the standard. o Alternative Access was requested through the 2022 Annual Network Certification. [AAS approved in March 2023]. • **NCQA Reports:** The following five new NCQA-required reports were presented and approved: o Primary Care NCQA Integrated Accessibility Report (MY 2022) o Behavioral Health NCQA Integrated Accessibility Report (MY 2022) o Specialty Care NCQA Integrated Accessibility Report (MY 2022) o Behavioral Health NCQA Network Adequacy Report (MY 2022) o NCQA Quality and Accuracy of CalViva Member Calls (MY 2023) o Physician Directory Accuracy Report (MY 2023)	
#10 **Compliance Update** - Compliance Regulatory Report (Attachment GG)	Mary Lourdes Leone presented the **Compliance Report.** **CalViva Health Oversight Activities: Health Net:** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings, and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG-level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits**. The following annual audits are in progress UMCM, Marketing, Provider Network, Claims/PDR, Health Equity, Privacy and Security, and Member Rights. No audits have been completed since the last Commission report. **Fraud, Waste & Abuse Activity.** Since the 5/16/24 report to the QI Committee, there have been three (3) new MC609 cases filed that involved: 1) A participating provider specializing in home health services was referred by DHCS for possible Kick Back Scheme; 2) A participating provider specializing in Applied Behavior Analysis (ABA) services regarding concerns of billing for services not rendered; and 3) A non-participating provider specializing in hospice services due to concerns for members receiving hospice services for greater than six months. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** In response to the 2022 DMHC Final Audit Report findings, the Plan issued CAPS to Health Net for failing to identify PQIs in	

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	exempt grievances and inappropriately denying post-stabilization care. The CAPs were issued on 6/11/24 and 6/17/24, respectively. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation.** On 6/18/24, the Plan received DHCS's Preliminary Final Report for the 2023 Focused Audit pertaining to Behavioral Health and Transportation. An exit conference to discuss the findings was held with DHCS on 6/25/24. The Preliminary Report listed nine (9) deficiencies: four (4) for Behavioral Health and five (5) for Transportation. The Plan formally responded to DHCS stating that we disagreed with all four (4) of the Behavioral Health findings and provided documents to support our rationale. The Plan also disagreed with three (3) of the five (5) Transportation findings and provided support for our rationale. The two (2) Transportation findings with which the Plan agreed were related to 1) not ensuring that a copy of the Physician Certification Statement (PCS) form was on file for all members receiving NEMT services, and 2) not ensuring its transportation delegate, ModivCare, provided the appropriate level of service for members requiring ambulatory door-to-door service. The Plan will issue corrective actions to Health Net to remediate these two findings while we await DHCS' decision on our rebuttal of the other findings. **Department of Health Care Services ("DHCS") 2024 Medical Audit.** DHCS held a Closing Session for the audit on 5/31/2024 and the Plan anticipates receiving the Preliminary Report in mid-August at the time of the Exit Conference. **2024 Network Adequacy Validation (NAV) Audit.** DHCS' external auditor, Health Systems Advisory Group (HSAG), conducted the first annual Network Adequacy Validation (NAV) audit on 6/18/24. Interview questions were based on information provided to HSAG on 5/15/24. The virtual audit went well, and we are awaiting an official response from HSAG. **California Advancing and Innovating Medi-Cal (CalAIM)** • **Community Supports (CS):** On 6/19/2024 DHCS approved the Community Supports MOC submitted on 1/29/24 for those services going live 7/1/24 [Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County]. On 7/1/24, the Plan updated its CS Final Elections to indicate that the following CS would be going live 1/1/25: o Recuperative Care (Medical Respite) – Kings County	

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	○ Recuperative Care (Medical Respite) -- Madera County ○ Short-Term Post-Hospitalization Housing – Madera County ○ Sobering Centers – Madera County **Long-Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities:** Phase II Network Readiness deliverables (i.e., additional attempts to contract and execute contracts) were submitted on 6/28/24. The Plan is awaiting approval. **Memorandum of Understanding (MOU):** DHCS requires each MCP to submit quarterly updates on the status of the multi-party MOUs with third-party entities (LGAs, LEAs, LHDs, and other MCPs in the county). The Q2 2024 status report is due 7/31/2024. **Annual Network Certifications:** • **2023 Subnetwork Certification (SNC)** – On 7/3/24, DHCS requested the Plan to submit quarterly updates on the status of all CAPs the Plan previously issued to PPGs for not meeting time & distance standards in their networks. The Plan submitted its response on 7/9/2024. • **2023 Annual Network Certification (ANC)** – The Plan is still awaiting DHCS' response to the Alternate Access Standards request that was submitted on 3/25/24. **Timely Access and Annual Network Reporting (TAR):** • **RY 2023 MY 2022**- DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan's response is due to the DMHC by September 9, 2024. **NCQA Plan Accreditation:** The NCQA Closing Conference was held on 6/24/24. On 7/1/24, the Plan received NCQA's Preliminary Plan Accreditation Score Report which indicated we had passed all categorical requirements (100%). We are just awaiting the Final NCQA Accreditation status to be determined. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2024. **Public Policy Committee (PPC):** The Public Policy Committee meeting was on June 5, 2024. The items presented were the Health Education Work Plan, Appeals and Grievance Report, Health Equity Work Plan and Program Description, and the Public Policy Charter. Dr. Marabella gave an	

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	overview of the A&G Dashboard, noting certain types of grievances reported, and that the total number of grievances in 2023 increased from 2022, however, the membership volume also increased in 2023. The next Public Policy Committee meeting will be held September 4, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	
#11 **Old Business**	None.	
#12 **Announcements**	Next meeting is September 19th, 2024.	
#13 **Public Comment**	None.	
#14 **Adjourn**	Meeting adjourned at 12:25 p.m.	

NEXT MEETING: September 19th, 2024

Submitted this Day: September 19th, 2024

Submitted by: Amy Schneider RN

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

X

Patrick Marabella, MD Committee Chair

Public Policy Committee
Meeting Minutes
June 5, 2024

CalViva Health
7625 N. Palm Ave. #109
Fresno, CA 93711

Committee Members			Community Base Organizations (Alternates)
✓	Joe Neves, Chairman	✓*	Jeff Garner, KCAO
✓	David Phillips, Provider Representative	✓	Roberto Garcia, Self Help
✓	Martha Miranda, Kings County Representative		**Staff Members**
	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations & Marketing
	Kristi Hernandez, Fresno County Representative	✓	Cheryl Hurley, Commission Clerk / Director, HR /Office
✓	Maria Arreola, At-Large Representative	✓	Mary Lourdes Leone, Chief Compliance Officer
✓	Norma Mendoza, Madera County Representative	✓	Steven Si, Compliance Manager
			Jeff Nkansah, CEO
		✓	Maria Sanchez, Senior Compliance Manager
		✓	Patrick Marabella, MD, CMO
		✓	Amy Schneider, RN, Senior Director, Medical Management
		✓	Sia Xiong-Lopez, Equity Officer
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:30 am. A quorum was present.		
#2 Meeting Minutes from March 6, 2024 **Action** Joe Neves, Chair	The March 6, 2024, meeting minutes were reviewed and approved. *Jeff Garner arrived at 11:34 am; not included in vote* Courtney Shapiro introduced Sia Xiong-Lopez, CalViva Health's new Equity Officer.		**Motion:** Approve March 6, 2024, Minutes 6-0-0-3 (R. Garcia / D. Phillips)

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#3 Enrollment Dashboard **Information** Maria Sanchez, Compliance Manager	Maria Sanchez presented the enrollment dashboard through March 2024. Membership as of March 31, 2024, was 435,626. CalViva Health maintains a 66.83% market share.		**No Motion**
#4 Health Education **2023 Year-End Evaluation Summary** **2024 Work Plan** **Information** Steven Si	<u>2023 Summary Work Plan Evaluation</u> The 2023 Health Education Work Plan consisted of 15 initiatives with 40 measurable objectives (there are multiple objectives within each initiative). Of the 40 measurable objectives: • 25 were attained as of the end of the year • 1 is partially attained as of the end of the year • 7 were attained and did not meet the measurable objective as of the end of the year • 2 were suspended given the Quality Department's quadrant analysis • 5 were canceled Accomplishments included: • 177 members enrolled in the Central California Asthma Collaborative in-home visitation program and 141 members completed the 12-month program. • 524 members attended 81 virtual and in-person Breast Cancer Screening/Cervical Cancer Screening classes. • 226 charlas with a 68% member participation rate. • Promotores Health Network conducted in-person and virtual classes on bailoterapia (physical activity), walking club, literacy club, and health education topics such as: A1C Diabetes, Vaccination, Cervical Cancer, and Cholesterol. • 364 members enrolled in myStrength. • 1,276 members enrolled in the pregnancy program. Barriers were:		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Tobacco Cessation Program Email promotion, Chronic Disease Education Asthma email and mailing campaigns were canceled because they have limited impact and are resource intensive. • Low enrollment for Obesity Prevention. • Outreach campaigns to promote new DPP delayed as implementation is contingent upon submission to DHCS and approval of the program. <u>2024 Health Education Work Plan</u> Focus areas for 2024 Health Education Programs are: • Continue onboarding process with new proposed vendor for the Diabetes Prevention Program. Submit application to DHCS. • Continue "charlas" and engagement with other stakeholders. • Continue to promote mental/behavioral health resources to members by way of providers and digital QR codes. • Continue promotion of BCS and CCS screenings via Every Woman Counts. • Continue enrollment of members in the CalViva Pregnancy Program. • Re-evaluate opportunities for Fit Families for Life and Healthy Habits Healthy People programs (obesity prevention) to increase access to available resources. • Continue promotion of the Kick It California program. Partnering with health plans to determine if a submission of the Tobacco Cessation Nicotine Replacement Therapy kits pilot project with Kick It California will be made. • Implement Fluvention education activities to encourage the promotion of Flu vaccinations during patient visits. • Collaborate with Marketing to update health educational resources as needed and increase member and provider promotion of the Krames online resources.		
#5 Appeals, Grievances and Complaints **Information** Maria Sanchez Dr. Marabella, CMO	For Q1 2024 there was one (1) Coverage Dispute (Appeals), 77 Disputes Involving Medical Necessity (Appeals), 48 Quality of Care, 110 Access to Care, and 289 Quality of Service, for a total of 525 appeals and grievances for Q1. The majority of which are from Fresno County.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	There were 58 appeal cases for Fresno County, 1 for Kings County, and 16 for Madera County, for a total of 75 for Q1 2024. There were 379 grievances cases for Fresno County, 29 for Kings County, and 40 for Madera County for a total of 448 for Q1 2024. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for Standard Grievances, Expedited Grievances, Standard Appeals and Expedited appeals. There was a total of 457 Exempt Grievances received in Q1 2024. Of the total grievances and appeals received in Q1, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 84 • Appeals: 14 • Exempt: 20 The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment). The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Other, Administrative, and Other. The majority of quality of care (QOC) cases were categorized as Other, PCP Care, and Specialist Care. The top categories of appeal cases were related to Advanced Imaging, Other, and DME. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received. Dr. Marabella presented the Appeals & Grievances Dashboard for Q1 2024. The total of grievances for Q1, as stated, was 448 which is consistent with previous year Q1 2023. The majority of grievances are Quality of Service, having to do with prior authorizations, administrative, phone calls, and balanced billing. The Plan is working on the balanced billing	*Martha Miranda asked if a member sees a physician out of town, does the member have to pay? And who can help a member find a doctor that CVH will cover?* *Dr. Marabella clarified that if the physician is "out of network" then the member would have to see a physician that is In network. CalViva Health members should not have to pay for services; unless it is a service that the Plan does not cover (i.e. elective plastic surgery/cosmetic). Members can contact Member Services for*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	issue as a lot of the issues stem from member ID cards, and physicians switching to different provider groups which causes billing issues. Transportation remains an issue; however, has improved slightly from same time last year. Exempt grievances remain consistent with same time last year Q1 2023. Appeals for Q1 2024 remain stable when compared with Q1 2023. The majority of pre-service appeals were Advanced Imaging and is showing an improvement as the numbers have decline when compared with Q1 2023.	*assistance with finding a physician in the CVH network.* *Amy Schneider confirmed if the member has a prior authorization for a physician outside of the network (i.e. specialty care), then the member can see that physician out of network.* *David Phillips asked if the Plan has data on how many members repeat grievances.* *Dr. Marabella stated the Plan tracks members complaints and complaints on physicians.* *Steven Si added that Member Services is available 24/7 and the phone number is listed on the back side of member ID*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
		cards, and also on the CVH website.	
#6 Health Equity **Information** Steven Si	Steven Si presented the Health Equity 2023 Summary and Work Plan Evaluation, and the 2023 Summary and Language Assistance Program; and the 2024 Summary and Program Description, and the 2024 Summary and Work Plan. Cultural and Linguistics has been renamed to Health Equity. <u>2023 Annual Evaluation of C&L</u> All 2023 work plan activities were completed: 1. Language Assistance Services: 86 staff completed a bilingual assessment/reassessment; and integrated sexual orientation and gender identity (SOGI) and preferred pronouns in OMNI. 2. Compliance Monitoring: Investigated and completed follow up on 45 cultural and linguistic grievances and 4 interpreter complaints; and conducted 2 findhelp trainings and added 753 overall new programs to findhelp. 3. Communication, Training and Education: Completed a coding and resolution training to A&G Department; and completed 9 trainings to new CCC hires, training includes HEQ Core areas, LAP program, Cultural Competency and Implicit Bias. 4. Health Literacy: completed 56 EMRs; and revised Plan Language training and posted online 5. Cultural Competency: Completed 6 cultural competency trainings for 350 providers. Trainings includes (2) Healthcare Barriers for Gender Diverse Populations, (2) Implicit Bias, (2) Special Needs and Cultural Competency; and completed 3 live cultural competency trainings for staff; 191 staff attended live trainings. Trainings includes LGBTQ+ 101 for Medical Professionals and Support Staff, Implicit Bias, and Healthcare Barriers for Gender Diverse Populations. 6. Health Equity: Successfully co-led and supported the completion of quality projects. Projects targets HEDIS measure: CIS-10, WCV, and CDC. <u>2023 Summary and Language Assistance Program</u> End of year summary includes: • A total of 5,662 interpreter requests were fulfilled for CalViva Health members, 4,763 (84%) of these requests were fulfilled utilizing telephonic interpreter services with 1,125 (20%) for in-person and 148 (3%) for sign language interpretation. • Member Services Department representatives handled a total of 139,171 calls across all languages. Of these, 43,598 (31%) were handled in Spanish and Hmong.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• MHN Member Services Department representatives handled a total of 4,049 calls across all languages with 624 in Spanish, 5 in Hmong and 12 in other languages. No requests for an alternate format translation were received. For written translation requests, 145 were received and fulfilled by MHN Services in 2023. • MHN Services fulfilled 287 interpreter requests. • English material review was completed for a total of 56 CalViva Health documents/materials. • A total of 86 staff were assessed or re-assessed for their bilingual skills during this reporting period. • A total of 45 grievances were reviewed by the Health Equity Department. Of these cases, 21 were coded as culture perceived discrimination, 13 were coded as culture non-discriminatory, none were coded as linguistic perceived discrimination, and 12 were coded as linguistic non-discriminatory. Interventions were identified in 2 of the cases and delivered with support by the Provider Engagement Department. As of December 31, 2023, CalViva Health membership totaled 431,853 members with 68% Latino/Hispanic, 11% White/Caucasian, 9% Asian/Pacific Islander, and 5% African American/Black. Of the 150,381 CalViva Health members with limited English proficiency (LEP), 81,108 (54%) identified as female and make up 34.8% of the overall female membership (232,834). Of the 150,381 members with LEP, there is a total of 69,273 (46%) who identified as male, and they make up 34.8% of the overall male membership (199,019). The majority of members with LEP are female, while both male and female with LEP make up an equal part of the overall membership. To assist in meeting CalViva Health members' language needs, the Member Services Department ensures that bilingual representatives and/or interpreters are available to speak with members in their preferred language. During 2023, a total of 5,662 requests for interpreter services were fulfilled. Of these, 84% (4,763) were fulfilled utilizing telephonic interpreter services, 20% (1,125) were fulfilled utilizing face-to-face interpreter services, 3% (148) were fulfilled by sign language. No video remote interpretation (VRI) services were requested in 2023.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	A total of 45 grievances were received and reviewed by the Health Equity Department. Of these cases, 22 were coded as culture perceived discrimination, 12 were coded as culture non-discriminatory, none were coded as linguistics perceived discrimination, and 11 were coded as linguistic non-discriminatory. Interventions were identified in 2 of the linguistic cases while 43 cases were identified as track and monitor. The two cases identified as corrective action plans include coaching the Call Center Staff on how to appropriately route the language request to the appropriate department, and ensuring the correct language is requested. The notable changes for the 2024 Health Equity Program Description include: • Mission, Goals, and Objective: o Expanded and added introduction to the Mission, Goals, and Objective section to align with the Health Equity Accreditation requirements. o Added vision to section. Edited heading to include "vision". o Replaced and enhanced goals • Health Equity Work Plan o Expanded on CLAS standards and the accreditation requirements it meets. • Public Policy Committee o Expanded on the roles and objectives of the Public Policy Committee. Include language regarding committee selection. • CalViva Health Monitoring and Evaluation o Expanded on the roles and objectives of the Governing Body and QI/UM Committee. • Data Collection o Broaden how data will be collected including SOGI data. • CalViva Health Staff Roles and Responsibilities o Added Equity Officer's role and responsibilities. For the 2024 Health Equity Work Plan, the 2023 initiatives will continue into 2024 with the following enhancements: • Information Technology: Updated technology efforts to include SOGI data collection. • Regulatory (Community Connect): Added measurable objectives to findhelp oversight based on PPC's comments and feedback. • Provider Communication & Training: Include new methods for how providers can obtain C&L materials: provider's library.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Health Equity (Operations): Updated PIP projects and included SUD/MH non-clinical project.		
#7 Annual Public Policy Committee Charter Review **Information** Courtney Shapiro	The PPC reviewed the Charter and approved to move forward to Commission for approval with stated revisions.		**Motion:** Approve PPC Charter to move forward to Commission for final approval. 6-0-0-3 (J. Garner / D. Phillips)
#8 Audit Updates **Information** Mary Lourdes Leone	Mary Lourdes provided updates to the following audits: 2022 DMHC Audit Final Report: The Plan received the final report from DMHC on 4/18/24. There were two findings. DMHC stated the Plan had not corrected those findings when the CAP was submitted in December so the DMHC will do an 18-month follow-up and the Plan will need to show by that time that the deficiencies have been corrected. 2023 DHCS Audit CAP Closure: The Plan received the DHCS CAP closure document in April. In 2023 when the Plan was audited, DHCS found a deficiency. The Plan had since, on a monthly basis, provided DHCS with how the deficiency would be corrected leading to the CAP closure. 2024 DHCS Audit: The Plan completed the 2024 DHCS audit on Friday, May 31st. The Plan expects to receive the DHCS final report in August. NCQA Plan Accreditation Audit: All Plans are required to achieve NCQA Accreditation by 2026. CVH has been preparing and submitting documents during the past year to attain this accreditation. Official submission was May 6th, 2024. Final determination will be in July. Annual Health Systems Advisory Group (HSAG) Network Validation Audit: This is a brand new annual DHCS audit conducted via an external vendor. This is a federal government requirement for the State to assess how the Plan validates the sufficient network of Providers to take care of members. This audit is to determine how the plan derived at the numbers, the systems used, what's the logic, how it's pulled, and the source data that produces a higher level output. The Plan filed this May 15th and currently pending response.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#9 2024 CVH Member Handbook / Evident of Coverage Update (Errata) **Information** Maria Sanchez	The Plan received an errata for the 2024 Evidence of Coverage (EOC); the changes include language revision to minor consent services, the removal of biomarker testing as an offered health benefit, and additional perinatal benefits identified under maternity and new born care. This errata will be posted to the CVH website by July 1, 2024.		**No Motion**
#10 Final Comments from Committee Members and Staff	Maria Arreola shared the promotores finished training for Parkinsons. Martha Miranda shared the farmers market opened in Hanford, sponsored by CVH. St. Bridget's in having a Christmas in July boutique sale. Norma Mendoza shared Madera had an Active Aging walking in collaboration with the City of Madera. The promotores also had Mental Health training to help promotores learn how to provide information to members in need of assistance. David Phillips shared UHC started performing in-house mammography at the Minnewawa (southeast Fresno) location. A second unit for Visalia will take place this summer. The UHC Fowler Health Center's open house will be June 26th. The UHC Fun Run will be on June 29th at Woodward Park. Jeff Garner shared the KCAO will be stopping their Medi-Cal outreach services May 31st due to State funding issues. When funding comes back, they will begin outreach again. KCAO is trying to get started with CalAIM. They have begun constructing their new shelter and food bank in Kings County. They just finished their "point in time" survey for Kings County, which looks at the homeless population in Kings County. The homeless population in Kings County dropped by 5 individuals, as compared to the other CVH service counties that have seen a spike in numbers. Kings County has approximately 433 individuals that are considered street homeless. KCAO will be planting a pumpkin patch at the location where they are building their shelter and food bank, as they have the area to grow pumpkins as it waits for the shelter and food bank to be built. Roberto Garcia shared Self-Help continues to build throughout the valley from Kern County to Stanislaus County. They are tapping into NPLH funding (No Place Like Home) and PSH		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	(Permanent Supportive Housing), in dealing with the homeless situation. They have over 55 multi-family communities throughout the valley. Courtney Shapiro shared the promotores team will join CVH at the Reading Heart Reading Extravaganza event at Storyland 6/8/24. CVH will now be sharing information on Instagram in addition to Facebook. CVH will be celebrating the promotores at the July Commission meeting and also at the September PPC meeting. There is a survey on the CVH website for anyone that visits the website to provide feedback. CVH funded a food pantry in conjunction with Family Health Care Network at the ambulatory care center in downtown Fresno at CRMC. Sia Xiong-Lopez, CVH Equity Officer, shared her background in that she came from Catholic Charities as a Program Manager. She graduated from FPU focusing on diversity and change management.		
#11 Announcements			
#12 Public Comment	None.		
#13 Adjourn	Meeting adjourned at 12:59 pm.		

NEXT MEETING September 4, 2024, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: September 4, 2024,

Submitted By: _____
Courtney Shapiro, Director Community Relations & Marketing

Approval Date: September 4, 2024

Approved By: _____
Joe Neves, Chairman

Fresno-Kings-Madera Regional Health Authority
2025 Commission Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			**No Meeting**
February 20, 2025	1:30 to 3:30	Fresno	CalViva Health
March 20, 2025	1:30 to 3:30	Fresno	CalViva Health
April			**No Meeting**
May 15, 2025	1:30 to 3:30	Fresno	CalViva Health
June			**No Meeting**
July 17, 2025	1:30 to 3:30	Fresno	CalViva Health
August			**No Meeting**
September 18, 2025	1:30 to 3:30	Fresno	CalViva Health
October 16, 2025	1:30 to 3:30	Fresno	CalViva Health
November 20, 2025	1:30 to 3:30	Fresno	CalViva Health
December			**No Meeting**

Fresno-Kings-Madera Regional Health Authority

Finance Committee

2025 Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			**No Meeting**
February 20, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
March 20, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
April 17, 2025	11:30 am to 12:00 pm ***TENTATIVE***	Fresno	CalViva Health
May 15, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
June			**No Meeting**
July 17, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
August			**No Meeting**
September 18, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
October 16, 2025	11:30 am to 12:00 pm * **Auditors presentation*	Fresno	CalViva Health
November 20, 2025	11:30 am to 12:00 pm	Fresno	CalViva Health
December			**No Meeting**

Fresno-Kings-Madera Regional Health Authority

Quality Improvement/Utilization Management

Revised Draft 2025 Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			**No Meeting**
February 20, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
March 20, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
April			**No Meeting**
May 15, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
June			**No Meeting**
July 17, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
August			**No Meeting**
September 18, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
October 16, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
November 20, 2025	10:00 am – 12:00 pm	Fresno	CalViva Health
December			**No Meeting**

Fresno-Kings-Madera Regional Health Authority

Credentialing Sub-Committee

2025 Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			**No Meeting**
February 20, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **1st Quarter**
March			**No Meeting**
April			**No Meeting**
May 15, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **2nd Quarter**
June			**No Meeting**
July 17, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **3rd Quarter**
August			**No Meeting**
September			**No Meeting**
October 16, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **4th Quarter**
November			**No Meeting**
December			**No Meeting**

Fresno-Kings-Madera Regional Health Authority

Peer Review Sub-Committee

2025 Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			**No Meeting**
February 20, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **1st Quarter**
March			**No Meeting**
April			**No Meeting**
May 15, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **2nd Quarter**
June			**No Meeting**
July 17, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **3rd Quarter**
August			**No Meeting**
September			**No Meeting**
October 16, 2025	12:00 pm – 12:30 pm	Fresno	CalViva Health **4th Quarter**
November			**No Meeting**
December			**No Meeting**

CalViva Health

Public Policy Committee
2025 Meeting Schedule

Date	Time	Meeting Location
January		**No Meeting**
February		**No Meeting**
March 5, 2025	11:30am – 1:30pm	Fresno County
April		**No Meeting**
May		**No Meeting**
June 4, 2025	11:30am – 1:30pm	Fresno County
July		**No Meeting**
August		**No Meeting**
September 3, 2025	11:30am – 1:30pm	Fresno County
October		**No Meeting**
November		**No Meeting**
December 3, 2025	11:30am – 1:30pm	Fresno County

Meeting Location:

Fresno County:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of DHCS Filings													
Administrative/ Operational	56	46	28	35	24	19	35	21	26	6			296
Member Materials Filed for Approval;	1	4	1	6	5	4	6	7	5	0			39
Provider Materials Reviewed & Distributed	10	14	9	10	8	16	17	9	18	2			113
# of DMHC Filings	8	8	8	11	19	7	10	7	16	2			96

DHCS Administrative/Operational filings include ad-hoc reports, policies & procedures, Commission changes, Plan and Program documents, etc.
DHCS Member & Provider materials include advertising, health education materials, flyers, letter templates, promotional items, etc.
DMHC Filings include ad-hoc reports, Plan and Program documents, policies & procedures, advertising, bylaw changes, Commission changes, undertakings, etc.

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	5	4	3	1	3	0	0	3	3	3			25
High-Risk	0	0	0	0	0	0	0	2	0	0			2

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of New MC609 Cases Submitted to DHCS	2	4	0	3	1	1	2	0	2	0			15
# of Cases Open for Investigation (Active Number)	17	17	15	18	21	21	22	23	23	24			

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 9/19/2024 Compliance Regulatory Report to the Commission, there have not been any new MC609 filings.

Compliance Oversight & Monitoring Activities:	Status
CalViva Health Oversight Activities	**Health Net** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc.
Oversight Audits	The following annual audits are in-progress: UMCM, ER, Provider Network, Claims, FWA, Call Center, Health Education, COC and Privacy and Security. The following annual audits have been completed since the last Commission report: PDR (CAP Required), A&G (CAP Required)

Regulatory Reviews/Audits and CAPS:	Status
Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	On 9/6/24, the Plan received DHCS' Final Report findings and formal CAP request. There were nine deficiencies in total (4 for behavioral health and 5 for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. All corrective actions must be implemented within 6 months from the date of the CAP request.
Department of Health Care Services ("DHCS") 2024 Medical Audit	On 9/16/2024, the Plan had the Exit Conference with DHCS. On 10/3/2024 DHCS sent out the Final Audit Report and CAP request. There were two findings: • The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. The Plan's first response to the CAP is due by November 2, 2024.

2024 Network Adequacy Validation (NAV) Audit	On 9/30/2024 the Plan received notice that HSAG has officially closed out the audit noting all items have been resolved. HSAG is working with DHCS on finalizing plan-specific validation rating determinations, which will be shared in late November 2024.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**

California Advancing and Innovating Medi-Cal (CalAIM)	On 10/9/2024, the Plan submitted an updated Community Supports Provider Capacity and Final Elections report to confirm that the Plan will be able to provide the following additional CS services in Kings and Madera counties:
	
	• **Kings**
	  ○ **Recuperative Care**: CityServe (Services on track for go live 1/1/2025)
	• **Madera**
	  ○ **Recuperative Care**: SOUL Housing (Services on track for go live 7/1/2025)
	  ▪ **Short-Term Post Hospitalization**: RH Builders (Services on track for go live 1/1/2025)
	  ○ **Sobering Center**: RH Builders went live earlier for this service

Memoranda of Understanding (MOUs)	Since the last Commission Meeting the Plan has not executed any additional MOUs.
Annual Network Certifications	➢ 2023 Annual Network Certification (ANC) – The Plan is awaiting final DHCS approval of its AAS request as revised and submitted on 9/18/2024. ➢ 2024 Subnetwork Certification (SNC) – On 9/25/2024, the Plan received the 2024 SNC Landscape Analysis request. The Plan must submit a response by 10/25/2024.

Timely Access and Annual Network Reporting (TAR)	➢ RY 2023 MY 2022- The Plan is still awaiting the Department's response to the Plan's response to the Network Findings Report which was submitted on 8/1/2024. ➢ RY2024 MY 2023 – Results of the 2023 DMHC Timely Access Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Survey (PHAS) indicated that the Plan met the compliance rate standards for all with the exception of the following: • Urgent Care Appointment with a specialist (that requires prior authorization) within 96 hours; and • Non-Urgent Care Appointment with a specialist within 15 business days.
Plan Administration:	**Status**
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2024.
Committee Report:	**Status**
Public Policy Committee (PPC)	The next Public Policy Committee meeting will be held December 4, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.

APPENDIX A

2024 DHCS All Plan Letters:

- APL 24-001 STREET MEDICINE PROVIDER DEFINITIONS AND PARTICIPATION IN MANAGED CARE
- APL 24-002 MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES FOR INDIAN HEALTH CARE PROVIDERS AND AMERICAN INDIAN MEMBERS
- APL 24-003 ABORTION SERVICES
- APL 24-004 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION REQUIREMENTS
- APL 24-005 CALIFORNIA HOUSING AND HOMELESSNESS INCENTIVE
- APL 24-006 COMMUNITY HEALTH WORKER SERVICES BENEFIT
- APL 24-007 TARGETED PROVIDER RATE INCREASES
- APL 24-008 IMMUNIZATION REQUIREMENTS
- APL 24-009 SKILLED NURSING FACILITIES
- APL 24-010 SUBACUTE CARE FACILITIES
- APL 24-011 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES
- APL 24-012 NON-SPECIALTY MENTAL HEALTH SERVICES MEMBER OUTREACH, EDUCATION, AND EXPERIENCE REQUIREMENTS
- APL 24-013 Child Welfare Liaison
- APL 24-014 CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO ARE FOSTER YOUTH AND FORMER FOSTER YOUTH IN SINGLE PLAN COUN...

2024 DMHC All Plan Letters:

- APL 24-003 Health Equity and Quality Program Policies and Requirements
- APL 24-005 - Change Healthcare Cyberattack (3.11.24)
- APL 24-006 Annual Provider Directory Filing
- APL 24-008 2024HealthPlanAnnualAssessments(4_15_24)
- APL 24-009 Change Healthcare Cyberattack Response Filing
- APL 24-011 Request for Health Plan Information and Addendum Revisions
- APL 24-012 Single Point of Contact for Hospitals to Request Authorization
- APL 24-013 Health Equity and Quality Program Policies and Requirements
- APL 24-016 Request for Health Plan Contact Information (7.25.24)
- APL 24-017 RY2025-MY2024 PAAS NPMH Rate of Compliance
- APL 24-018 - Compliance with SB 923 (8.15.24)

Item #5

Attachment 5.A

Financial Audit Report
Fiscal Year 2024

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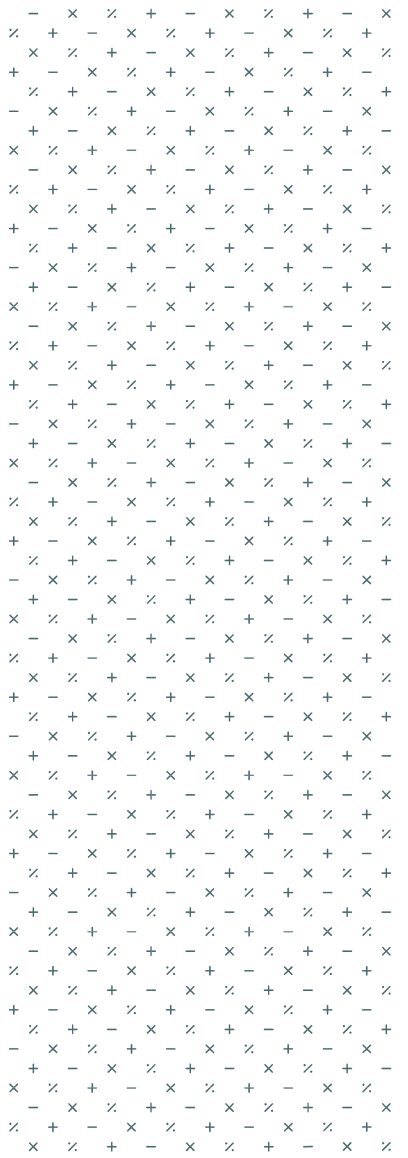
Report of Independent Auditors

The Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Rianne Suico
Health Care Services Partner

Eleanor Garibaldi
Health Care Services Senior Manager

(415) 956-1500



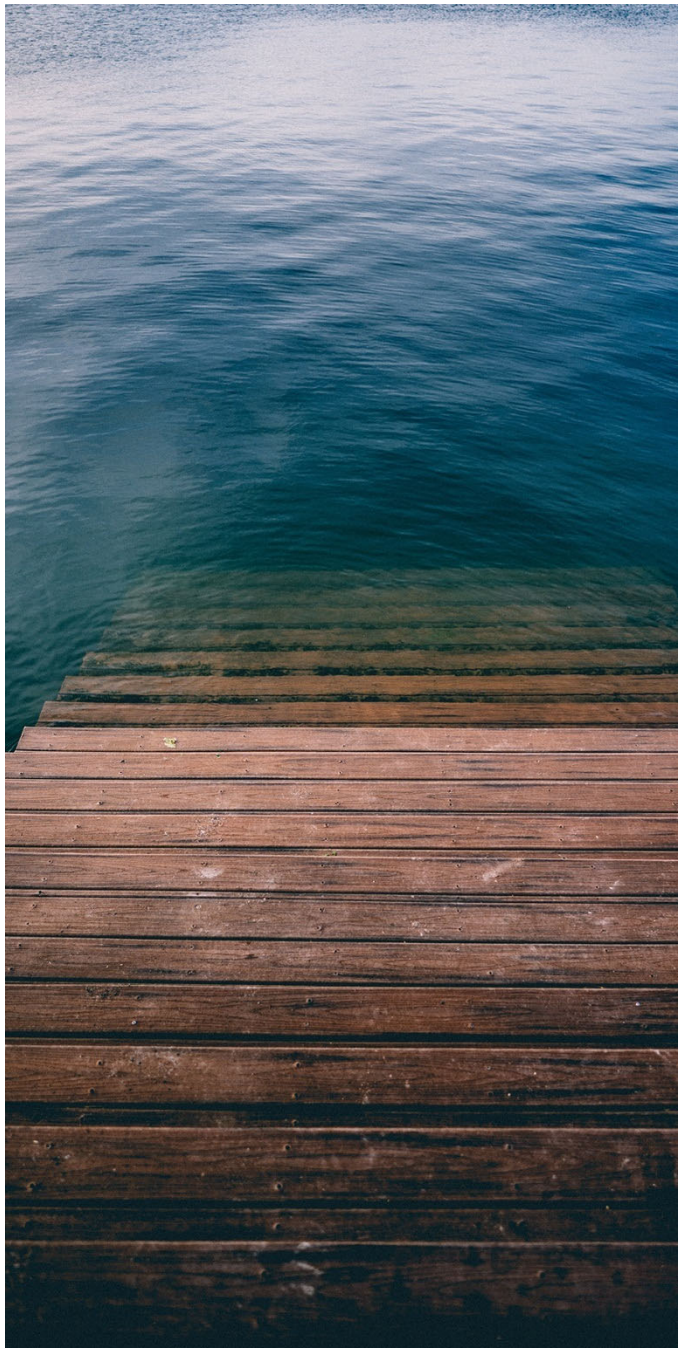
Audit Objectives

- Opinion on whether the financial statements of CalViva are *reasonably* stated and free of material misstatement in accordance with generally accepted accounting principles
- Consideration of internal controls
- Audit is required under the State of California Department of Managed Health Care

Report of Independent Auditors

Unmodified Opinion

Financial statements are fairly presented in accordance with generally accepted accounting principles.



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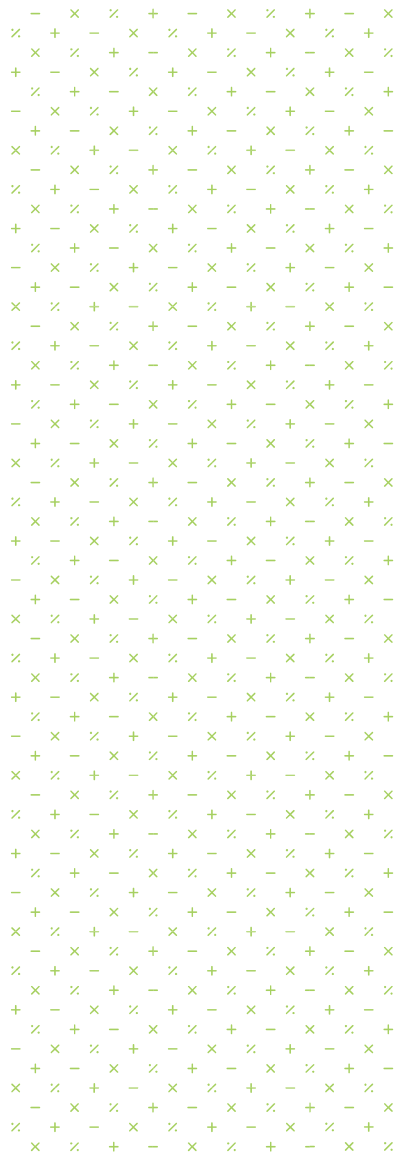
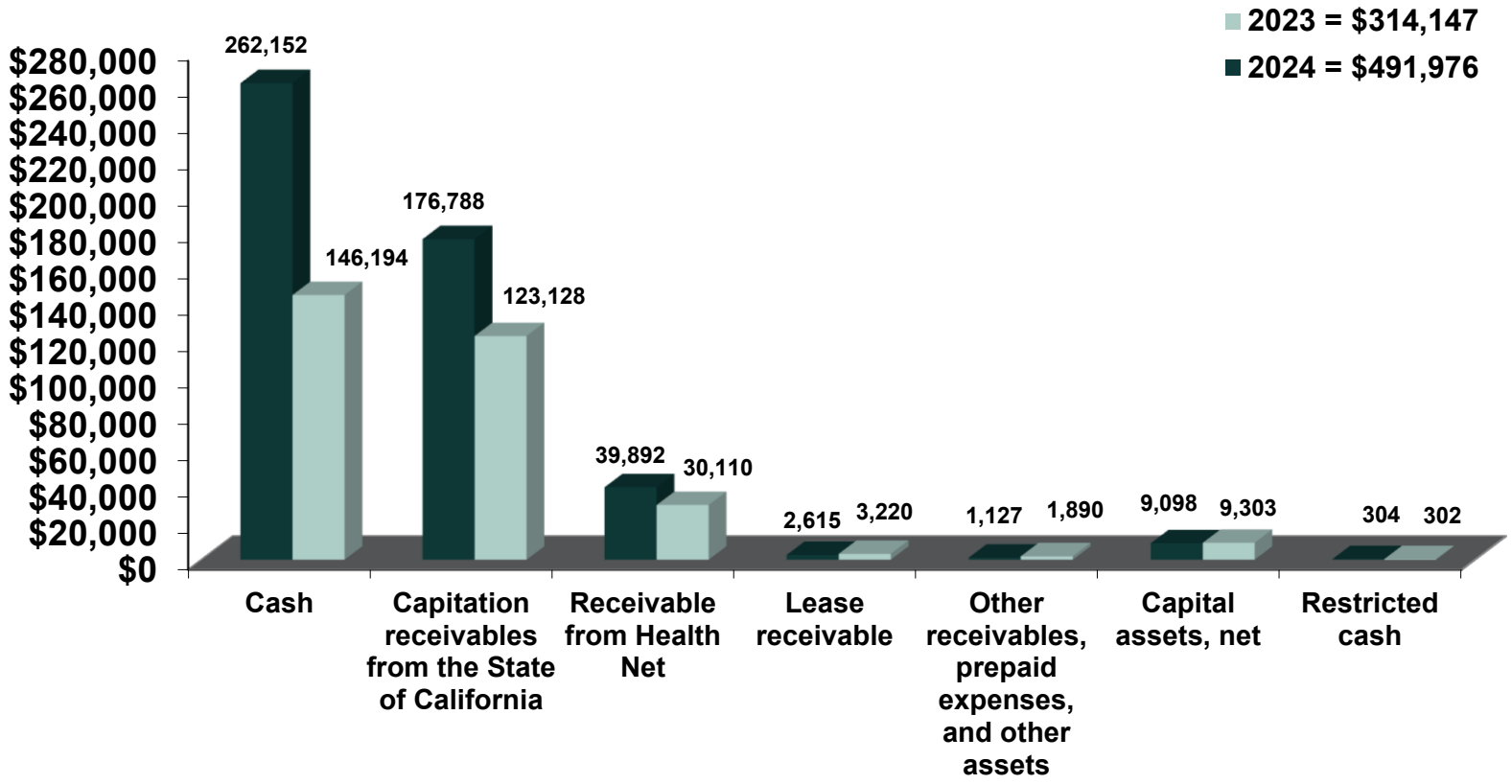
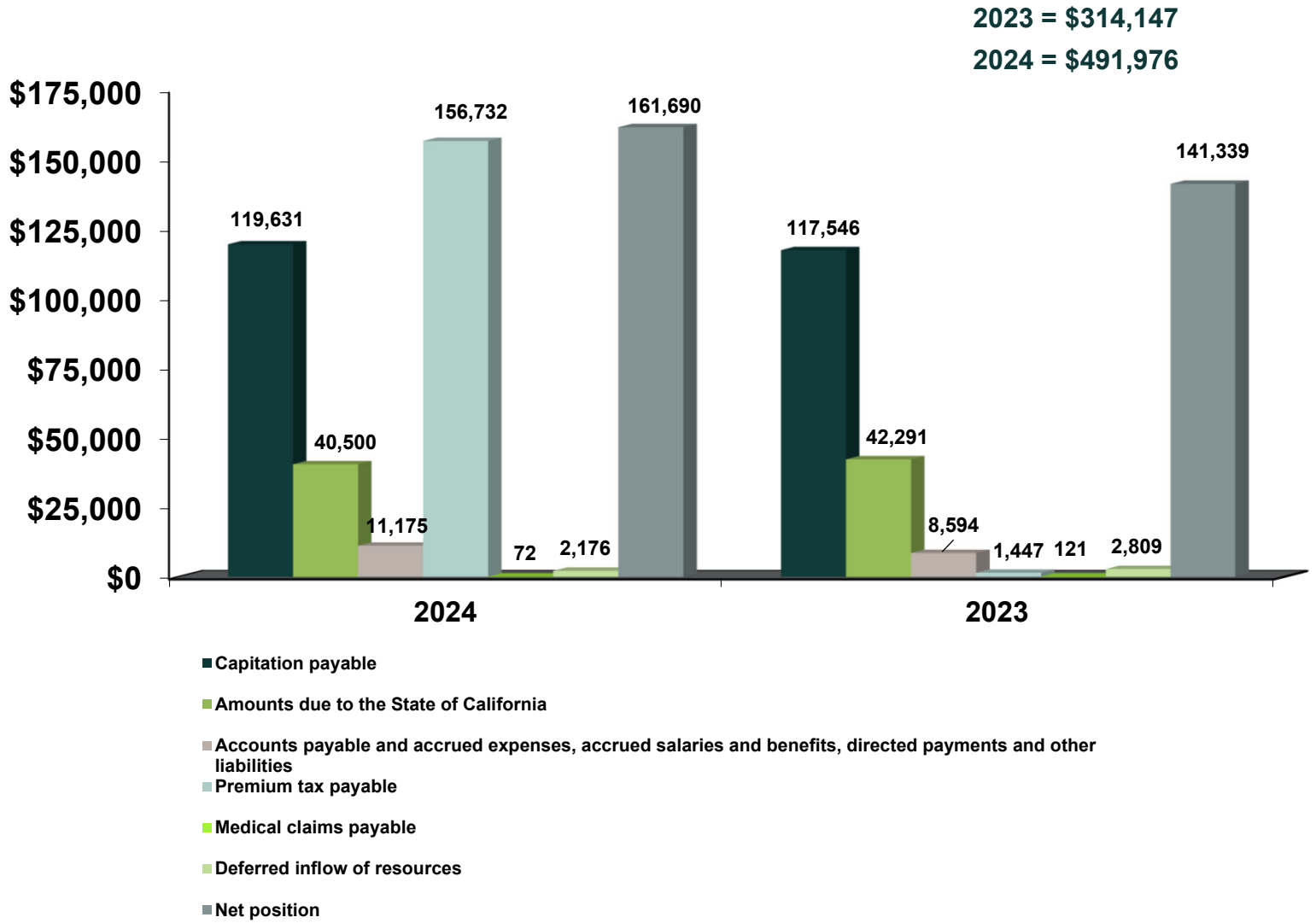
Statements of Net Position



Asset Composition (in thousands)



Liabilities and Net Position Balance (in thousands)



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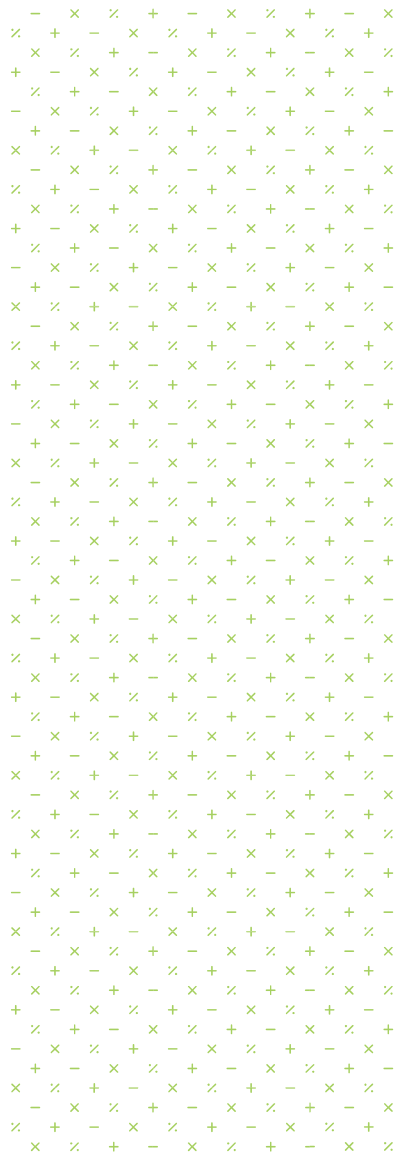
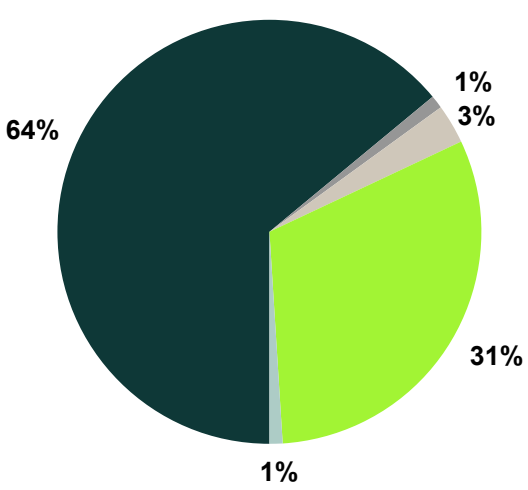
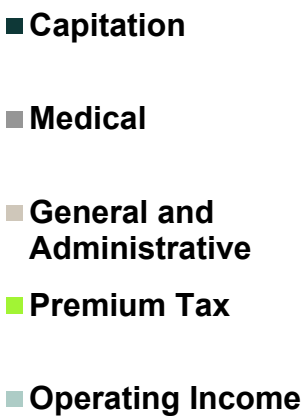
Operations



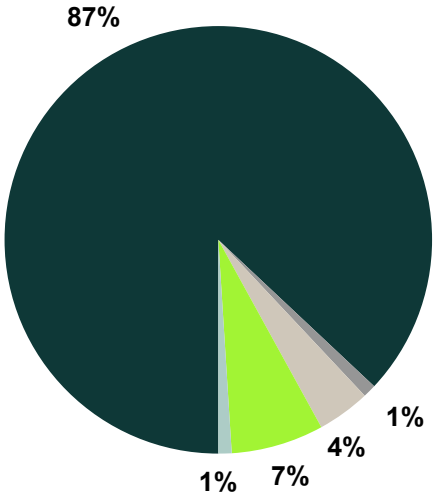
Total Operating Expenses as a % of Total Operating Revenues (in thousands)

June 30, 2024
$2,048,061
(2024 Revenue)

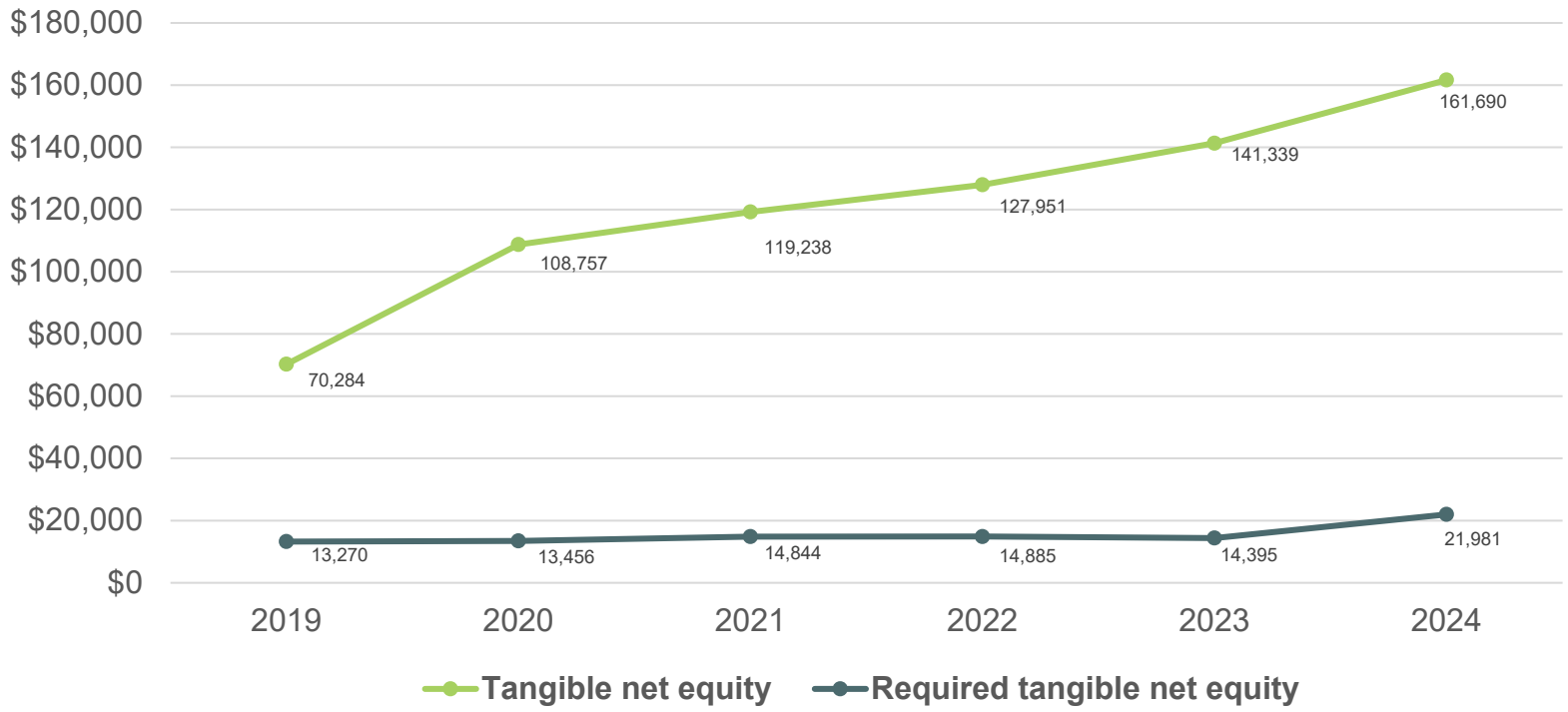




June 30, 2023
$1,289,511
(2023 Revenue)



Tangible Net Equity (in thousands)



Important Board Communications

- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of material fraud or noncompliance with laws and regulations

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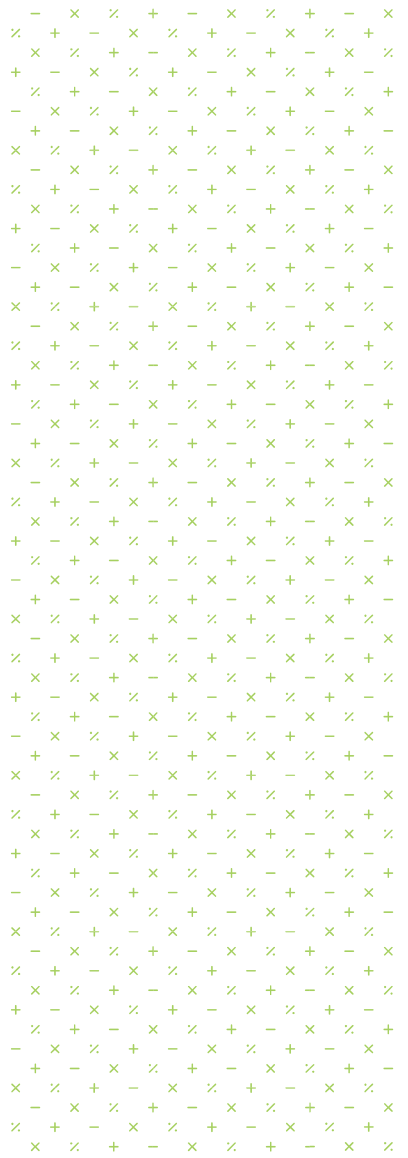
Questions?



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Report of Independent Auditors and
Financial Statements

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

June 30, 2024 and 2023

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Table of Contents

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Management's Discussion and Analysis

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2024, 2023, and 2022

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The Management's Discussion and Analysis of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is intended to provide readers and interested parties with an overview of the Plan's financial activities for the fiscal years ended June 30, 2024, 2023, and 2022. It should be reviewed in conjunction with the Plan's financial statements and accompanying notes to enhance the reader's understanding of the Plan's financial performance.

Overview of CalViva's Financial Statements

The Fresno-Kings-Madera Regional Health Authority, dba CalViva Health (CalViva or the Plan) is a local governmental health insuring organization that operates in the Counties of Fresno, Kings, and Madera (Tri-Counties). The Boards of Supervisors for the Tri-Counties established the Fresno-Kings-Madera Regional Health Authority (the Authority) in March 2009, in accordance with the State of California Welfare and Institutions Code (the Code) Section 14087.38. Through the provisions of the "Joint Exercise of Powers Agreement between the Counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs" agreement, dated March 2009, and pursuant to the Code, CalViva became financially independent of Fresno, Kings, and Madera Counties. In addition, the Code provides that CalViva is a public entity, separate and apart from the Counties of Fresno, Kings, and Madera. CalViva received its Knox-Keene license from the California Department of Managed Health Care (DMHC) on December 30, 2010, and commenced operations on March 1, 2011.

The mission and purpose of CalViva is to improve access to care and provide quality health care to families in the Fresno, Kings, and Madera County areas at the right place and the right time.

CalViva has contracted with the California Department of Health Care Services (DHCS) to receive funding to provide health care services to the Medi-Cal eligible Tri-County area residents who are enrolled as members of CalViva under the two-plan model. The DHCS contract is effective March 1, 2011, through December 31, 2024. The DHCS contract specifies capitation rates based on a per-member, per-month basis, which may be adjusted annually. DHCS revenue is paid monthly and is based upon the contracted capitation rates and actual Medi-Cal enrollment. In addition, DHCS pays CalViva supplemental capitation rates such as a fixed maternity case rate for each eligible birth incurred by a CalViva Medi-Cal member. CalViva, in turn, provides services to Medi-Cal beneficiaries through a contract with Health Net Community Solutions, Inc. (Health Net), a wholly owned subsidiary of Centene Corporation. Further, CalViva has an administrative service agreement with Health Net in which Health Net performs specific administrative functions for CalViva.

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On September 2, 2009, the California State Legislature ratified Assembly Bill (AB) No. 1422 (AB 1422), which levies a 2.35% gross premium tax (GPT) on all Medi-Cal capitated revenue received. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. This provision was effective retroactively to January 1, 2009. The GPT program was concluded on June 30, 2012. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026.

On September 8, 2010, the California State Legislature ratified AB No. 1653 (AB 1653), which established a Quality Assurance Fee (QAF) program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions (W&I) Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services," and Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass-through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the QAF program through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. In October of 2013, California approved SB 239, which extended the QAF program for an additional 36 months from January 1, 2014 through December 31, 2016. In November of 2016, the voters of California passed Proposition 52, which permanently extended the QAF program.

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Beginning with the July 1, 2017, rating period, DHCS implemented the following managed care Directed Payment programs: (1) Private Hospital Directed Payment (PHDP), (2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP), and (3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, this program provides supplemental reimbursement to participating Network Provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The PHDP program was created to maintain access and improve the quality of care for Medi-Cal beneficiaries. (2) For EPP-FFS and EPP-CAP, this program provides supplemental reimbursement to Network Provider designated public hospitals through either a uniform dollar or percentage increase based on actual utilization of network contracted qualifying services. (3) For QIP, DHCS has directed the Medi-Cal managed care health plans (MCPs) to make QIP payments to designated public hospitals and University of California hospitals which are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments will be linked to delivery of services and increase the amount of funding tied to quality outcomes.

Beginning with a January 1, 2023, date of service, DHCS implemented the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) to provide performance-based directed payments to eligible network provider SNFs to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP is authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB)186 (Chapter 46, Statutes of 2022)) for dates of service from January 1, 2023, through December 31, 2026. DHCS has directed Medi-Cal managed care plans to make SNF WQIP payments to eligible SNFs according to utilization and performance on designated WQIP metrics.

CalAIM Implementation – Beginning January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. This requires managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. Components that began on January 1, 2022, include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. In addition, institutional Long-Term Care (LTC) benefit including skilled nursing facilities transitioned to Medi-Cal managed care plans effective January 1, 2023. Effective January 1, 2024, all Medi-Cal managed care plans became responsible for the full LTC benefit at facility types such as Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, Pediatric Subacute Care Facility and Subacute Care Facility.

Using this annual report – CalViva's financial statements consist of three statements: Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows.

Fiscal Year 2024 Compared to Fiscal Years 2023 and 2022

On June 30, 2024, CalViva had assets of $492.0 million, liabilities of $328.1 million and deferred inflow of resources of $2.2 million. On June 30, 2023, CalViva had assets of $314.1 million, liabilities of $170.0 million and deferred inflow of resources of $2.8 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by $20.4 million to $161.7 million from $141.3 million at June 30, 2023.

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On June 30, 2023, CalViva had assets of $314.1 million, liabilities of $170.0 million and deferred inflow of resources of $2.8 million. On June 30, 2022, CalViva had assets of $292.5 million, liabilities of $160.6 million and deferred inflow of resources of $3.9 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by $13.3 million to $141.3 million from $128.0 million at June 30, 2022.

Assets

Cash and cash equivalents – Cash and cash equivalents increased $116.0 million from $146.2 million at June 30, 2023, to $262.2 million at June 30, 2024. The increase is primarily due to net cash provided by operating activities.

Cash and cash equivalents decreased $15.0 million from $161.2 million at June 30, 2022, to $146.2 million at June 30, 2023. The decrease is primarily due to net cash used in operating activities.

Cash and cash equivalents increased $18.8 million from $142.4 million at June 30, 2021, to $161.2 million at June 30, 2022. The increase is primarily due to net cash provided by operating activities.

Capitation receivables from the State of California – Capitation receivables from the State of California increased $53.7 million from $123.1 million at June 30, 2023, to $176.8 million at June 30, 2024. The increase is primarily due to the increase in capitation rates, and accrued MCO tax revenue from DHCS, as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

Capitation receivables from the State of California increased $7.1 million from $116.0 million at June 30, 2022, to $123.1 million at June 30, 2023. The increase is primarily due to an increase in membership and capitation rates paid by DHCS, offset by the decrease in accrued MCO tax revenue from DHCS due to its expiration on December 31, 2022.

Capitation receivables from the State of California decreased $6.8 million from $122.8 million at June 30, 2021, to $116.0 million at June 30, 2022. The decrease is primarily due to the decrease in capitation rates paid by DHCS, as DHCS transitioned all pharmacy services from Medi-Cal managed care plans to a DHCS fee-for-service benefit, known as Medi-Cal Rx, effective January 1, 2022, offset by an increase in membership and accrued MCO tax revenue from DHCS.

Receivable from Health Net – Receivable from Health Net increased $9.8 million from $30.1 million at June 30, 2023, to $39.9 million at June 30, 2024. The increase is attributable to the accrual of $39.9 million capitation overpayments made to Health Net during the current fiscal year as a result of DHCS' retroactive capitation rate reduction covering the time period of January 2023 through December 2023, offset by full collection of $30.1 million receivable balance from Health Net during the current fiscal year, related to the Proposition 56 directed payment program two-sided risk corridor recoupment.

Receivable from Health Net increased $30.1 million from $0 at June 30, 2022, to $30.1 million at June 30, 2023. The increase is attributable to accrued capitation recoupment from Health Net as a result of the DHCS Proposition 56 directed payment program two-sided risk corridor recoupment from the Plan. This risk corridor is subject to a certain threshold of medical expenses compared to premium revenues. Medical expenditures not meeting a minimum threshold as a percentage of revenue paid by DHCS requires CalViva to refund the premium revenue to the State of California. As CalViva pays a percent of premium revenue received from DHCS to Health Net, any recoupment from DHCS results in a receivable from Health Net to CalViva.

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Other receivables – Other receivables increased $380,115 from $496,762 at June 30, 2023, to $876,877 at June 30, 2024. The increase is primarily due to the timing of receipts of interest payments from various investment accounts and increase in interest rates.

Other receivables increased $411,624 from $85,138 at June 30, 2022, to $496,762 at June 30, 2023. The increase is primarily due to the timing of receipts of interest payments from various investment accounts and increase in interest rates.

Other receivables increased $32,998 from $52,140 at June 30, 2021, to $85,138 at June 30, 2022. The increase is primarily due to the timing of receipts of interest payments from various investment accounts, increase in interest rates and implementation of GASB Statement No. 87, *Leases*.

Prepaid expenses – Prepaid expenses decreased $1,119,274 from $1,369,227 at June 30, 2023, to $249,953 at June 30, 2024. The decrease is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2024.

Prepaid expenses increased $105,494 from $1,263,733 at June 30, 2022, to $1,369,227 at June 30, 2023. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2023. Furthermore, the increase in prepaid expenses is also attributable to the increase in prepaid license fees assessed by DMHC.

Prepaid expenses increased $370,770 from $892,963 at June 30, 2021, to $1,263,733 at June 30, 2022. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2022. Furthermore, the increase in prepaid expenses is also attributable to the increase in prepaid license fees assessed by DMHC.

Other assets – Other assets decreased $23,662 from $23,662 at June 30, 2023, to $0 at June 30, 2024. The decrease is due to the security deposits being applied to construction in progress for the office building improvement project during the year ended June 30, 2024.

Other assets increased $23,662 from $0 at June 30, 2022, to $23,662 at June 30, 2023. The increase is due to security deposits that were made during the year ended June 30, 2023 to secure the office building improvement project.

Capital assets, net of accumulated depreciation and amortization – Capital assets, net of accumulated depreciation and amortization, decreased $205,506 from $9.3 million at June 30, 2023, to $9.1 million at June 30, 2024. The decrease is primarily due to the depreciation and amortization expense of $327,624 recorded, offset by the purchase of $122,118 capital assets during the year ended June 30, 2024.

Capital assets, net of accumulated depreciation and amortization, decreased $117,152 from $9.4 million at June 30, 2022, to $9.3 million at June 30, 2023. The decrease is primarily due to the depreciation and amortization expense of $299,109 recorded, offset by the purchase of $196,556 capital assets during the year ended June 30, 2023.

Capital assets, net of accumulated depreciation and amortization, decreased $279,117 from $9.7 million at June 30, 2021, to $9.4 million at June 30, 2022. The decrease is primarily due to the depreciation and amortization expense of $286,517 recorded during the year ended June 30, 2022.

Lease receivable – The Plan as a lessor, recognized a lease receivable, which represents the present value of future lease payments expected to be received by the Plan during the lease term.

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The lease receivable balance decreased $605,142 from $3.2 million at June 30, 2023, to $2.6 million at June 30, 2024. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2024.

The lease receivable balance decreased $1.0 million from $4.2 million at June 30, 2022, to $3.2 million at June 30, 2023. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2023.

During the fiscal year ended June 30, 2022 and June 2021, the Plan retrospectively adopted GASB Statement No. 87, *Leases*. The lease receivable balance was $4.2 million as of June 30, 2022.

Assets restricted as to use – Restricted assets balance increased $2,364 from $301,821 at June 30, 2023, to $304,185 at June 30, 2024. The increase is due to accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2024 and 2023.

Restricted assets balance decreased $323 from $302,144 at June 30, 2022, to $301,821 at June 30, 2023. The decrease is due to distribution of accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2023 and 2022.

Restricted assets balance increased $1,221 from $300,923 at June 30, 2021, to $302,144 at June 30, 2022. The increase is due to accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2022 and 2021.

Liabilities and Deferred Inflow of Resources

Capitation payable – The capitation payable balance increased $2.1 million from $117.5 million at June 30, 2023, to $119.6 million at June 30, 2024. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in capitation rates paid by DHCS.

The capitation payable balance increased $22.8 million from $94.7 million at June 30, 2022, to $117.5 million at June 30, 2023. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in membership and capitation rates paid by DHCS.

The capitation payable balance decreased $9.4 million from $104.1 million at June 30, 2021, to $94.7 million at June 30, 2022. The decrease is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the decrease in capitation payable is also attributable to the decrease in capitation rates paid by DHCS, as DHCS transitioned all pharmacy services from Medi-Cal managed care plans to a DHCS fee-for-service benefit, known as Medi-Cal Rx, effective January 1, 2022, offset by an increase in membership.

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Amounts due to the State of California – The amounts due to the State of California decreased $1.8 million from $42.3 million at June 30, 2023, to $40.5 million at June 30, 2024. The decrease is attributable to full payment of $42.3 million payable balance to the State of California during the current fiscal year, related to DHCS' recoupment of the MCO tax gain and Proposition 56 premium revenue risk corridor, offset by the Plan accruing for $40.5 million payable balance to the State of California as a result of DHCS' retroactive capitation rate reduction covering the time period of January 2023 through December 2023.

The amounts due to the State of California increased $33.8 million from $8.5 million at June 30, 2022, to $42.3 million at June 30, 2023. The increase is a result of the Plan accruing for DHCS' future recoupment of the MCO tax gain relating to the time period of July 2022 through December 2022 and Proposition 56 premium revenue risk corridor recoupment.

The amounts due to the State of California increased $8.5 million from $0 at June 30, 2021, to $8.5 million at June 30, 2022. The increase is a result of the Plan accruing DHCS' future recoupment of the MCO tax gain for the time period of July 2021 through June 2022.

Accounts payable and accrued expenses – Accounts payable and accrued expenses consist of the cost of services received in the current period for which payment has yet to be made. The accounts payable and accrued expenses balance decreased by $59,406 from $6.1 million at June 30, 2023, to $6.0 million at June 30, 2024. The decrease is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

The accounts payable and accrued expenses balance increased by $380,874 from $5.7 million at June 30, 2022, to $6.1 million at June 30, 2023. The increase is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

The accounts payable and accrued expenses balance decreased by $23,639 from $5.69 million at June 30, 2021, to $5.67 million at June 30, 2022. The decrease is primarily due to the timing of payments to nonmedical vendors.

Accrued salaries and benefits – The accrued salaries and benefits balance increased $51,515 from $352,199 at June 30, 2023, to $403,714 at June 30, 2024. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off (PTO). The increase is primarily due to additional PTO accrued by employees and an increase in payroll expenses during the fiscal year ended June 30, 2024.

The accrued salaries and benefits balance increased $37,791 from $314,408 at June 30, 2022, to $352,199 at June 30, 2023. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off (PTO). The increase is primarily due to additional PTO accrued by employees and the timing of the pay period end date in relation to the Plan's fiscal year end date of June 30, 2023.

The accrued salaries and benefits balance decreased $168,906 from $483,314 at June 30, 2021, to $314,408 at June 30, 2022. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off ("PTO"). The decrease is primarily due to PTO taken by employees and the timing of the pay period end date in relation to the Plan's fiscal year end date of June 30, 2022.

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Premium tax payable – The premium tax payable balance increased $155.3 million from $1.4 million at June 30, 2023, to $156.7 million at June 30, 2024. The premium tax payable balance primarily represents the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis, and the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues. The increase is primarily due to the increase in the MCO tax amount for the fiscal year ended June 30, 2024, as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

The premium tax payable balance decreased $46.2 million from $47.6 million at June 30, 2022, to $1.4 million at June 30, 2023. The premium tax payable balance primarily represents the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues, and the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis. The decrease is primarily attributable to SB 78 premium tax payments made to the State of California during the current fiscal year ended June 30, 2023, and the decrease in accrued MCO taxes as a result of the MCO tax expiring on December 31, 2022.

The premium tax payable balance increased $4.1 million from $43.5 million at June 30, 2021, to $47.6 million at June 30, 2022. The premium tax payable balance primarily represents the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues, and the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis. The increase is primarily due to the increase in the MCO tax amount for the fiscal year ended June 30, 2022.

Medical claims payable – The medical claims payable balance represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed and reported but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but not yet reported to the Plan.

The medical claims payable balance decreased $48,806 from $120,689 at June 30, 2023, to $71,883 at June 30, 2024. The balance at June 30, 2024, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2024.

The medical claims payable balance increased $24,356 from $96,333 at June 30, 2022, to $120,689 at June 30, 2023. The balance at June 30, 2023, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2023.

The medical claims payable balance increased $32,935 from $63,398 at June 30, 2021, to $96,333 at June 30, 2022. The balance at June 30, 2022, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2022.

Directed payment payable – The directed payment payable balance represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

The directed payment payable balance increased $2.6 million from $2.2 million at June 30, 2023, to $4.8 million at June 30, 2024. The increase is primarily due to the timing of directed payments to the network hospitals and skilled nursing facilities.

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The directed payment payable balance decreased $1.5 million from $3.7 million at June 30, 2022, to $2.2 million at June 30, 2023. The decrease is primarily due to the timing of directed payments to the network hospitals.

The directed payment payable balance increased $469,090 from $3.2 million at June 30, 2021, to $3.7 million at June 30, 2022. The increase is primarily due to the timing of directed payments to the network hospitals.

Other liabilities – Other liabilities remained a balance of $25,907 during the years ended June 30, 2024 and 2023.

Other liabilities increased $25,907 from $0 at June 30, 2021, to $25,907 at June 30, 2022. The increase is due to the Plan receiving a tenant's security deposit related to a lease agreement entered into during the year ended June 30, 2022.

Deferred inflow of resources – The Plan as a lessor, recognized a deferred inflow of resources corresponding to the lease receivable amount, and it is defined as an acquisition of net position by the Plan that is applicable to future reporting periods.

Deferred inflow of resources balance decreased $632,410 from $2.8 million at June 30, 2023, to $2.2 million at June 30, 2024. The decrease is due to recognition of lease revenue corresponding to collection of lease payments from tenants by the Plan during the year ended June 30, 2024.

Deferred inflow of resources balance decreased $1.1 million from $3.9 million at June 30, 2022, to $2.8 million at June 30, 2023. The decrease is due to recognition of lease revenue corresponding to collection of lease payments from tenants by the Plan during the year ended June 30, 2023.

During the fiscal year ended June 30, 2022 and 2021, the Plan retrospectively adopted GASB Statement No. 87, *Leases*. Deferred inflow of resources balance was $3.9 million as of June 30, 2022.

Statements of Revenues, Expenses, and Changes in Net Position

The Statements of Revenues, Expenses, and Changes in Net Position are a presentation of the Plan's operating results for the fiscal years ended June 30, 2024, 2023, and 2022. In accordance with Governmental Accounting Standards Board (GASB) requirements, certain significant revenues are mandated to be recorded as nonoperating revenues, including investment income. The following is a summary of the operating results for fiscal years ended June 30, 2024, 2023, and 2022.

Capitation revenue – The capitation revenue balance increased $758.6 million from $1,289.5 million at June 30, 2023, to $2,048.1 million at June 30, 2024.The increase is primarily due to the increase in capitation rates from DHCS, membership, and the MCO tax revenue as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

The capitation revenue balance decreased $49.0 million from $1,338.5 million at June 30, 2022, to $1,289.5 million at June 30, 2023. The decrease is primarily due to the expiration of the MCO tax related revenues on December 31, 2022, and the Proposition 56 premium revenue recoupment by DHCS, offset by the increase in membership and capitation rates from DHCS.

The capitation revenue balance increased $4.1 million from $1,334.4 million at June 30, 2021, to $1,338.5 million at June 30, 2022. The increase is primarily due to the increase in membership and the MCO tax revenue, offset by the decrease in capitation rates from DHCS.

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Nonoperating revenue – The nonoperating revenue balance increased $3.2 million from $5.9 million at June 30, 2023, to $9.1 million at June 30, 2024. The increase is due to the increase in investment income and rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

The nonoperating revenue balance increased $5.0 million from $897,393 at June 30, 2022, to $5.9 million at June 30, 2023. The increase is due to the increase in investment income and rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

The nonoperating revenue balance increased $172,181 from $725,212 at June 30, 2021, to $897,393 at June 30, 2022. The increase is due to the increase in investment income and rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

Health care expenses – Overall health care expenses consists of the capitation payment that the Plan pays to its subcontracting entities for health care services provided to CalViva members and for the direct payment of medical claims, including claims which have been incurred but not yet reported.

Overall health care expenses increased $186.0 million from $1,123.9 million at June 30, 2023, to $1,309.9 million at June 30, 2024. The increase is primarily due to the increase in capitation rates from DHCS and membership.

Overall health care expenses increased $21.4 million from $1,102.5 million at June 30, 2022, to $1,123.9 million at June 30, 2023. The increase is primarily due to the increase in membership and capitation rates from DHCS, offset by Proposition 56 capitation recoupment from Health Net.

Overall health care expenses decreased $12.8 million from $1,115.3 million at June 30, 2021, to $1,102.5 million at June 30, 2022. The decrease is primarily due to the decrease in capitation rates from DHCS, as DHCS transitioned all pharmacy services from Medi-Cal managed care plans to a DHCS fee-for-service benefit, known as Medi-Cal Rx, effective January 1, 2022, offset by an increase in membership.

General and administrative expenses – Overall general and administrative expenses increased $1.9 million from $66.7 million at June 30, 2023, to $68.6 million at June 30, 2024. The increase is primarily attributable to the increase in expenditures related to administrative service agreement fees, insurance, and salary and benefits, offset by a decrease in grants. General and administrative expenses as a percentage of revenue totaled 3.3% and 5.1% for the fiscal years ended June 30, 2024 and 2023, respectively.

Overall general and administrative expenses increased $4.8 million from $61.9 million at June 30, 2022, to $66.7 million at June 30, 2023. The increase is primarily attributable to the increase in expenditures related to administrative service agreement fees, license, and grants. General and administrative expenses as a percentage of revenue totaled 5.1% and 4.6% for the fiscal years ended June 30, 2023 and 2022, respectively.

Overall general and administrative expenses increased $2.3 million from $59.6 million at June 30, 2021, to $61.9 million at June 30, 2022. The increase is primarily attributable to the increase in expenditures related to administrative service agreement fees, license, marketing, and salary and benefits, offset by a decrease in grants. General and administrative expenses as a percentage of revenue totaled 4.6% and 4.5% for the fiscal years ended June 30, 2022 and 2021, respectively.

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Premium tax – In 2009, AB 1422 was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal managed care plans would be subject to a gross premium tax (GPT). CalViva is required to pay 2.35% on gross Medi-Cal capitation revenues to the State of California. The GPT program concluded on June 30, 2012. In June 2013, SB 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. The collected taxes are matched by federal dollars and are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. The State of California calculates the gross premium tax amount in CalViva's capitation rates; as such, the premium tax has no financial impact on the Plan.

On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined.

On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare and Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. The premium tax recorded was $658.3 million, $91.4 million, and $166.2 million for the fiscal years ended June 30, 2024, 2023, and 2022, respectively.

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Report of Independent Auditors

The Commissioners
The Fresno-Kings-Madera Regional Authority
dba CalViva Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of The Fresno-Kings-Madera Regional Authority dba CalViva Health, which comprise the statements of net position as of June 30, 2024 and 2023, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of The Fresno-Kings-Madera Regional Authority dba CalViva Health as of June 30, 2024 and 2023, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS") and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of The Fresno-Kings-Madera Regional Authority dba CalViva Health and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Authority dba CalViva Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

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Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 11 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of The Fresno-Kings-Madera Regional Authority dba CalViva Health's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

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San Francisco, California
October __, 2024

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Financial Statements

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position
June 30, 2024 and 2023

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	2024	2023
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 262,152,446	$ 146,193,997
Capitation receivables from the State of California	176,787,742	123,128,027
Receivable from Health Net	39,892,500	30,109,892
Other receivables	876,877	496,762
Prepaid expenses	249,953	1,369,227
Other assets	-	23,662
Lease receivable - current portion	675,406	605,142
Total current assets	480,634,924	301,926,709
CAPITAL ASSETS		
Nondepreciable	3,273,089	3,161,419
Depreciable, net of accumulated depreciation and amortization	5,824,694	6,141,870
Total capital assets	9,097,783	9,303,289
LEASE RECEIVABLE - NONCURRENT PORTION	1,939,362	2,614,768
ASSETS RESTRICTED AS TO USE	304,185	301,821
Total assets	$ 491,976,254	$ 314,146,587

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position (Continued)
June 30, 2024 and 2023

	2024	2023
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Capitation payable	$ 119,630,944	$ 117,545,662
Amounts due to the State of California	40,500,000	42,291,066
Accounts payable and accrued expenses	5,991,385	6,050,791
Accrued salaries and benefits	403,714	352,199
Premium tax payable	156,731,654	1,447,177
Medical claims payable	71,883	120,689
Directed payment payable	4,754,619	2,165,916
Total current liabilities	328,084,199	169,973,500
OTHER LIABILITIES	25,907	25,907
Total liabilities	328,110,106	169,999,407
DEFERRED INFLOWS OF RESOURCES	2,176,214	2,808,624
Total liabilities and deferred inflow of resources	$ 330,286,320	$ 172,808,031
NET POSITION		
Invested in capital assets	$ 9,097,783	$ 9,303,289
Restricted by legislative authority	304,185	301,821
Unrestricted	152,287,966	131,733,446
Total net position	161,689,934	141,338,556
Total liabilities, deferred inflow of resources, and net position	$ 491,976,254	$ 314,146,587

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See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2024 and 2023

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	2024	2023
OPERATING REVENUES		
Capitation revenue	$ 2,048,060,849	$ 1,289,511,475
OPERATING EXPENSES		
Health care expenses:		
Capitation expense	1,308,574,628	1,122,512,458
Medical expense	1,349,780	1,384,580
Total health care expenses	1,309,924,408	1,123,897,038
General and administrative expenses:		
Administrative service fees	57,606,857	56,171,137
Other expense	5,171,849	5,230,143
Salaries and benefits	3,677,058	3,277,790
Marketing and promotion	1,392,135	1,393,787
Depreciation and amortization	327,624	299,109
Legal and professional	413,163	342,677
Total general and administrative expenses	68,588,686	66,714,643
Premium tax	658,279,779	91,436,708
Total operating expenses	2,036,792,873	1,282,048,389
Income from operations	11,267,976	7,463,086
NONOPERATING REVENUE		
Other income	632,410	632,410
Interest income	8,450,992	5,292,062
Total nonoperating revenue	9,083,402	5,924,472
CHANGES IN NET POSITION	20,351,378	13,387,558
NET POSITION, beginning of year	141,338,556	127,950,998
NET POSITION, end of year	$ 161,689,934	$ 141,338,556

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Cash Flows
Years Ended June 30, 2024 and 2023

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	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	$ 1,984,618,526	$ 1,252,247,915
Health care expenses paid	(1,307,090,295)	(1,068,721,846)
Administrative expenses paid	(570,501,434)	(204,141,194)
Net cash provided by (used in) operating activities	107,026,797	(20,615,125)
CASH FLOWS FROM NONCAPITAL FINANCING AND RELATED ACTIVITY		
Proceeds from lease receivable	786,031	745,426
Net cash provided by noncapital financing and related activity	786,031	745,426
CASH FLOWS FROM CAPITAL FINANCING AND RELATED ACTIVITY		
Payments for purchase of capital assets	(122,118)	(196,556)
Net cash used in capital financing and related activity	(122,118)	(196,556)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest income, net	8,267,739	5,079,172
Net cash provided by investing activity	8,267,739	5,079,172
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	115,958,449	(14,987,083)
CASH AND CASH EQUIVALENTS, beginning of year	146,193,997	161,181,080
CASH AND CASH EQUIVALENTS, end of year	$ 262,152,446	$ 146,193,997
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
Income from operations	$ 11,267,976	$ 7,463,086
Adjustments to reconcile income from operations to net cash provided by (used in) operating activities:		
Depreciation and amortization	327,624	299,109
Changes in operating assets and liabilities:		
Capitation receivables from the State of California	(53,659,715)	(7,153,668)
Receivable from Health Net	(9,782,608)	(30,109,892)
Other receivables	(380,115)	(411,624)
Prepaid expenses	1,119,274	(105,494)
Other assets	23,662	(23,662)
Capitation payable	2,085,282	22,846,581
Amounts due to the State of California	(1,791,066)	33,814,496
Accounts payable and accrued expenses	(59,406)	380,874
Accrued salaries and benefits	51,515	37,791
Premium tax payable	155,284,477	(46,166,837)
Medical claims payable	(48,806)	24,356
Directed payment payable	2,588,703	(1,510,241)
Net cash provided by (used in) operating activities	$ 107,026,797	$ (20,615,125)

See accompanying notes.

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Note 1 – Organization

The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is a local governmental health insuring organization that operates in the counties of Fresno, Kings, and Madera (Tri-Counties). The Boards of Supervisors for the Tri-Counties established The Fresno-Kings-Madera Regional Health Authority (the Authority) in March 2009, in accordance with the State of California Welfare and Institutions Code (the Code) Section 14087.38. Through the provisions of the "Joint Exercise of Powers Agreement between the counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs" agreement, dated March 2009, and pursuant to the Code, CalViva became financially independent of Fresno, Kings, and Madera counties. In addition, the Code provides that CalViva is a public entity, separate and apart from the counties of Fresno, Kings, and Madera. CalViva received its Knox-Keene license from the California Department of Managed Health Care (DMHC) on December 30, 2010, and commenced operations on March 1, 2011.

The mission and purpose of CalViva is to improve access to care and provide quality health care to families in the Fresno, Kings, and Madera County areas at the right place and the right time.

CalViva has contracted with the California Department of Health Care Services (DHCS) to receive funding to provide health care services to the Medi-Cal eligible Tri-County area residents who are enrolled as members of CalViva under the two-plan model. The DHCS contract is effective March 1, 2011, through December 31, 2024. The DHCS contract specifies capitation rates based on a per-member, per-month basis, which may be adjusted annually. DHCS revenue is paid monthly and is based upon the contracted capitation rates and actual Medi-Cal enrollment. In addition, DHCS pays CalViva supplemental capitation rates such as a fixed maternity case rate for each eligible birth incurred by a CalViva Medi-Cal member. CalViva, in turn, provides services to Medi-Cal beneficiaries through a contract with Health Net Community Solutions, Inc. (Health Net), a wholly owned subsidiary of Centene Corporation. Further, CalViva has an administrative service agreement with Health Net in which Health Net performs specific administrative functions for CalViva.

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On September 2, 2009, the California State Legislature ratified Assembly Bill (AB) No. 1422 (AB 1422), which levies a 2.35% gross premium tax (GPT) on all Medi-Cal capitated revenue received. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. This provision was effective retroactively to January 1, 2009. The GPT program was concluded on June 30, 2012. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026.

On September 8, 2010, the California State Legislature ratified AB No. 1653 (AB 1653), which established a Quality Assurance Fee (QAF) program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions (W&I) Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding:
Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services," and Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass-through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the QAF program through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. In October of 2013, California approved SB 239, which extended the QAF program for an additional 36 months from January 1, 2014, through December 31, 2016. In November of 2016, the voters of California passed Proposition 52, which permanently extended the QAF program.

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Beginning with the July 1, 2017, rating period, DHCS implemented the following managed care Directed Payment programs: (1) Private Hospital Directed Payment (PHDP), (2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP), and (3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, this program provides supplemental reimbursement to participating Network Provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The PHDP program was created to maintain access and improve the quality of care for Medi-Cal beneficiaries. (2) For EPP-FFS and EPP-CAP, this program provides supplemental reimbursement to Network Provider designated public hospitals through either a uniform dollar or percentage increase based on actual utilization of network contracted qualifying services. (3) For QIP, DHCS has directed the Medi-Cal managed care health plans (MCPs) to make QIP payments to designated public hospitals and University of California hospitals that are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments will be linked to delivery of services and increase the amount of funding tied to quality outcomes.

Beginning with January 1, 2023 date of service, DHCS implemented the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) to provide performance-based directed payments to eligible network provider SNFs to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP is authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB)186 (Chapter 46, Statutes of 2022)) for dates of service from January 1, 2023, through December 31, 2026. DHCS has directed Medi-Cal managed care plans to make SNF WQIP payments to eligible SNFs according to utilization and performance on designated WQIP metrics.

CalAIM implementation – Beginning January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. This requires managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. Components that began on January 1, 2022, include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. In addition, institutional Long-Term Care (LTC) benefit including skilled nursing facilities transitioned to Medi-Cal managed care plans effective January 1, 2023. Effective January 1, 2024, all Medi-Cal managed care plans became responsible for the full LTC benefit at facility types such as Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, Pediatric Subacute Care Facility and Subacute Care Facility.

Note 2 – Summary of Significant Accounting Policies

Accounting standards – Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements, as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts, and the State Controller's Office prescribed reporting guidelines.

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Proprietary fund accounting – The Plan utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Use of estimates – The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates used in preparing the financial statements include capitation receivables from the State of California, receivable from Health Net, medical claims payable such as liability for incurred but not reported claims expense, useful lives of capital assets, lease receivable, and deferred inflow of resources.

Risks and uncertainties – The Plan's business could be impacted by external price pressure on new and renewal business; additional competitors entering the Plan's markets; federal and state legislation; and governmental licensing regulations of Health Maintenance Organizations (HMOs) and insurance companies. External influences in these areas could have the potential to adversely impact the Plan's operations in the future.

Income taxes – The Plan operates under the purview of the Internal Revenue Code (IRC) Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, the Plan is not subject to federal or state income taxes.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits and other short-term, highly liquid securities with original maturities of three months or less.

Concentration of risk – Financial instruments potentially subjecting the Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (FDIC) insurance thresholds. If any of the financial institutions with whom the Plan does business were placed into receivership, the Plan may be unable to access the cash on deposit with such institutions in order to operate its business without adverse effect. As of June 30, 2024 and 2023, the Plan's uninsured cash and cash equivalent balance totaled $261,761,773 and $145,802,741, respectively. To date, the Plan has not experienced any losses on these accounts.

The Plan is highly dependent upon the State of California for its revenues. All capitation receivable and capitation revenues are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Plan.

The Plan has a contract with Health Net whereby Health Net provides virtually all administrative services vital to the Plan's successful daily operation. In addition, the Plan has a capitation agreement with Health Net whereby the Plan utilizes Health Net's network of contracted providers to furnish care for most of the Plan's members. The inability of Health Net to meet its obligations under these contracts could significantly impact the Plan's ability to operate in the short term until alternative arrangements could be made.

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Capital assets – Capital assets are recorded at cost. The capitalization threshold of such assets is $10,000. Depreciation of capital assets is based on the straight-line method over the estimated useful lives of the assets, estimated to be three to 30 years. Expenditures for maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized.

The Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Lease receivable and deferred inflow of resources – Pursuant to GASB Statement No. 87, *Leases*, the Plan as a lessor recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Plan during the lease term. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Plan that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Plan recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative future receipts on the contract exceed $100,000 that meet the definition of an other than short-term lease. The Plan uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Assets restricted as to use – The Plan is required by the DMHC to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amount recorded was $304,185 and $301,821 at June 30, 2024 and 2023, respectively. Restricted cash comprises certificates of deposit and is stated at fair value.

Medical claims payable – Medical claims payable balance of $71,883 and $120,689 at June 30, 2024 and 2023, respectively, represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but not yet reported to the Plan. The balances at June 30, 2024 and 2023, were determined by factors such as cost of services and enrollment for providers paid on a fee-for-service basis.

Net position – Net position is classified as invested in capital assets and restricted or unrestricted net position. Invested in capital assets represents investments in land, building, furniture and fixtures, and computer equipment and software, net of depreciation and amortization. Restricted net position is noncapital assets that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Plan. Unrestricted net position consists of net position that does not meet the definition of invested in capital assets or restricted net position.

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Operating revenues and expenses – The Plan's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. The primary operating revenue is derived from capitation in support of providing health care services to its members. Operating expenses are all expenses incurred to provide such health care services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to investing and financing activities.

Capitation revenue – Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. The State of California pays the Plan capitation revenue on a monthly basis based on initial membership, which is adjusted monthly for retroactivity. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by the Fresno County Department of Social Services, the Madera County Department of Social Services, and the Kings County Human Services Agency, and validated by the State of California. The State of California provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

Premium deficiencies – The Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2024 and 2023.

Capitation expense and medical expenses – CalViva contracts with providers to furnish health care services to enrolled members. The expenses related to these provisions for covered services to enrolled CalViva members are recognized on an accrual basis.

Premium tax – The Plan paid the State of California a gross premium tax (AB 1422), which was levied in September 2009 pursuant to Section 28 of Article XIII of the California Constitution and is effective retroactively from January 1, 2009, to June 30, 2012. The payment amount is determined by multiplying the Plan's capitation revenue by 2.35%. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans, as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016--2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 2019, Assembly Bill 115 authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115. The new MCO tax was effective retroactively from April 1, 2023, through December 31, 2026. The premium tax equaled $658,279,779 and $91,436,708 for the years ended June 30, 2024 and 2023, respectively. Premium tax is recognized in the period the related capitation revenue is recognized.

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Insurance coverage – The Plan maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the "claims-made" policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the term of the "claims-made" policies but reported subsequent to the termination of the insurance contract may be uninsured.

New accounting pronouncements – In June 2022, the GASB issued Statement No. 100, *Accounting Changes and Error Corrections—an amendment of GASB Statement No. 62*. This Statement enhances accounting and financial reporting requirements for accounting changes and error corrections. It defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity. This statement requires that (1) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (2) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (3) changes in accounting estimates be reported prospectively by recognizing the change in the current period. The statement is effective for fiscal years beginning after June 15, 2023. The Plan adopted the standard effective July 1, 2023, and the adoption had no material impact on the financial statements.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences*. The Statement updates the recognition and measurement guidance for compensated absences. This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. This statement is effective for fiscal years beginning after December 15, 2023. The Plan is currently evaluating the impact of the adoption of this standard on its financial statements.

Note 3 – Investments

The Plan held investments as of June 30 as follows:

	2024	2023
Assets restricted as to use	$ 304,185	$ 301,821
	$ 304,185	$ 301,821

Investments authorized by the Plan's investment policy – Investments may only be made as authorized by the Plan's investment policy. The objective of the policy is to ensure the Plan's funds are prudently invested to preserve capital and provide necessary liquidity.

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Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, an entity will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, an entity will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code requires that a financial institution secure deposit made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit).

As of June 30, 2024 and 2023, none of the Plan's deposits with financial institutions in excess of federal depository insurance limits were held in uncollateralized accounts and none of the Plan's investments were subject to custodial credit risk.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Plan did not have any investments that were considered highly sensitive to changes in interest rates as of June 30, 2024 and 2023.

Information about the sensitivity of the fair values of the Plan's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the Plan's investments by maturity:

	Remaining Maturity (in Months) as of June 30, 2024			
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	$ 304,185	$ 304,185	$ -	$ -
Total	$ 304,185	$ 304,185	$ -	$ -

	Remaining Maturity (in Months) as of June 30, 2023			
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	$ 301,821	$ -	$ 301,821	$ -
Total	$ 301,821	$ -	$ 301,821	$ -

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Investments made by the Plan are not rated by Standard & Poor's, but are fully FDIC insured.

Concentration of credit risk – The investment policy of the Plan contains no limitation on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code. More than 5% of the Plan's investments are in certificates of deposit issued by the United Security Bank and the First Federal Savings and Loan Association as of June 30, 2024. These investments were 83.45% and 16.55%, respectively, of the Plan's total investments as of June 30, 2024. More than 5% of the Plan's investments are in certificates of deposit issued by the United Security Bank and the First Federal Savings and Loan Association as of June 30, 2023. These investments were 83.38% and 16.62%, respectively, of the Plan's total investments as of June 30, 2023.

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Note 4 – Capital Assets, Net

A summary of changes in capital assets, net for the years ended June 30, 2024 and 2023, is as follows:

	Balance at July 1, 2023	Additions	Retirements	Balance at June 30, 2024
Land	$ 3,161,419	$ -	$ -	$ 3,161,419
Construction in Progress	-	111,670	-	111,670
Building	7,993,729	-	-	7,993,729
Furniture and fixtures	228,486	10,448	-	238,934
Computer equipment and software	91,982	-	(20,259)	71,723
Total assets	11,475,616	122,118	(20,259)	11,577,475
Less: depreciation expense and accumulated depreciation related to retirements	(2,172,327)	(327,624)	20,259	(2,479,692)
Capital assets, net	$ 9,303,289	$ (205,506)	$ -	$ 9,097,783

	Balance at July 1, 2022	Additions	Retirements	Balance at June 30, 2023
Land	$ 3,161,419	$ -	$ -	$ 3,161,419
Building	7,915,914	77,815	-	7,993,729
Furniture and fixtures	219,213	62,741	(53,468)	228,486
Computer equipment and software	40,028	56,000	(4,046)	91,982
Total assets	11,336,574	196,556	(57,514)	11,475,616
Less: depreciation expense and accumulated depreciation related to retirements	(1,916,133)	(299,109)	42,915	(2,172,327)
Capital assets, net	$ 9,420,441	$ (102,553)	$ (14,599)	$ 9,303,289

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Note 5 – Capitation Receivables from the State of California

CalViva receives capitation from the State of California based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State of California makes monthly payments based on actual members for the current month and retroactive adjustments related to prior months. The capitation receivable represents amounts due from the State of California under the Medi-Cal program. CalViva had capitation receivable of $176,787,742 and $123,128,027 due from the State of California as of June 30, 2024 and 2023, respectively.

Note 6 – Receivable from Health Net

CalViva recoups capitation from Health Net based upon premium revenue CalViva repays DHCS. Due to changes in DHCS' actuarial assumptions such as but not limited to the difference between the actual enrollment data and DHCS' original enrollment projections for the period of January 1, 2023, through December 31, 2023, DHCS actuarially determined there would be lower costs and utilization for this period and therefore retroactively reduced the calendar year 2023 capitation rates for capitation premium previously paid to the Plan. This has resulted in CalViva needing to recoup from Health Net a portion of the capitation payments it previously overpaid to Health Net. The Plan recorded a receivable from Health Net of $39,892,500 as of June 30, 2024.

For the Proposition 56 directed payment program funded by the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56), DHCS uses a two-sided risk corridor, retrospectively, to set certain thresholds of medical expenses compared to premium revenue from the program. Medical expenditures not meeting a minimum threshold as a percentage of revenue will require the Plan to refund premium revenue to DHCS. As a result of the Proposition 56 premium revenue recoupment by DHCS, the Plan recorded capitation receivable from Health Net in the amount of $30,109,892 as of June 30, 2023. This capitation receivable balance was fully collected from Health Net during the fiscal year ended June 30, 2024.

Note 7 – Capitation Payable

CalViva contracts with providers to furnish certain health care services to enrolled members. The cost of health care services provided or contracted for is accrued in the period in which it is provided to an enrolled member. The Plan recorded capitation payable of $119,630,944 and $117,545,662 as of June 30, 2024 and 2023, respectively.

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Note 8 – Amounts Due to the State of California

The initial Medi-Cal managed care rates for the period of January 1, 2023, through December 31, 2023 were developed assuming the start of the unwinding of Medicaid enrollment to be April 1, 2023, which was postponed to be July 1, 2023, in actuality. In addition, the implementation date of the Intermediate Care Facility for Developmentally Disabled (ICF/DD) and Subacute Long-Term Care (LTC) member transition was delayed from July 1, 2023, to January 1, 2024. Considering the difference between the actual enrollment data and the original enrollment projections, including the delayed implementation of the ICF/DD and Subacute LTC services, DHCS anticipated lower costs and utilization for this period. As a result, DHCS amended the calendar year 2023 rates which results in retroactive rate reductions to capitation premiums previously paid to the Plan, and, consequently, will be recouping funds accordingly. As such, CalViva recorded amounts due to the State of California of $40,500,000 as of June 30, 2024.

When DHCS created the MCO tax revenue rate for calendar year 2022, DHCS utilized a lower enrollment projection as DHCS assumed that the public health emergency (PHE) for the novel coronavirus (COVID-19) pandemic would end in December 2021. When utilizing a lower enrollment projection, it resulted in a higher MCO tax revenue rate. As the PHE was extended through May 11, 2023, the Plan's enrollment was higher than DHCS' projection from January 2022, through December 2022. The higher MCO tax revenue rate and higher enrollment have contributed to the Plan recognizing an MCO tax gain for the period of January 1, 2022, through December 31, 2022. Due to the extension of the PHE and DHCS' recalculation of the MCO tax revenue rate for the time period of January 1, 2022, through December 31, 2022, CalViva recorded amounts due to the State of California of $11,722,648 as of June 30, 2023, related to DHCS' future recoupment of the MCO tax gain. This payable balance was fully paid to DHCS during the fiscal year ended June 30, 2024.

Under the two-sided risk corridor provision for the Proposition 56 program, medical expenditures not meeting a minimum threshold as a percentage of revenue set by DHCS will require the Plan to refund premium revenue to DHCS, resulting in a liability owed to the State of California. CalViva recorded amounts due to the State of California of $30,568,418 as of June 30, 2023, related to the Proposition 56 two-sided risk corridor. This payable balance was fully paid to DHCS during the fiscal year ended June 30, 2024.

Note 9 – Directed Payment Payable

CalViva is under the direction of the DHCS to implement the directed payment program for enhanced reimbursements to eligible and participating network hospitals and skilled nursing facilities for qualifying contracted services. Directed payment payable balance of $4,754,619 and $2,165,916 as of June 30, 2024 and 2023, respectively, represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

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Note 10 – Retirement and Deferred Compensation Plans

Retirement plan – Effective January 1, 2010, the Plan established a defined contribution money purchase pension plan, 401(a), for its executive employees. The contribution requirement is established by the Plan. Employees do not make contributions to the Plan. Furthermore, employer contributions are immediately vested. The amounts are not available to employees until termination, retirement, death, disability, and other specific conditions. The Plan's contributions to the retirement plan totaled $226,938 and $206,486 for the years ended June 30, 2024 and 2023, respectively.

Deferred compensation plan – The Plan offers its employees a deferred compensation plan created in accordance with IRC Section 457. The 457b deferred compensation plan is available to all employees and permits them to defer a portion of their salary. An employer match is also provided and is vested at the rate of 33% per year. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency. The Plan's contributions to the deferred compensation plan totaled $112,517 and $92,101 for the years ended June 30, 2024 and 2023, respectively.

The market value of the investments held equals the amounts due to plan participants under both deferred compensation plans. The assets in both deferred compensation plans referenced above are not available to pay the liabilities of CalViva. CalViva is not controlling the assets in both deferred compensation plans, and employees who participate in these plans are responsible for the direction, use, exchange, or employment of the assets. Therefore, the respective assets and liabilities are not reflected in the statements of net position.

Note 11 – Lessor Lease Arrangements

The Plan is a lessor for noncancelable leases of office space with lease terms through 2029. Lease revenue from the lease arrangements was $632,410 for the years ended June 30, 2024 and 2023, and is included in other income in the statements of revenues, expenses, and changes in net position. Interest revenue from the lease arrangements was $243,260 and $285,600 for the years ended June 30, 2024 and 2023, respectively, and is included in interest income in the statements of revenues, expenses, and changes in net position.

Note 12 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity was $21,980,608 and $14,395,115 at June 30, 2024 and 2023, respectively. The Plan's tangible net equity was $161,689,934 and $141,338,556 at June 30, 2024 and 2023, respectively.

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Note 13 – Risk Management

The Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Plan's commercial coverage.

Note 14 – Commitments and Contingencies

Litigation – In the ordinary course of business, the Plan is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the Plan's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Plan.

Note 15 – Health Care Reform

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates, or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted, cannot presently be determined.

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COMMUNICATIONS WITH THE COMMISSIONERS

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

June 30, 2024

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Communications with the Commissioners

The Commissioners
The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

We have audited the financial statements of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva) as of and for the year ended June 30, 2024, and have issued our report thereon dated October __, 2024. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated May 2, 2022, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. As part of an audit conducted in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control over financial reporting. Accordingly, we considered The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you, as stated in our engagement letter dated May 2, 2022.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by The Fresno-Kings-Madera Regional Health Authority dba CalViva Health are described in Note 2 to the financial statements. During fiscal year 2024, The Fresno-Kings-Madera Regional Health Authority dba CalViva Health adopted Governmental Accounting Standards Board Statement No. 100, *Accounting Changes and Error Corrections*. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2024. We noted no transactions entered into by CalViva during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transactions occurred.

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Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management recorded estimated capitation receivables from the State of California. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosure affecting the financial statements was related to capitation revenue and is disclosed in Note 2 to the financial statements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of CalViva's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of CalViva's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements the effects of which, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October __, 2024.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to CalViva's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health and management of the Commissioners of the Fresno-Kings-Madera Regional Health Authority dba CalViva Health, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October __, 2024

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Item #6
Attachment 6.A-B

2024 Health Equity

A. Executive Summary
B. Work Plan Mid-Year Evaluation

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist Sia Xiong Lopez, Health Equity Officer
COMMITTEE DATE:	October 17, 2024
SUBJECT:	Health Equity 2024 Work Plan Mid-Year Evaluation – Summary Report

Summary:

This report provides information on the Health Equity Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The Health Equity Work Plan is broken down into the following four sections: 1) Language Assistance Program (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of June 30, 2024, all work plan activities are on target to be completed by the end of the year with some already completed.

Purpose of Activity:

To evaluate the mid-year progress against the work plan activities and identify changes to be made to meet end of year goals. CalViva Health (CVH) has delegated all language services to Health Net's Health Equity Department.

Data/Results (include applicable benchmarks/thresholds):

Below is a high-level summary of the activities completed during the first six months of 2024. For complete report and details per activity, please refer to the attached 2024 Health Equity Work Plan Mid-Year Evaluation Report.

a. Language Assistance Services

a. Completed audit requirements for Behavioral Health and Health Equity Oversight.
b. Amended 3 language vendors' contracts, amendment includes adding tactile and CART service and updating vendors' rates.
c. One hundred and forty-five staff completed their bilingual assessment or were re-assessed.
d. Eight translation reviews were completed.
e. Completed annual report of the LAP assessment results for the Timely Access Reporting.

b. Compliance Monitoring

a. Health Equity reviewed 20 grievance cases with no intervention identified and 4 interpreter complaints.

b. Completed, presented and received approval for the 2023 End of Year Language Assistant Program, 2023 End of Year Work Plan reports, the 2024 Program Description, and 2024 Work Plan.
c. Attended all Public Policy Committee meetings.
d. Completed one findhelp training for providers.
e. 871 referrals for CalViva Members were made in findhelp, 147 members got help, and 584 new programs were added to the platform.

c. Communication, Training and Education

a. Annual coding and resolution of grievance training for new hires and current A&G staff on track to complete in Q3.
b. Provider newsletter on track to complete in Q3.
c. Provider materials available in provider library, materials include LAP program and findhelp How-to guide.

d. Health Literacy, Cultural Competency and Health Equity

a. English material review completed for a total of 8 materials.
b. Hosted two Readability and EMR Database training.
c. National Health Literacy Month on track to complete in Q4.
d. Trained providers on LAP and the use of plain language in Q2 with 93 attendees.
e. Cultural Competency and Implicit Bias Training for providers and staff are on track to complete in Q3 & Q4.
f. Completed key informant interviews and focus group for W30-6+ and MH/SUD PIP projects.

5) CalViva Health Equity

a. Administered Diversity, Equity and Inclusion (DEI) survey to Board, Public Policy Committee, Leadership and Staff Members. Opportunities identified surrounding DEI and results presented to Commission. Implementation of actions to start in Q4 2024.
b. Collaborated with Fresno Superintendent of Schools and the Cradle to Career Project of the Fresno Network Improvement Committee. The focus includes upstream measures to improve reading levels for children grades Pre-K to 3rd. Two schools identified in Fresno County rural areas to initiate project pilot to address Social Determinants of Health impacting performance.
c. To assist in improving follow up after an ED Visit for SUD or Mental Health issue in Fresno and Madera Counties, HEQ staff will utilize trusted community CBO to deliver cultural training for hospital staff serving this population. Binational, was identified as the CBO to deliver cultural training. Additional opportunities with Binational will also be considered.
d. DHCS/NCQA mandatory annual DEI CLAS training for all staff is on track to be completed in Q4 2024.

Analysis/Findings/Outcomes:

All activities are on target to be completed by the end of the year with some already completed. The Health Equity Department will continue to implement, monitor, and track C&L related services and activities.

Next Steps:

Continue to implement the remaining six months of the Health Equity 2024 CalViva Health Work Plan and report to the QI/UM Committee.

2024
Health Equity
Mid-Year Work Plan

Submitted by:
Patrick Marabella, MD, Chief Medical Officer
Amy Schneider, RN, BSN, Senior Director Medical Management

Mission:

CalViva Health's Health Equity mission is to be an industry leader in ensuring health equity for all members and their communities.

Goals:

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:
1. To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
2. To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
3. To advance and sustain cultural and linguistic innovations.

Objectives:

To meet these goals, the following objectives have been developed:
A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).
B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.
C. To be champions of cultural and linguistic services in the communities CalViva Health serves.
D. To promote and be champions for diversity of CalViva Health members, providers and Plan staff.

Selection of the Cultural and Linguistics Activities and Projects:

The Cultural and Linguistics Work Plan activities and projects are selected based on the results from the CalViva 2022 Population Needs Assessment Report (PNA) (i.e., demographics, health status, risk factors, and surveys), regulatory requirements, department evaluation report from the previous year, HEDIS results, contractual requirements, and strategic corporate goals and objectives. After review and input from senior management staff, projects and new departmental activities are identified and incorporated into this work plan. Programs and services are developed with special attention to the cultural and linguistic needs of our membership. This work plan addresses the needs of our Medi-Cal (MC) members.

Strategies:

The Health Equity Work Plan supports and maintains excellence in the cultural and linguistics activities through the following strategies:

^

A. Goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities;
B. Work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements;
C. Support information-gathering and addressing needs through Population Needs Assessment (PNA), data analysis, and participation in the CalViva Health Public Policy Committee (PPC);
D. Interacting with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The Health Equity Work plan is divided into the following areas in support of the Principal CLAS Standard (To provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs): 1) Language Assistance Program Activities, 2) Compliance Monitoring, 3) Communication, Training and Education and 4) Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity.

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Table of Contents

^ revision
* new

	Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/24 - 6/30/24)	Year-End Update (7/1/24 - 12/31/24)
	Language Assistance Program Activities					
1	**Rationale**	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2	**Responsible Staff:**	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3	Audit	Assure C&L audit readiness to support DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: collecting requested documentation, submitting documents as requested, participate in on-site interviews as requested	Annual	Completed audit requirements for CalViva Behavioral Health & CalViva Health Equity Oversight Reviewed Provider Operations manual to ensure compliance with Medi-Cal and LAP requirements.	
4	Contracted Vendors	Conduct language assistance vendor management oversight	Review and update vendor contracts to ensure alignment with requirements	Ongoing	Amended 3 language vendors' contracts, amendment includes adding CART & tactile service and updated rates.	
5	Interpreter	Monthly collection of language utilization data for CalViva	Updated LAP utilization report to contain: monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log	Semi-annual	Interpreter requests include 735 face-to-face, 128 ASL, and 1 VRI. 4,021 calls handled with 2,218 being bilingual calls.	

^	**6**	Data	Conduct membership data pulls. Facilitate alignment and collection of demographic data. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly	Reports collected and stored on a monthly basis, from January to June 2024.	
	7	Operational	Create language and alternate format standing request report	Number of reports generated and posted	Weekly	These reports were uploaded and posted weekly for a total of 25 weeks.	
	8	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing	26 providers were audit. All received 100% compliance, except one with 92% compliance.	
	9	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint	June and December	Ongoing. No updates.	
^	**10**	Member Communication	Annual mailing to members advising how to access language assistance services and sending language assistance notice to assess language needs. Annual LAP mailing to survey REAL and SOGI.	Write or revise annual language assistance article distributed to CalViva members	Annual	The newsletter is scheduled to be mailed to members in September.	
	11	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified annually	Annual	145 staff were assessed or reassessed.	
	12	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis	Report to summarize utilization of LAP services, number of bilingual staff and provide year over year trends for the utilization of LAP services	Q2	2023 EOY LAP report was completed, submitted, and approved by committee in April.	

13	Operational	Oversight of interpreter and translation operations. Review of metrics for interpreter/translation coordination	Conduct oversight meetings to review metrics for timeliness. Hold quarterly meetings with Centralized Unit and escalate when metrics are not being met. The number of interpreter/translation coordinated.	Quarterly	Quarterly meetings conducted 1/24/2024 and 4/22/2024.	
14	Operational	Review interpreter service complaints (exempt grievance) reports and conduct trend analysis. Provide complaint information to impacted area for resolution, e.g., vendor, internal process	Monitor interpreter service vendors through service complaints	Annual (trend)	Interpreter service Call Center complaint logs are being received and monitored on a monthly basis.	
15	Operational	Coordinate and deliver Health Equity Department Quarterly meetings to review requirements and department procedures for language and health literacy services	Minutes of meetings	Quarterly	Quarterly meetings conducted 1/24/2024 and 4/22/2024.	
16	Operational	Complete Population Needs Assessment (PNA) in collaboration with Health Education. Review new PNA requirement and participate in PNA Workgroup to complete assessment report.	Support PNA data collection, interpretation for member demographics, disparity analysis and development of an action plan that addresses identified member needs	June	Ongoing and on track to be completed in 2025.	
17	Operational	Develop, update and maintain translation, alternate formats, interpreter services, bilingual assessment, and all Health Equity policies and procedures (P&Ps)	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Equity P&Ps	Annual	Annual updates completed in March 2024.	
18	Operational	Collect and review LAP P&Ps from other departments to assure compliance with use of tagline, NDN, translation process and interpreter coordination	P&Ps will be reviewed and placed in Health Equity LAP compliance folder	Annual	Annual tracking and updating of vital documents to be completed in Q3.	
19	Operational	Complete Health Equity Geo Access report documenting Provider Network Management (PNM) findings every two years	Data collection and data analysis for Health Equity Geo Access report, production of HEQ Geo Access report.	Q3 2025	On track to complete in 2025.	
20	Operational	Complete annual Timely Access Reporting on the Language Assistance Program Assessment	LAP Assessment Timely Access Report	Annually	TAR report completed in March and presented to committee in June.	

21	Operational	Coordinate and provide oversight to translation review process	Number of translation reviews completed	Ongoing	From January to June, done a total of 8 translation reviews.	
22	Training	Review, update and/or assign LAP online Training	Number of staff who are assigned training and percentage of completion	Annual	Updated training content in May/June 2024.	
23		Lead IT projects related to language assistance services such as standing request and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories	Successful implementation of IT projects	Ongoing	SOGI implementation ongoing; data fields successfully built through IT work streams in May 2024. REL updates pending for Q3.	
24	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing	Strategic partner contracts were collected in Q2 of 2024	
25	Translation and Alternate Format Management	Develop and maintain Translation and Alternate Format Tracking (TAFT) database with comprehensive list of members informing materials available and department responsible. Database will help support prompt identification of document and department responsible. Ongoing updating with bi-annual requests to all departments to review/update their list. Oversee implementation, management and updating of TAFT database	List of available materials	Ongoing	2024 document updates in April 2024.	
	Compliance Monitoring					
26	**Rationale**	**Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.**				
27	**Responsible Staff:**	**Primary: P. Lee, A. Said**	**Secondary: I. Diaz, N. Buller**			

28	Complaints and Grievances	Oversight of complaints and grievances related to LAP or C&L services, including monitoring and responding to all C&L related grievances. Collect grievance and call center reports. Maintain contact with the call center to ensure C&L complaints are monitored. Grievance reports include grievances coded to C&L codes (including discrimination due to language or culture). Maintain grievance response log and list of materials, develop and document interventions when indicated	Report on grievance cases and interventions	Ongoing	Investigated, responded, and provided resolution to 4 complaints. There were 20~~1~~ cases sent to C&L. A total of 20 cases coded to C&L with the following codes: 1) Cultural [C] code and 2) Linguistic [L]. 1 Cases was classified as a Quality of Care and re-coded as a non C&L Case. Of all of the cases, a total of 3 cases required a corrective action and/or a provider intervention. Information, tools and resources addressing each individual case were compiled and delivered via provider engagement to these providers.	
29	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers	Production of trend analysis report	August	2023 trend analysis completed and submit in Q2.	
30	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December	Annual Review and updates of desktop procedures for grievance resolution process to be completed in Q4.	

31	Oversight	Complete all CalViva required Health Equity/C&L reports	Develop Health Equity CalViva work plan, write/revise and submit Health Equity CalViva Program Description. Prepare and submit work plan, LAP mid year and end of year reports	Ongoing	Completed and presented HEQ 2023 EOY LAP report, 2023 HEQ EOY Workplan report, 2024 HEQ Program Description, and 2024 HEQ Workplan. Reports were accepted by committee in April.	
32	Oversight	Participate in CalViva required work groups and committees	Participate in the ACCESS workgroup, QI/UM workgroup, QI/UM committee, monthly operations management meetings. Provide support for Regional Health Authority meetings as needed or requested.	Ongoing	Attended weekly QI/UM meetings quarterly Access workgroup meetings.	
33	Oversight	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings as required.	Quarterly	Attended quarterly PPC meetings in March and June.	

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34	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal departments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within findhelp to address social risks within each month.	Ongoing	One provider training in May where 56 providers attended. 121 SNA completed 930 referrals 193 closed loops 147 members got help 871 referrals 193 closed loops 147 members got help 584 program added in Q1 and Q2. Added between 46-197 programs every month (Jan 131, Feb 70, March 79, April 61, May 46, June 197).	
	Communication, Training and Education					
35	**Rationale**	**To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.**				
36	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, N. Buller**			
37	Training and Support	Provide support and training to A&G on coding and resolution of grievances; re-align coding per 1557 non-discrimination reporting	Revised/updated Quick Reference Guide (QRG) for A&G staff regarding grievance responses, coding and process on sending to Health Equity, etc.	Ongoing	Training to be completed in September.	
38	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations).	Curriculum/power point, name of department and total number of participants who attended the in-service	Ongoing	Hosted and completed HEQ Collaboration Workgroup quarterly.	

39	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g. vendor attestation forms, threshold languages list, etc.	Ongoing	Completed and ongoing support.	
40	Provider Communication	Prepare and submit articles for publication to providers. Potential topics: LAP services, culture and health care, and promotion of on-line cultural competence/Office of Minority Health (OMH) training	Copies of articles and publication dates	Ongoing	Provider Update on LAP: N/A for Q1 and Q2; pending for Q3 2024.	
41	Provider Communication and Training	Promote C&L flyer and provider material about Health Equity Department consultation and resources available, inclusive of LAP program and interpreter services.	Provider material made available on provider's library.	Ongoing	Provider materials inclusive of LAP program and interpreter services are available on the provider library. Provider's findhelp How to Guide posted in Q2.	
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
42	**Rationale**	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**				
43	**Responsible Staff:**	**Primary: A. Kelechian**	**Secondary: A. Schoepf**			
44	English Material Review	Conduct English Material Review (EMR) per end-end document production guidelines (review of content and layout of materials for C&L appropriateness and low literacy)	Completion of all EMRs as tracked through the C&L database	Ongoing	8 EMRs were completed in Q1 and 20 completed in Q2.	
45	Operational	Review and update Health Literacy materials as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials	Update and post materials on Health Literacy SharePoint Explore new system platform to host EMR data	Ongoing	Review and updates completed in Q2. Fully migrated the EMR platform from IBM notes to Workfront in April.	

46	Training	Quarterly training for staff on how to use the C&L database and write in plain language, including online training.	Number of staff trained. Quarterly training	Quarterly	Quarterly training was offered for staff in Q1 & Q2. In Q2, 2 staff trainings were completed for the new Workfront EMR Request form. Plain language training to be scheduled for Q4.	
47	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities	October	On track for Q4.	
	Cultural Competency					
48	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**				
49	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, I. Diaz**			
50	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) for Health external workgroup	Minutes of meetings that reflect consultation and shared learning	Ongoing	Meetings attended 1/8/24; 3/11/2024; 5/13/2024; HICE Provider Toolkit update committee participation for 2024 toolkit. HICE Health Equity Accreditation Workgroup meetings attended 4/11/2024 HICE Ad Hoc C&L Meeting DEI 2/16/24 HICE Sub group meeting DEI/SB923 attended 2/16/24	

51	Provider Training	Conduct cultural competency, implicit bias, and gender identity training/workshops for contracted providers and provider groups upon request. Training content to include access to care needs for all members from various cultural and ethnic backgrounds, with limited English proficiency, disabilities, and regardless of their gender, sexual orientation or gender identity. Work with provider communication to implement ICE for Health computer based training through provider update and/or provider newsletters and/or medical directors, promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates. Work with provider engagement to publish invites for trainings and as warranted create on-demand trainings. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	Output number of providers who received cultural competency training by type of training received	Annual	Language Assistance Programs and the Use of Plain Language for Health Literacy; 06/26/2024; 93 attendees	
52	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations	Online tracking. Event summary and activity specific participation totals	Q3	On track to complete in August	
	Health Equity					
53	**Rationale**	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				
54	**Responsible Staff:**	**Primary: P. Lee, D. Fang,**	**Secondary: A. Schoepf**			

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	55	Operational	Increase interdepartmental alignment between population health, SDoH, cultural competency and disparity initiatives across departments on disparity reduction efforts. Facilitate quarterly meetings. Provide consultation and support to internal departments on SDoH and disparities.	Facilitation of health disparity collaborative quarterly meetings and intra departmental collaboration on Health disparities. Conduct trainings and share resources to staff/departments on disparities model, SDoH, and disparities in health outcomes among disparate population. Consultation provided to other departments.	Quarterly	Health Equity Collaboration Workgroup meetings held 1/22; 3/11; 4/29; 6/3; 7/15	
^	**56**	Operational	Implement disparity model for PIP projects (W30-6+) include formative research, community, member and provider interventions	Development of modules; meet PIP disparity reduction targets	Ongoing	Ongoing. Complete KIIs with 8 community members and 2 community leaders. Completed 1 focus group with 4 participants. Barrier Analysis report presented to Team in Jan.	
*	**57**	Operational	Provide support for SUD/MH non-clinical PIP project.	Disparity reduction project work plan; evaluation, documentation of process outcomes	Ongoing	Ongoing. Completed KIIs with 3 providers (CRMC, Saint Agnes, and internal Behavior Health Team). Presented barrier analysis in Feb.	
*	**58**	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project.	Disparity reduction project work plan; evaluation, documentation of process outcomes	Ongoing	Ongoing, attended bi-weekly meetings	
	59	Operational	Provide consultation to departments on cultural competency and improving health care outcomes (including enrollment) for key demographics and key metrics to support health equity	Consultation and /or trainings provided	Ongoing	Ongoing support for material review and provide consultation to internal teams.	

60	**Responsible Staff:**	**Primary: S. Xiong-Lopez**	**Secondary: J. Nkansah**			
61	HEQ Project/ Activity	Distribute DEI survey to CVH Leadership, and Staff Members to identify opportunities/ improvement needed surrounding DEI	**Survey completed 8/2024-** 61.05% of staff and leadership Disagreed/Strongly Disagreed that CVH took time to celebrate/ acknowledge most celebrated cultures. **Goal:** Decrease the percentage of staff disagreement (CVH takes time to acknowledge/ celebrate most celebrated cultures) to below 50% by Q3 2025 Implement Cultural celebration and heritage month 2x a year Rearrange settings of staff meeting with ice breakers and team activities to promote inclusivess	Annually	Rearrange settings of staff meeting with ice breakers and team activities to promote inclusivess (implemented 10/14/2024) Cultural celebration and cultural potluck to be implemented Q1 2025	
62	HEQ Project/ Activity	Distribute DEI survey to CVH Board, Committee, to identify opportunities/ improvement needed surrounding DEI	**Survey Completed**- No major concerns as it relates to DEI. **Action:** Review of CVH Bylaws to account for changes such as equity, inclusion, or cultural humility for governance bodies. **Goal:** Implementation of new Bylaws to include HEQ initiatives Q3 2024	Annually	2/2024- Review Bylaws 7/2024 RHA approval of Bylaw changes Implemented by 10/2024	
63	HEQ Project/ Activity	Assist and/or serve as consultant witth Fresno County Network Improvement Committee Pilot to address leading health indicators focusing on upstream measures such as risk factors and behaviors, rather than disease outcomes (focusing on pregnant moms, families with children ages 0-9)	**Data:** 39% of the 53 identified students are reading grade level. Identified impact of reading level influenced by, poverty, socioeconomically disadvantage, access to health care. **Goal:** 100% of the 53 identified students are reading at grade level by 6/2025 **Action:** Children and families are set up with trained CHW to assist in community navigation. School liason, Social workers, representative will recieve training to become CHW. CBOs, and policy makers to identify strategies to help with SoDH, improve health, wellness and academics outcomes	Ongoing	2 identified locations (93722, and 93648) identified as rural and high poverty. 53 children and their families from 2 schools were identified as most in need. School employees started CHW certification training 10/2024	

64	HEQ Project/ Activity	Provide support for SUD/MH non-clinical PIP and QMIP project.	**Data:** CVH does not meet minimum performance level for FUA/FUM (54.87/36.34). A majority of members in this population in Fresno and Madera are Hispanic, cultural drivers negatively impact follow up care rates. **Goal:** This is a Year over year Improvement project. HEQ Dept. goal is to provide assistance with development of Cultural training curriculum for ER staff such as Social Workers, CHWs and Substance Use Counselors to be receptive to the Hispanic patients' needs and to provide comprehensive treatment information and range of available treatment options to improve follow up care. **Action:** Utilize community trusted CBO to deliver Cultural training	Ongoing	CBO identified: BiNational and we are currently developing a cultural training to meet the needs of members and the hospital.	
65	HEQ Project/ Activity	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations	Q3	Scheduled for 11/1/2024	

Ongoing support for material review and consultation.

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^ Indicates revision.

*** Indicates new.**

Item #7
Attachment 7.A

2024 Quality Improvement Health Equity Transformation Program

2024
QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP)

Table of Contents

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1.0 Executive Summary

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera in California. Under California's Medi-Cal Managed care program, the RHA dba CalViva Health is designated as the Local Initiative. CalViva Health is contracting with Health Net Community Solutions (HNCS) to provide cultural and linguistic services and programs for CalViva Health membership. CalViva Health ("CalViva" or "Plan") may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva Health. CalViva Health, in collaboration with HNCS, is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, provider networks, and CalViva Health and HNCS.

The HNCS Health Equity Department, on behalf of CalViva Health, develops programs and services to facilitate understanding, communication and cultural responsiveness between members, providers, and Plan staff. The Quality Improvement Utilization Management Committee (QIUMC) reviews and adopts these programs.

CalViva Health is committed to developing and implementing a comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions.

2.0 Staff Resources and Accountability

2.1 Quality Improvement (QI) and Health Equity Governance Structure.
The CalViva Health Quality Improvement Utilization Management Committee (QIUMC) has responsibility for the Quality Improvement and the Health Equity Transformation activities of CalViva Health according to the responsibilities given to them by the Regional Health Authority Commissioners. This responsibility includes reviewing, analyzing, evaluating, and acting on the results of QI and Health Equity activities and ensuring appropriate follow-up on performance deficiencies and gaps in care. The QIUMC is chaired by the Chief Medical Officer and the CalViva Health Equity Officer is a member of the QIUM Committee in an advisory capacity. The UM Committee meets seven times per year. External practitioners from Primary Care and a variety of specialties reflecting an appropriate geographic and specialty mix participate on this committee including a Behavioral Health provider, along with representatives from Compliance and Medical Management which includes Utilization Management, Care Management, and Quality Improvement.

2.2 QIUMC oversight activities include but are not limited to:

- Annually assess Utilization Management (UM), QI, and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program at the regional and/or county level.
- Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities.
- Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP).

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- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
- Institute actions to address performance deficiencies, including policy recommendations.
- Ensure follow-up of identified performance deficiencies or gaps in care.
- Shall provide input and advice on a non-exclusive list of topics including Population Health Management; Coordination of Care Clinical quality of physical and behavioral health care; Access to primary and specialty health care providers and services; member experience with respect to clinical quality, access, and availability, culturally and linguistically competent health care and services, and continuity and coordination of care.

2.3 CalViva Health has enhanced the Quality Improvement and Utilization Management Committee to support health equity projects and collaboration across the Plan.

- As part of the Committee support, the QIUM Work Group will meet weekly to prepare and drive content for the upstream Committee. This supports a focused and meaningful discussion for decision making.
- The CalViva Health Equity Officer will consolidate the data & recommendations received from QIUM Work Group, Public Policy Committee (PPC), Community Advisory Groups (CAGs) and the PHM annual assessment and recommend strategies and interventions that will inspire actionable recommendations and discussions at the QIUM Committee.
- Key outcomes include identification of discussion topics or decision points for discussion during the QIUM Committee, informing or engaging social & community partners, and implementing with or evaluating the success of local partners, for example Community Advisory Groups (CAGs) and targeted projects or pilots.

3.0 MISSION, GOALS AND OBJECTIVES

3.1 Mission

CalViva Health's Health Equity mission is to:

- Improve structural determinants of health equity, by working within and across societal institutions and systems.
- Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities.
- Improve institutional drivers of health equity, by working within our institution, all lines of business, with providers, and with other key stakeholders.
- Improve individual & household-level social needs & networks, by improving access, quality, and value of services for our members.

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3.2 Goals

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:

- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services for members and providers.
- To promote and support active participation of our members and potential members in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

3.3 Objectives

To meet these goals, the following objectives have been developed:

- CalViva Health's QIHETP will monitor, evaluate, and require timely action to address necessary improvement in the quality of care delivered and to improve upon health equity and address health disparities. The QIHETP will be accomplished and maintained through cross-functional participation, engagement, and prioritization, and through a collaborative governance structure.

4.0 Program Activities

4.1 Quality Improvement Activities

A. CalViva Health annually assesses the overall effectiveness of its Quality Improvement (QI) Program at improving clinical and service practices. Interventions are monitored through the QI Work Plan and an annual evaluation is provided to measure the effectiveness of the Quality Program.

B. The Quality Improvement Work Plan includes eight categories to determine CalViva Health's success in achieving specified goals. The plan calculates the number and percentage of activities completed and objectives met per category and outlines performance against goals. Categories include:

1. Behavioral Health
2. Chronic Conditions
3. Pharmacy & Related Measures
4. Member Engagement and Experience
5. Hospital Quality/ Patient Safety
6. Pediatric/ Perinatal/ Dental
7. Preventive Health

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8. Provider Engagement/ Communication

C. Quality goals vary according to regulatory and accreditation standards which can change annually.

4.2 Health Equity Activities

A. The Health Equity Department provides an annual overview of activities, achievements, and barriers. All activities described in the Year End Report are reflective of our commitment to providing culturally competent services to our membership. The Department presents and requires approval of the Program Description, Year End Report, Work Plan, and biannual Work Plan Evaluations.
B. The Health Equity Work Plan is divided into 6 content areas. Each workplan activity is assigned a lead and support. These are aligned with the subject matter experts. The activities are tracked with mid-year and year-end updates to discuss at the QIUMC biannually.
    - Content area 1 outlines activities and deliverables related to Language Assistance Services
    - Content area 2 outlines activities and deliverables related to Compliance Monitoring
    - Content area 3 outlines activities and deliverables related to Communication, Training, and Education
    - Content area 4 outlines activities and deliverables related to Health Literacy
      Content area 5 outlines activities and deliverables related to Cultural Competency.
    - Content area 6 outlines activities and deliverables related to Health Equity.

4.3 Population Health Management Activities

A. Annually, CalViva Health evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. CalViva examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records (EHRs), data from health plan UM and/or CM programs, and advanced data sources such as claims databases or regional health information.
B. Evaluation is conducted based on the characteristics and needs of the member population (including social determinants of health), health status and health risks broken down by ages birth to 65 and over and needs of child members with Special Health Care Needs (CSHCN), disabilities, and severe and persistent mental illness. Data is analyzed to determine changes to the PHM programs or resources. Modifications to program design and resources are made based on findings.
C. CalViva Health obtained Health Plan Accreditation (HPA) with the National Committee for Quality Assurance (NCQA) in May 2024 to ensure PHM standards are maintained.

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5.0 Delegated Subcontractors & Downstream Delegated Subcontractors

A. CalViva Health delegates utilization management, credentialing, case management and complex care management, claims processing and payment to Health Net Community Solutions, an NCQA accredited organization, who may sub-delegate these functions to designated practitioners, provider groups, contracted vendors or ancillary organizations. Comprehensive delegation policies and processes have been established to address oversight of these entities.

B. Annually, delegated organizations must demonstrate the willingness, capability, proficiency and experience to manage the delegated responsibilities. The Plan will institute corrective action and/or may revoke delegation when it determines the delegate is unable or unwilling to carry out the delegated responsibilities.

C. Delegates that are certified or NCQA accredited are not required to undergo an annual on-site review for elements included in the accreditation; however, the Plan will conduct reviews for all other elements not included in the NCQA accreditation.

5.1 External Quality Review (EQR) Technical Report

A. CalViva Health follows the PIP approach as provided by the Department of Health Care Services (DHCS) and its designated External Quality Review Organization (EQRO).

B. CalViva Health's EQRO is Health Services Advisory Group (HSAG).

6. Delivery of Services and Quality of Care Analysis

A. CalViva Health leadership and the QIUMC is charged with monitoring the health equity activities, medical management, and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions.

B. The Quality Program impacts the following:

- CalViva Health Members in all demographic groups and in all counties for which CalViva Health is licensed.
- Network Providers include practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- Aspects of Care including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by CalViva Health.
- Health Disparities by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- Communication to meet the cultural and linguistic needs of all members.

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- Behavioral Health Aspects of Care integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- Practitioner/Provider Performance relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- Services Covered by CalViva Health including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS), and Multi-purpose Senior Services Program (MSSP) that meets the special, cultural and linguistic, complex or chronic needs of all members.
- Internal Administrative Processes which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

C. Encounter Data
- Provider Engagement and Provider Performance & Analytics departments provide oversight and capabilities in support of improving and maintaining performance with providers and their membership. Collaboration between the departments involves the Provider Relations, Practice Transformation, Encounters, RAF, and Data Analytics and Solutions teams.
- Encounter data is integrated in the Operational Data Warehouse (ODW) and TruCare. Data collection improvement projects include deploying contracts with health information exchanges and vendors that receive or process claims, encounters, member demographics or clinical data to improve efficiency of operations.
- The data is utilized for Incentive Programs for Providers and the PHM program. Finally, encounter data is used to prioritize interventions along the strategic tracks, under Data, Analytics, & Technology.

D. Grievances and Appeals
- The Appeals & Grievances (A&G) Department will regularly conduct aggregate analysis of appeals and grievances to track and trend potential issues and barriers to care. The QIUMC will annually review appeals and grievances system policies and procedures.

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- CalViva Health leadership will monitor compliance with regulations, policies and procedures as well as conduct analysis to track potential issues and barriers to care.
- The system will allow monitoring of appeals and grievances to include the number received, pending and resolved for all levels of the system, disposition of resolution in favor of the member or Plan, number of cases pending over 30 calendar days, and member by eligibility category.
- An analysis of the Grievance System will be included in the annual QI Program Evaluation. The QI Program shall define that the monitoring and tracking of the grievance submitted is reported to an appropriate level (i.e.: medical vs. care delivery issues). The QI Program shall monitor outcomes that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance or an appeal that involves clinical issues shall be resolved by an appropriate clinical health care professional.
- The Appeals and Grievances Department works with the Credentialing and the Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recredentialed every three years. All practitioners and providers are monitored monthly for Medicare/Medicaid sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions.
- The Peer Review Committee (PRC) is an independent review body established to achieve an effective mechanism for continuous review and evaluation of the quality of care and service delivered to enrollees. This includes monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies, deliberating corrective actions, and when necessary, initiating remedial actions with follow up monitoring. The overall goal is to ensure that CalViva Health members receive comparable appropriate quality of care and services.
- Analysis and evaluation of results of focused audits, studies, quality of care and safety issues and quality of service issues are presented to the QIUMC.

E. Utilization Review

- The Utilization Management (UM) program involves pre-service, concurrent and post-service evaluation of the utilization of services provided to members and management of member appeals.
- The UM program requires cooperative participation of practitioners, delegates, hospitals and other providers to ensure a timely, effective and medically sound program. The program is structured to assure that medical decisions are made by qualified health professionals, using written criteria

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based on sound clinical evidence, without undue influence of the Plan's management or concerns for the plan's fiscal performance.

F. Consumer Satisfaction Surveys

- CalViva Health continuously monitors member experience throughout the year using the CAHPS survey results, and monitoring member pain points including member appeals and grievances, and Call Center drivers.
- CAHPS goals are based on contribution to the Quality Rating Programs. The goal for Medi-Cal is year-over-year improvement with a target goal of the 25th percentile.

7. Equity-Focused Interventions

7.1Health Equity Model

- Disparity reduction efforts are implemented through a model that integrates departments across Quality Improvement, Provider Engagement, Health Equity, Community Engagement, Health Education, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach and media, provider interventions and system level initiatives. The following highlights the core components of the disparity reduction model:
- Planning inclusive of key informant interviews, focus groups, literature reviews and data analysis (spatial and descriptive).
- The Health Disparity model gives the Plan a unique ability to understand target population(s) and implement tailored disparity reductions efforts to improve the quality of health care. Race/ethnicity, language, gender identity, and sexual orientation are analyzed to develop targets for disparity reduction efforts and specific interventions to address the disparities and the barriers associated with that.

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- The CAHPS Survey is deployed annually for CalViva to fulfill accreditation and regulatory requirements.
- The survey requests member feedback on health plan (call center, claims), provider (doctor communication, access, care coordination), and overall rating of health plan and health care quality. Supplemental questions may be added to gain additional insights around the experience with the health plan including (but not limited to) interpreter services, call center drivers, access standards.
- Due to the anonymous nature of the survey, the CAHPS Program Managers conduct a quarterly root cause analysis of member pain points by reviewing grievances, appeals, and call center data.

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- The Health Equity Department and the CAHPS Department have established a bi-monthly meeting to review results, identify areas of opportunity, and discuss a joint Action Plan. The Health Equity-CAHPS meetings review CAHPS results and stratification of the results by race/ethnicity, sex assigned at birth (gender), age, and other demographics. This review is based on self-reported member data.

B. Performance Improvement Projects (PIPs)

- CalViva Health's overall aim is to provide equitable, high-quality care services to its culturally and linguistically diverse population no matter the individual's personal characteristics. The purpose of the organization's HE program is to reduce health care inequities and disparities by implementing interventions for identified individuals who are likely to experience or are experiencing obstacles to health care services due to their race/ethnicity, language preference, gender identity, and/or sexual orientation.
- By working to eliminate bias and discrimination within communities and the healthcare industry, the goal is to improve care.
- Performance Improvement Projects (PIPs) are two-year projects required of each Medi-Cal health plan by the California Department of Health Care Services (DHCS). DHCS requires two PIPs of each health plan during the two-year PIP process. Health Plans may choose their PIP topic from the categories provided by DHCS.
- The plan follows the PIP approach as provided by the Department of Health Care Services (DHCS) and its designated External Quality Review Organization (EQRO). This approach guides the Plan through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. The EQRO provides technical assistance throughout the process with frequent contact and feedback to ensure that PIP projects are well-designed at the onset and provide opportunities for mid-course corrections.
- Summary of progress and outcomes of PIP's are reported to the QIUMC. A summary of each PIP is also documented in the Annual QI Program Evaluation. Upon completion of each PIP, the EQRO provides a confidence level on the validity and reliability of the results.

C. Population Needs Assessment (PNA)

- The Health Education and Health Equity Departments conduct a Population Needs Assessment (PNA) every three years to improve health outcomes for members. The PNA is conducted through an analysis of CAHPS survey data and follows the DHCS guidance provided in APL 23-021.
- Participants in CalViva Health's Public Policy Committee (PPC) provide input to the PNA and review the PNA results.
- The results of the PNA are used to identify C&L/health equity program strategies to improve health outcomes and to reduce health disparities.

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- The Health Equity work plan is adjusted to include all strategies that have been identified to improve health outcomes and reduce health disparities for members. The Health Equity work plan serves as the PNA action plan that is submitted to DHCS.

8. Engagement Strategy

A. CalViva Health has a policy to provide CalViva Health associates with guidelines in developing health equity practices and engagement of members, their family members, and communities. CalViva Health is committed to supporting the health of our members and promoting the reduction of health disparities across our membership. To accomplish this, Health Equity collaborates across departments and with external partners in order to analyze, design, implement and evaluate health disparity interventions.

B. Public Policy Committee (PPC)

- Information provided by the PPC participants is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for CalViva to understand that perception, experience and satisfaction of services.
- As part of their involvement, the group's focus is to serve meaningful community and consumer advisory functions that includes taking part in identifying and prioritizing CLAS opportunities for improvement, as well as identifying and prioritizing social risks and needs of individuals for the program to address.
- The PPC also reviews the Population Needs Assessment. Through this review and feedback process, the PPC members are able to provide their views and preferences for our strategies and projects. Feedback is incorporated into the project plans and cultural and linguistic services programs. Additional PPC and PNA process details are in Public Program and Health Education P&Ps, respectively.

C. Member & Family Engagement

- The Health Equity department completes community assessments that include key informant interviews and focus groups. The community assessments identify community, member, and provider level barriers that contribute to identified disparities.
- Community assessments are completed by inviting members, their family members, and caregivers to participate in focus groups and/or key informant interviews. Feedback from members and their family is used to design interventions to address disparities.

D. Community-Based Organizations

- CalViva Health draws from community and individual social needs and risk data to determine partnerships with community partners. Engaging with partner organizations that share in the same goal to reduce the negative

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effects of social risks and improve outcomes for individuals within communities provides more effective ways to address social needs. Cross-collaboration is mutually beneficial and enables partners to support each other in providing resources and interventions.

- CalViva Health and the Health Equity Department are active in the community through participation in local community workgroups and collaboratives, and other CBO activities.
- Creating and maintaining a community network allows for input and guidance on member services and programs and assures that the Health Equity work reflects the needs of CalViva Health members. Social needs and social risks all play into determining the appropriate partners, selecting and engaging in initiatives with community-based organizations.

9. Communication and Ongoing Commitment

A. CalViva Health has obtained NCQA's Health Plan Accreditation and is committed to obtaining Health Equity Accreditation by 2026.

- CalViva Health will be able to provide annual copies of Accreditation status, survey type, and level (as applicable).
- CalViva Health will share results, recommended actions, and any Corrective Action Plans (as applicable).
- CalViva Health will share expiration date of accreditation.

B. As applicable, CalViva Health will develop and submit to DHCS a QI and Health Equity plan annually which will include the following:

- A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions identified through activities in Section 2. Quality Improvement Activities, above.
- A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities and actions to address deficiencies identified through activities in Section 5. Fully Delegated Subcontractors & Downstream Fully Delegated Subcontractors, above.
- An analysis of actions taken to address any Contractor-specific recommendations in the ERQ Technical Report and CalViva Health's specific evaluation reports identified through activities in Section 6. External Quality Review (EQR) Technical Report, above.
- An analysis of the delivery of services and quality of care of CalViva Health and its fully delegated subcontractor, based on data from a variety of sources included, but not limited to, those outlined in Section 7. Equity-focused Interventions, above.
- Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services.

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- A description of CalViva Health's commitment to member and/or family focused care through the activities outlined in Section 9. Engagement Strategy, above, and how CalViva Health utilizes this information from this engagement to inform CalViva Health policies and decision making.
- PHM activities and findings as outlined in CalViva Health's contract with DHCS which will be derived from activities in Section 4. Population Health Management Activities, above; and
- Outcomes and findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

C. CalViva Health is committed to making the QI and Health Equity plan publicly available on its website on an annual basis.

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STAFF RESOURCES AND ACCOUNTABILITY

1. CalViva Health Committees

A. Governing Body/RHA Commission

The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of CalViva Health.

B. QI/UM Committee

The QI/UM Committee monitors the quality and safety of care and services rendered to CalViva Health members. This Committee identifies opportunities for improvement, recommends policy decisions, evaluates the results of activities, institutes needed actions, and ensures follow-up as appropriate. The Health Equity program description, work plan, language assistance utilization report and end of year reports are all submitted to the CalViva Health QI/UM committee for review and approval. The QI/UM committee provides regular reports to the RHA Commission.

C. Public Policy Committee

The Public Policy Committee includes CalViva Health members, member advocates (supporters), an RHA Commissioner, and a health care provider. Committee responsibilities include obtaining feedback and guidance in the delivery of culturally and linguistically appropriate health care services and establishing and maintaining community linkages. The Health Equity program description, work plan, language assistance utilization report and end of year reports are shared as information to the Public Policy Committee. The Public Policy Committee provides regular reports to the QI/UM Committee and the RHA Commission.

2. CalViva Health Staff Roles and Responsibilities

A. Chief Medical Officer

CalViva Health's Chief Medical Officer's responsibilities include assuring that CalViva Health's programs are compatible and interface appropriately with the provider network

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and the overall scope of CalViva Health's QI program. A medical management team is under the direction of the Chief Medical Officer.

B. Chief Compliance Officer

CalViva Health's Chief Compliance Officer's responsibilities include assuring that CalViva Health's programs are compliant with the DHCS contract, regulatory standards and reporting requirements. A compliance team is under the direction of the Chief Compliance Officer.

C. Health Equity Officer

CalViva's Health's Health Equity Officer reports to the Chief Executive Officer and is responsible for providing leadership and health equity services across the organization.

3. HNCS Health Equity Department Staff Roles and Responsibilities

The Health Equity Department is unique in its cross-functional support structure. The Department's function is to fulfill all cultural and linguistic contractual and regulatory requirements and serve as a resource and support for all health equity and C&L services. The Health Equity Department is staffed by the Director of Program Accreditation, a Manager of Health Equity Department, a Program Manager III, five Senior Health Equity Specialists, one Health Equity Specialist, a Project Coordinator II, and one supplemental staff.

A. HNCS Leadership Team

HNCS is a subsidiary of Health Net LLC. Through a dedicated and qualified staff, important cultural and linguistic services are developed and coordinated within the CalViva Health service area by HNCS. HNCS, as a subsidiary of Health Net LLC., continues to maintain their internal reporting responsibilities (e.g. Chief Executive Officer (CEO), Vice Presidents, Officers, Directors, etc.) however, activities conducted within the CalViva Health service area are subject to oversight by CalViva Health's staff and respective committees.

The Chief Health Equity Officer, under the Chief Medical Officer, is responsible for providing leadership in Health Equity efforts across the organization. Under the Chief Health Equity Officer, the Health Equity Department contributes to planning the program structure for Health Net. The Chief Health Equity Officer ensures the plan's health equity structure is aligned with Corporate and other state plans, as appropriate.

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A. Fresno-Kings-Madera Regional Health Authority Commission Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description

_____ ____ _____

David Hodge, MD Date

Regional Health Authority Commission Chairperson

_____ _____

Patrick Marabella, MD, Chief Medical Officer Date

Chair, CalViva Health QI/UM Committee

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Item #8

Attachment 8.A

Financials as of August 31, 2024

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of August 31, 2024

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	230,767,919.64
5	Total Bank Accounts	$ 230,767,919.64
6	Accounts Receivable	
7	Accounts Receivable	302,909,914.86
8	Total Accounts Receivable	$ 302,909,914.86
9	Other Current Assets	
10	Interest Receivable	790,456.05
11	Investments - CDs	0.00
12	Prepaid Expenses	1,564,398.07
13	Security Deposit	20,357.57
14	Total Other Current Assets	$ 2,375,211.69
15	Total Current Assets	$ 536,053,046.19
16	Fixed Assets	
17	Buildings	5,891,376.31
18	Computers & Software	32,666.60
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	81,397.38
22	Total Fixed Assets	$ 9,166,859.39
23	Other Assets	
24	Investment -Restricted	304,583.77
25	Lease Receivable	1,938,715.72
26	Total Other Assets	$ 2,243,299.49
27	TOTAL ASSETS	$ 547,463,205.07
28	LIABILITIES, DEFFERED INFLOW OF RESOURCES, AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	73,740.99
33	Accrued Admin Service Fee	4,816,372.00
34	Capitation Payable	122,826,886.71
35	Claims Payable	18,805.43
36	Directed Payment Payable	87,254,264.20
37	Total Accounts Payable	$ 214,990,069.33
38	Other Current Liabilities	
39	Accrued Expenses	252,837.18
40	Accrued Payroll	128,494.70
41	Accrued Vacation Pay	338,769.16
42	Amt Due to DHCS	40,500,000.00
43	IBNR	51,789.65
44	Loan Payable-Current	0.00
45	Premium Tax Payable	0.00
46	Premium Tax Payable to BOE	325,404.28
47	Premium Tax Payable to DHCS	124,895,833.34
48	Total Other Current Liabilities	$ 166,493,128.31
49	Total Current Liabilities	$ 381,483,197.64
50	Long-Term Liabilities	
51	Renters' Security Deposit	25,906.79
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	$ 25,906.79
54	Total Liabilities	$ 381,509,104.43
55	Deferred Inflow of Resources	1,511,984.88
56	Equity	
57	Retained Earnings	161,689,933.96
58	Net Income	2,752,181.80
59	Total Equity	$ 164,442,115.76
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 547,463,205.07

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2024 - August 2024

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Earned	1,862,681.05	1,000,000.00	862,681.05
3	Premium/Capitation Income	335,729,546.64	308,509,727.00	27,219,819.64
4	**Total Income**	**337,592,227.69**	**309,509,727.00**	**28,082,500.69**
5	Cost of Medical Care			
6	Capitation - Medical Costs	228,339,325.79	201,856,436.00	26,482,889.79
7	Medical Claim Costs	213,755.66	233,333.34	(19,577.68)
8	**Total Cost of Medical Care**	**228,553,081.45**	**202,089,769.34**	**26,463,312.11**
9	**Gross Margin**	**109,039,146.24**	**107,419,957.66**	**1,619,188.58**
10	Expenses			
11	Admin Service Agreement Fees	9,632,326.00	9,199,850.00	432,476.00
12	Bank Charges	0.00	1,200.00	(1,200.00)
13	Computer/IT Services	20,735.28	42,993.34	(22,258.06)
14	Consulting Fees	7,710.00	66,666.66	(58,956.66)
15	Depreciation Expense	55,419.54	62,000.00	(6,580.46)
16	Dues & Subscriptions	40,568.86	49,600.00	(9,031.14)
17	Grants	1,496,072.59	1,756,820.00	(260,747.41)
18	Insurance	55,727.26	74,595.16	(18,867.90)
19	Labor	658,008.67	771,952.00	(113,943.33)
20	Legal & Professional Fees	15,105.32	53,800.00	(38,694.68)
21	License Expense	248,815.12	237,526.16	11,288.96
22	Marketing	159,329.09	250,000.00	(90,670.91)
23	Meals and Entertainment	2,647.89	4,725.00	(2,077.11)
24	Office Expenses	13,450.11	19,000.00	(5,549.89)
25	Parking	10.49	260.00	(249.51)
26	Postage & Delivery	260.55	820.00	(559.45)
27	Printing & Reproduction	737.86	820.00	(82.14)
28	Recruitment Expense	(549.00)	26,250.00	(26,799.00)
29	Rent	0.00	2,000.00	(2,000.00)
30	Seminars and Training	5,747.24	5,800.00	(52.76)
31	Supplies	2,018.83	2,166.66	(147.83)
32	Taxes	93,958,333.34	93,958,333.34	0.00
33	Telephone	8,330.40	7,000.00	1,330.40
34	Travel	1,110.45	4,000.00	(2,889.55)
35	**Total Expenses**	**106,381,915.89**	**106,598,178.32**	**(216,262.43)**
36	**Net Operating Income/ (Loss)**	**2,657,230.35**	**821,779.34**	**1,835,451.01**
37	Other Income			
38	Other Income	94,951.45	72,500.00	22,451.45
39	**Total Other Income**	**94,951.45**	**72,500.00**	**22,451.45**
40	**Net Other Income**	**94,951.45**	**72,500.00**	**22,451.45**
41	**Net Income/ (Loss)**	**2,752,181.80**	**894,279.34**	**1,857,902.46**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2025 vs FY 2024

		Total	
		July 2024 - August 2024	July 2023 - August 2023 (PY)
1	Income		
2	Interest Earned	1,862,681.05	1,179,839.49
3	Premium/Capitation Income	335,729,546.64	256,439,184.06
4	Total Income	**337,592,227.69**	**257,619,023.55**
5	Cost of Medical Care		
6	Capitation - Medical Costs	228,339,325.79	242,793,181.53
7	Medical Claim Costs	213,755.66	205,429.18
8	Total Cost of Medical Care	**228,553,081.45**	**242,998,610.71**
9	Gross Margin	**109,039,146.24**	**14,620,412.84**
10	Expenses		
11	Admin Service Agreement Fees	9,632,326.00	9,721,954.00
12	Computer/IT Services	20,735.28	27,808.25
13	Consulting Fees	7,710.00	19,200.00
14	Depreciation Expense	55,419.54	54,589.40
15	Dues & Subscriptions	40,568.86	39,143.74
16	Grants	1,496,072.59	1,329,545.45
17	Insurance	55,727.26	58,596.55
18	Labor	658,008.67	563,466.70
19	Legal & Professional Fees	15,105.32	11,351.00
20	License Expense	248,815.12	210,841.16
21	Marketing	159,329.09	217,067.32
22	Meals and Entertainment	2,647.89	993.74
23	Office Expenses	13,450.11	11,438.32
24	Parking	10.49	4.00
25	Postage & Delivery	260.55	405.20
26	Printing & Reproduction	737.86	0.00
27	Recruitment Expense	(549.00)	0.00
28	Rent	0.00	0.00
29	Seminars and Training	5,747.24	3,281.98
30	Supplies	2,018.83	1,970.24
31	Taxes	93,958,333.34	(156.70)
32	Telephone	8,330.40	4,896.62
33	Travel	1,110.45	354.81
34	Total Expenses	**106,381,915.89**	**12,276,751.78**
35	Net Operating Income/ (Loss)	**2,657,230.35**	**2,343,661.06**
36	Other Income		
37	Other Income	94,951.45	90,948.49
38	Total Other Income	**94,951.45**	**90,948.49**
39	Net Other Income	**94,951.45**	**90,948.49**
40	Net Income/ (Loss)	**2,752,181.80**	**2,434,609.55**

Item #8

Attachment 8.B

Medical Management
Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2024

Current as of End of the Month: August
Revised Date: 09/16/2024

CalViva - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	15	8	2	25	7	6	7	20	4	11	0	15	0	0	0	0	60	126
Standard Grievances Received	144	132	147	423	218	198	164	580	193	179	0	372	0	0	0	0	1375	1761
Total Grievances Received	**159**	**140**	**149**	**448**	**225**	**204**	**171**	**600**	**197**	**190**	**0**	**387**	**0**	**0**	**0**	**0**	**1435**	**1887**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	10
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.93%**	**99.4%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	13	9	3	25	7	6	7	20	4	11	0	15	0	0	0	0	60	126
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	160	125	133	418	166	213	178	557	191	170	0	361	0	0	0	0	1336	1702
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.93%**	**99.9%**
Total Grievances Resolved	**173**	**134**	**136**	**443**	**174**	**219**	**185**	**578**	**195**	**181**	**0**	**376**	**0**	**0**	**0**	**0**	**1397**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**153**	**118**	**120**	**391**	**154**	**183**	**156**	**493**	**165**	**161**	**0**	**326**	**0**	**0**	**0**	**0**	**1210**	**1468**
Access - Other - DMHC	25	24	10	59	23	29	19	71	26	23	0	49	0	0	0	0	179	270
Access - PCP - DHCS	7	4	4	15	13	15	13	41	10	17	9	36	0	0	0	0	7	118
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	10	7	2	19	3	3	4	10	9	4	0	13	0	0	0	0	42	78
Administrative	25	30	36	91	30	34	49	113	48	39	0	87	0	0	0	0	291	186
Balance Billing	23	18	14	55	32	33	25	90	23	20	0	43	0	0	0	0	188	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	12	12	16	40	16	23	19	58	17	13	0	30	0	0	0	0	128	122
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	5	11	28	16	13	12	41	5	15	0	20	0	0	0	0	89	339
Pharmacy/RX Medical Benefit	1	1	1	3	2	0	0	2	1	2	0	3	0	0	0	0	8	1
Transportation - Access	18	7	10	35	11	14	3	28	9	9	0	18	0	0	0	0	81	175
Transportation - Behavior	8	1	4	13	0	1	1	2	9	8	0	17	0	0	0	0	32	89
Transportation - Other	12	9	12	33	8	18	11	37	8	11	0	19	0	0	0	0	89	86
Quality Of Care Grievances	**20**	**16**	**16**	**52**	**20**	**36**	**29**	**85**	**30**	**20**	**0**	**50**	**0**	**0**	**0**	**0**	**187**	**361**
Access - Other - DMHC	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Behavioral Health	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	2	0
Other	2	3	5	10	4	3	2	8	5	4	0	9	0	0	0	0	27	60
PCP Care	8	5	5	18	7	13	13	33	9	5	0	14	0	0	0	0	65	94
PCP Delay	1	3	4	8	4	7	5	16	10	5	0	15	0	0	0	0	39	116
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	1	2	9	1	7	6	14	3	4	0	7	0	0	0	0	30	60
Specialist Delay	2	3	0	5	3	6	2	11	2	1	0	3	0	0	0	0	19	24
Exempt Grievances Received	146	135	176	**457**	224	185	211	**620**	196	219	0	**415**	0	0	0	**0**	**1492**	1885
Access - Avail of Appt w/ PCP	4	1	2	**7**	7	3	4	**14**	5	2	0	**7**	0	0	0	**0**	**28**	15
Access - Avail of Appt w/ Specialist	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	3	**3**	0	4	1	**5**	2	0	0	**2**	0	0	0	**0**	**10**	7
Access - Wait Time - in office for appt	0	1	0	**1**	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	**3**	2
Access - Panel Disruption	0	0	2	**2**	4	2	0	**6**	3	10	0	**13**	0	0	0	**0**	**21**	15
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	**2**	3
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	1	**1**	0	0	0	**0**	3	0	0	**3**	0	0	0	**0**	**4**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0
Attitude/Service - Health Plan Staff	0	1	1	**2**	5	1	0	**6**	1	2	0	**3**	0	0	0	**0**	**11**	14
Attitude/Service - Provider	6	9	16	**31**	13	9	27	**49**	18	20	0	**38**	0	0	0	**0**	**118**	43
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
Attitude/Service - Vendor	0	0	6	**6**	6	0	6	**12**	6	9	0	**15**	0	0	0	**0**	**33**	4
Attitude/Service - Health Plan	0	1	3	**4**	3	2	1	**6**	0	4	0	**4**	0	0	0	**0**	**14**	12
Authorization - Authorization Related	0	2	1	**3**	0	4	7	**11**	3	4	0	**7**	0	0	0	**0**	**21**	6
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	2	1	**4**	0	1	0	**1**	0	0	0	**0**	**5**	4
Eligibility Issue - Member not eligible per Provider	2	1	4	**7**	17	10	6	**33**	4	8	0	**12**	0	0	0	**0**	**52**	48
Health Plan Materials - ID Cards-Not Received	19	17	20	**56**	26	22	38	**86**	30	29	0	**59**	0	0	0	**0**	**201**	210

Health Plan Materials - ID Cards-Incorrect Information on Card	0	2	0	**2**	4	2	0	**6**	0	1	0	**1**	0	0	0	**0**	**9**	2
Health Plan Materials - Other	0	0	0	**0**	1	0	2	**3**	0	1	0	**1**	0	0	0	**0**	**4**	4
Behavioral Health Related	2	3	4	**9**	3	8	9	**20**	10	11	0	**21**	0	0	0	**0**	**50**	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	50	48	49	**147**	82	61	67	**210**	62	64	0	**126**	0	0	0	**0**	**483**	652
PCP Assignment/Transfer - HCO Assignment - Change Request	15	15	19	**49**	21	18	8	**47**	12	15	0	**27**	0	0	0	**0**	**123**	301
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	4	4	11	**19**	7	7	1	**15**	3	2	0	**5**	0	0	0	**0**	**39**	37
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
PCP Assignment/Transfer - Mileage Inconvenience	0	1	0	**1**	2	1	1	**4**	1	1	0	**2**	0	0	0	**0**	**7**	14
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider No Show	7	4	6	**17**	1	0	1	**2**	1	1	0	**2**	0	0	0	**0**	**21**	65
Transportation - Access - Provider Late	2	2	1	**5**	1	0	0	**1**	0	2	0	**2**	0	0	0	**0**	**8**	32
Transportation - Behaviour	4	0	1	**5**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	**6**	76
Transportation - Other	2	4	3	**9**	0	1	3	**4**	1	1	0	**2**	0	0	0	**0**	**15**	53
OTHER - Other	1	4	5	**10**	4	5	2	**11**	7	6	0	**13**	0	0	0	**0**	**34**	14
Claims Complaint - Balance Billing from Provider	28	15	18	**61**	15	22	24	**61**	24	22	0	**46**	0	0	0	**0**	**168**	235

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	1	1	2	4	2	3	0	5	0	0	0	0	15	34
Standard Appeals Received	22	17	32	71	39	40	43	122	50	39	0	89	0	0	0	0	282	331
Total Appeals Received	**24**	**19**	**34**	**77**	**40**	**41**	**45**	**126**	**52**	**42**	**0**	**94**	**0**	**0**	**0**	**0**	297	**365**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.4%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	**6**	1	1	2	**4**	2	3	0	**5**	0	0	0	0	15	35
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Resolved Compliant	16	30	11	57	30	39	40	109	49	45	0	94	0	0	0	0	260	325
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**18**	**31**	**14**	**63**	**31**	**40**	**42**	**113**	**51**	**48**	**0**	**99**	**0**	**0**	**0**	**0**	**275**	**361**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**18**	**31**	**14**	**63**	**31**	**40**	**42**	**113**	**51**	**48**	**0**	**99**	**0**	**0**	**0**	**0**	**275**	353
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	1	4	6	11	8	2	0	10	0	0	0	0	21	9
DME	2	3	3	8	7	6	8	21	9	8	0	17	0	0	0	0	46	37
Experimental/Investigational	0	0	3	3	0	0	2	2	1	0	0	1	0	0	0	0	6	0
Mental Health	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Advanced Imaging	11	18	0	29	15	14	15	44	15	21	0	36	0	0	0	0	109	162
Other	1	4	4	9	1	7	4	12	5	9	0	14	0	0	0	0	35	35
Pharmacy/RX Medical Benefit	2	3	2	7	2	0	2	7	8	5	0	13	0	0	0	0	27	47
Surgery	2	3	2	7	5	6	5	16	5	2	0	7	0	0	0	0	30	62
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	8	8	6	**22**	11	20	18	49	21	16	0	37	0	0	0	0	108	156
Uphold Rate	**44.4%**	**25.8%**	**42.9%**	**34.9%**	**35.5%**	**50.0%**	**42.9%**	**43.4%**	**41.2%**	**33.3%**	**0.0%**	**37.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**39.3%**	**43.2%**
Overturns - Full	9	22	7	**38**	20	18	22	**60**	28	30	0	**58**	0	0	0	**0**	156	194
Overturn Rate - Full	**50.0%**	**71.0%**	**50.0%**	**60.3%**	**64.5%**	**45.0%**	**52.4%**	**53.1%**	**54.9%**	**62.5%**	**0.0%**	**58.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**56.7%**	**53.7%**
Overturns - Partials	1	1	1	**3**	0	2	2	**4**	2	0	0	**2**	0	0	0	**0**	9	10
Overturn Rate - Partial	**5.6%**	**3.2%**	**7.1%**	**4.8%**	**0.0%**	**5.0%**	**4.8%**	**3.5%**	**3.9%**	**0.0%**	**0.0%**	**2.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**3.3%**	**2.8%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	2	0	**2**	0	0	0	0	**2**	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.2%**	**0.0%**	**2.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.7%**	**0.3%**
Membership	434,122	434,443	434,459		434,072	433,828	434,041		435,904	435,734	-		-	-	-			430,517
Appeals - PTMPM	0.04	0.07	0.03	0.05	0.07	0.09	0.10	0.09	0.12	0.11	-	0.11	-	-	-	-	0.08	0.09
Grievances - PTMPM	0.40	0.31	0.31	0.34	0.40	0.50	0.43	0.44	0.45	0.42	-	0.43	-	-	-	-	0.40	0.24

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Fresno County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	13	7	2	22	6	4	5	15	3	8	0	11	0	0	0	0	48	107
Standard Grievances Received	117	109	131	357	173	167	149	489	161	153	0	314	0	0	0	0	1160	1447
Total Grievances Received	**130**	**116**	**133**	**379**	**179**	**171**	**154**	**504**	**164**	**161**	**0**	**325**	**0**	**0**	**0**	**0**	**1208**	**1554**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	11	8	3	22	6	4	5	15	3	8	0	11	0	0	0	0	48	107
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	130	102	110	342	153	163	152	468	172	140	0	312	0	0	0	0	1122	1389
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.9%**	**99.9%**
Total Grievances Resolved	**141**	**110**	**113**	**364**	**160**	**167**	**157**	**484**	**175**	**148**	**0**	**323**	**0**	**0**	**0**	**0**	**1171**	**1497**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**124**	**97**	**98**	**319**	**142**	**137**	**133**	**412**	**149**	**132**	**0**	**281**	**0**	**0**	**0**	**0**	**1012**	**1194**
Access - Other - DMHC	21	19	9	49	22	22	16	60	22	16	0	38	0	0	0	0	147	225
Access - PCP - DHCS	4	4	3	11	11	14	11	36	9	15	0	24	0	0	0	0	71	102
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	9	7	2	18	2	3	4	9	8	3	0	11	0	0	0	0	38	69
Administrative	24	24	30	78	28	28	39	95	43	32	0	75	0	0	0	0	248	160
Balance Billing	19	17	11	47	30	28	22	80	22	19	0	41	0	0	0	0	168	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	10	10	13	33	16	15	18	49	17	12	0	29	0	0	0	0	111	97
Behavioral Health	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0
Other	9	5	10	24	16	9	10	35	5	14	0	19	0	0	0	0	78	283
Pharmacy/RX Medical Benefit	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	3	1
Transportation - Access	13	6	6	25	8	6	3	17	8	7	0	15	0	0	0	0	57	126
Transportation - Behaviour	7	1	3	11	0	0	1	1	8	6	0	14	0	0	0	0	26	70
Transportation - Other	7	4	11	22	7	12	8	27	7	8	0	15	0	0	0	0	64	61
Quality Of Care Grievances	**17**	**13**	**15**	**45**	**18**	**30**	**24**	**72**	**26**	**16**	**0**	**42**	**0**	**0**	**0**	**0**	**159**	**303**
Access - Other - DMHC	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Behavioral Health	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	2	0
Other	1	2	4	7	4	1	0	5	5	3	0	8	0	0	0	0	20	51
PCP Care	6	5	5	16	6	13	11	30	9	3	0	12	0	0	0	0	58	78
PCP Delay	1	2	4	7	4	6	5	15	8	5	0	13	0	0	0	0	35	97
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	1	2	9	0	4	6	10	2	3	0	5	0	0	0	0	24	54
Specialist Delay	2	3	0	5	3	6	1	10	2	1	0	3	0	0	0	0	18	17

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	1	0	2	3	2	2	0	4	0	0	0	0	13	32
Standard Appeals Received	16	10	26	52	33	30	35	98	41	33	0	74	0	0	0	0	224	278
Total Appeals Received	**18**	**12**	**28**	**58**	**34**	**30**	**37**	**101**	**43**	**35**	**0**	**78**	**0**	**0**	**0**	**0**	237	**310**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.6%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	6	1	0	2	3	2	2	0	4	0	0	0	0	13	32
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	11	19	8	38	25	32	29	**86**	41	39	0	**80**	0	0	0	**0**	204	280
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**13**	**20**	**11**	**44**	**26**	**32**	**31**	**89**	**43**	**41**	**0**	**84**	**0**	**0**	**0**	**0**	**217**	**312**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**13**	**20**	**11**	**44**	**26**	**32**	**31**	**89**	**43**	**41**	**0**	**84**	**0**	**0**	**0**	**0**	**217**	**304**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	1	4	5	10	7	2	0	9	0	0	0	0	19	8
DME	1	2	2	5	4	6	7	17	6	7	0	13	0	0	0	0	35	36
Experimental/Investigational	0	0	2	2	0	0	1	1	0	0	0	0	0	0	0	0	3	0
Behavioral Health	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Advanced Imaging	8	9	0	17	15	10	10	35	14	19	0	33	0	0	0	0	85	137
Other	1	4	4	9	0	4	3	7	5	8	0	13	0	0	0	0	29	32
Pharmacy/RX Medical Benefit	1	2	1	4	2	3	0	5	7	4	0	11	0	0	0	0	20	39
Surgery	2	3	2	7	4	5	5	14	4	0	0	4	0	0	0	0	25	51
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	5	4	**14**	10	15	14	**39**	17	12	0	**29**	0	0	0	**0**	82	139
Uphold Rate	**38.5%**	**25.0%**	**36.4%**	**31.8%**	**38.5%**	**46.9%**	**45.2%**	**43.8%**	**39.5%**	**29.3%**	**0.0%**	**34.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.8%**	**44.6%**
Overturns - Full	7	14	6	**27**	16	15	16	**47**	24	27	0	**51**	0	0	0	**0**	125	167
Overturn Rate - Full	**53.8%**	**70.0%**	**54.5%**	**61.4%**	**61.5%**	**46.9%**	**51.6%**	**52.8%**	**55.8%**	**65.9%**	**0.0%**	**60.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**57.6%**	**53.5%**
Overturns - Partials	1	1	1	**3**	0	2	1	**3**	2	0	0	**2**	0	0	0	**0**	8	6
Overturn Rate - Partial	**7.7%**	**5.0%**	**9.1%**	**6.8%**	**0.0%**	**6.3%**	**3.2%**	**3.4%**	**4.7%**	**0.0%**	**0.0%**	**2.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**	**1.9%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	2	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.9%**	**0.0%**	**2.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.9%**	**0.0%**
Membership	347,177	347,177	347,194		346,867	346,814	346,990		348,462	348,258								**345,319**
Appeals - PTMPM	0.04	0.06	0.03	0.04	0.07	0.09	0.09	0.09	0.12	0.12	-	0.08	-	-	-	0.00	0.05	0.06
Grievances - PTMPM	0.41	0.32	0.33	0.35	0.46	0.48	0.45	0.47	0.50	0.42	-	0.31	-	-	-	0.00	0.28	0.26

Kings County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	0	1	0	1	0	2	2	4	1	1	0	2	0	0	0	0	7	9
Standard Grievances Received	11	11	6	28	18	11	7	36	14	15	0	29	0	0	0	0	93	151
Total Grievances Received	**11**	**12**	**6**	**29**	**18**	**13**	**9**	**40**	**15**	**16**	**0**	**31**	**0**	**0**	**0**	**0**	**100**	**160**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	0
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	1	0	1	0	2	2	4	1	1	0	2	0	0	0	0	7	9
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	17	9	10	36	4	20	10	34	9	13	0	22	0	0	0	0	92	148
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	100.00%
Total Grievances Resolved	**17**	**10**	**10**	**37**	**4**	**22**	**12**	**38**	**10**	**14**	**0**	**24**	**0**	**0**	**0**	**0**	99	157
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**9**	**10**	**33**	**4**	**19**	**9**	**32**	**9**	**14**	**0**	**23**	**0**	**0**	**0**	**0**	**88**	128
Access - Other - DMHC	0	3	1	4	1	2	2	5	2	1	0	3	0	0	0	0	12	22
Access - PCP - DHCS	2	0	0	2	0	1	1	2	0	2	0	2	0	0	0	0	6	7
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	5
Administrative	1	2	5	8	0	3	2	5	3	3	0	6	0	0	0	0	19	11
Balance Billing	3	1	0	4	1	1	2	4	1	0	0	1	0	0	0	0	9	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	0	1	2	0	5	0	5	0	1	0	1	0	0	0	0	8	10
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	2	1	3	0	1	0	1	0	0	0	0	4	25
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0
Transportation - Access	1	0	1	2	2	2	0	4	1	1	0	2	0	0	0	0	8	22
Transportation - Behaviour	1	0	1	2	0	0	0	0	0	2	0	2	0	0	0	0	4	6
Transportation - Other	4	3	1	8	0	3	1	4	1	2	0	3	0	0	0	0	15	20
Quality Of Care Grievances	**3**	**1**	**0**	**4**	**0**	**3**	**3**	**6**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**11**	29
Access - Other - DMHC	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	4
PCP Care	2	0	0	2	0	0	2	2	0	0	0	0	0	0	0	0	4	11
PCP Delay	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	9
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	4
Specialist Delay	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1

CalViva Health Appeals and Grievances Dashboard 2024 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0
Standard Appeals Received	1	1	1	3	2	1	3	6	3	0	0	3	0	0	0	0	12	11
Total Appeals Received	**1**	**1**	**1**	**3**	**2**	**2**	**3**	**7**	**3**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	13	11
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	0
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	1
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	2	2	0	4	1	2	1	4	4	2	0	6	0	0	0	0	14	11
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	100.00%
Total Appeals Resolved	**2**	**2**	**0**	**4**	**1**	**3**	**1**	**5**	**4**	**2**	**0**	**6**	**0**	**0**	**0**	**0**	**15**	0
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**2**	**0**	**4**	**1**	**3**	**1**	**5**	**4**	**2**	**0**	**6**	**0**	**0**	**0**	**0**	**15**	12
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	1	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	1
Experimental/Investigational	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	1	1	0	2	0	1	1	2	1	0	0	1	0	0	0	0	5	4
Other	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	2
Pharmacy/RX Medical Benefit	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Surgery	0	0	0	0	1	0	0	1	1	2	0	3	0	0	0	0	4	2
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	1	0	**2**	0	2	0	**2**	2	2	0	**4**	0	0	0	**0**	8	5
Uphold Rate	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**66.7%**	**0.0%**	**40.0%**	**50.0%**	**100.0%**	**0.0%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**53.3%**	41.70%
Overturns - Full	1	1	0	**2**	1	1	1	**3**	2	0	0	**2**	0	0	0	**0**	7	7
Overturn Rate - Full	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**100.0%**	**33.3%**	**100.0%**	**60.0%**	**50.0%**	**0.0%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**46.7%**	58.30%
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	0
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	0
Membership	38,436	38,757	38,756		38,740	38,515	38,259		38,274	38,149								38436
Appeals - PTMPM	0.05	0.05	-	0.03	0.03	0.08	0.03	0.04	0.10	0.05	-	0.05	-	-	-	0.00	0.03	0.026019
Grievances - PTMPM	0.44	0.26	0.26	0.32	0.10	0.57	0.31	0.33	0.26	0.37	-	0.21	-	-	-	0.00	0.21	0.33536

Madera County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	2	0	0	2	1	0	0	1	0	2	0	2	0	0	0	0	5	10
Standard Grievances Received	16	12	10	38	27	20	8	55	18	11	0	29	0	0	0	0	122	163
Total Grievances Received	**18**	**12**	**10**	**40**	**28**	**20**	**8**	**56**	**18**	**13**	**0**	**31**	**0**	**0**	**0**	**0**	**127**	173
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**90.9%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.4%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	2	0	0	2	1	0	0	1	0	2	0	2	0	0	0	0	5	10
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	14	13	40	9	30	16	55	10	17	0	27	0	0	0	0	122	0
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**14**	**13**	**42**	**10**	**30**	**16**	**56**	**10**	**19**	**0**	**29**	**0**	**0**	**0**	**0**	**127**	**175**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**12**	**12**	**39**	**8**	**27**	**15**	**50**	**7**	**15**	**0**	**22**	**0**	**0**	**0**	**0**	**111**	**146**
Access - Other - DMHC	4	2	0	6	0	5	1	6	2	6	0	8	0	0	0	0	20	27
Access - PCP - DHCS	1	0	1	2	2	0	1	3	1	0	0	1	0	0	0	0	6	9
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	1	0	1	0	0	0	0	2	4
Administrative	0	4	1	5	2	3	8	13	2	4	0	6	0	0	0	0	24	15
Balance Billing	1	0	3	4	1	4	2	7	0	1	0	1	0	0	0	0	12	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	2	2	5	0	3	1	4	0	0	0	0	0	0	0	0	9	15
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	0	1	4	0	2	1	3	0	0	0	0	0	0	0	0	7	31
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	1	1	0	2	0	0	0	0	4	0
Transportation - Access	4	1	3	8	1	6	0	7	0	1	0	1	0	0	0	0	16	27
Transportation - Behaviour	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	2	13
Transportation - Other	1	2	0	3	1	3	1	5	0	1	0	1	0	0	0	0	9	5
Quality Of Care Grievances	**0**	**2**	**1**	**3**	**2**	**3**	**1**	**6**	**3**	**4**	**0**	**7**	**0**	**0**	**0**	**0**	**16**	**29**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	1	2	0	1	1	2	0	1	0	1	0	0	0	0	5	5
PCP Care	0	0	0	0	1	0	0	1	0	2	0	2	0	0	0	0	3	5
PCP Delay	0	1	0	1	0	1	0	1	1	0	0	1	0	0	0	0	3	10
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	1	1	0	2	1	1	0	2	0	0	0	0	4	2
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6

CalViva Health Appeals and Grievances Dashboard 2024 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	2
Standard Appeals Received	5	6	5	16	4	9	5	18	6	6	0	12	0	0	0	0	46	38
Total Appeals Received	**5**	**6**	**5**	**16**	**4**	**9**	**5**	**18**	**6**	**7**	**0**	**13**	**0**	**0**	**0**	**0**	47	40
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	6
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	9	3	15	4	5	10	**19**	4	4	0	**8**	0	0	0	**0**	42	31
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**9**	**3**	**15**	**4**	**5**	**10**	**19**	**4**	**5**	**0**	**9**	**0**	**0**	**0**	**0**	**43**	**37**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**9**	**3**	**15**	**4**	**5**	**10**	**19**	**4**	**5**	**0**	**9**	**0**	**0**	**0**	**0**	**43**	**37**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	1	1	1	0	0	1	0	0	0	0	2	0
DME	1	0	1	2	3	0	1	4	2	1	0	3	0	0	0	0	9	0
Experimental/Investigational	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	2	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	8	0	10	0	3	4	7	0	2	0	2	0	0	0	0	19	21
Other	0	0	0	0	1	1	1	3	0	1	0	1	0	0	0	0	4	1
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	2	2	1	1	0	2	0	0	0	0	6	6
Surgery	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	2	2	**5**	1	3	4	**8**	2	2	0	**4**	0	0	0	**0**	17	12
Uphold Rate	**33.3%**	**22.2%**	**66.7%**	**33.3%**	**25.0%**	**60.0%**	**40.0%**	**42.1%**	**50.0%**	**40.0%**	**0.0%**	**44.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**39.5%**	**32.4%**
Overturns - Full	2	7	1	**10**	3	2	5	**10**	2	3	0	**5**	0	0	0	**0**	25	20
Overturn Rate - Full	**66.7%**	**77.8%**	**33.3%**	**66.7%**	**75.0%**	**40.0%**	**50.0%**	**52.6%**	**50.0%**	**60.0%**	**0.0%**	**55.6%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**58.1%**	**54.1%**
Overturns - Partials	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	1	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.0%**	**5.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.3%**	**10.8%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.7%**
Membership	48,509	48,509	48,509		48,465	48,499	48,792		49,168	49,327								**46,762**
Appeals - PTMPM	0.06	0.19	0.06	0.10	0.08	0.10	0.20	0.13	0.08	0.10	-	0.06	-	-	-	0.00	0.07	0.06
Grievances - PTMPM	0.31	0.29	0.27	0.29	0.21	0.62	0.33	0.38	0.20	0.39	-	0.20	-	-	-	0.00	0.22	0.31

CalViva SPD only - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	1	3	0	4	0	1	4	5	0	1	0	1	0	0	0	0	10	42
Standard Grievances Received	22	29	29	80	47	72	67	186	59	57	0	116	0	0	0	0	382	564
Total Grievances Received	**23**	**32**	**29**	84	**47**	**73**	**71**	**191**	**59**	**58**	**0**	**117**	**0**	**0**	**0**	**0**	**392**	**606**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.65%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	3	0	4	0	1	4	5	0	1	0	1	0	0	0	0	10	42
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	28	18	30	76	35	67	65	167	72	53	0	125	0	0	0	0	368	550
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.1%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.7%**	**100.0%**
Total Grievances Resolved	**29**	**21**	**30**	**80**	**36**	**68**	**69**	**173**	**72**	**54**	**0**	**126**	**0**	**0**	**0**	**0**	379	592
Grievance Descriptions - Resolved Cases	**29**	**21**	**30**	**80**	**36**	**68**	**69**	**173**	**72**	**54**	**0**	**126**	**0**	**0**	**0**	**0**	379	592
Access to primary care	0	0	1	1	2	7	5	14	5	4	0	9	0	0	0	0	24	41
Access to specialists	7	6	6	19	0	9	13	22	15	10	0	25	0	0	0	0	66	169
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0
Other	3	4	3	10	8	2	5	15	7	10	0	17	0	0	0	0	42	142
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	6	2	2	10	2	5	8	15	7	2	0	9	0	0	0	0	34	60
QOS Non Access	13	9	18	22	24	45	37	106	38	28	0	66	0	0	0	0	194	164
Exempt Grievances Received	9	6	5	**20**	19	9	21	**49**	30	21	0	**51**	0	0	0	**0**	**120**	**88**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**2**	0
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	**2**	0
Attitude/Service - Provider	1	2	1	**4**	3	2	2	**7**	4	0	0	**4**	0	0	0	**0**	**15**	1
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Vendor	0	0	0	**0**	5	0	2	**7**	4	5	0	**9**	0	0	0	**0**	**16**	1
Attitude/Service - Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	1	**1**	1	2	0	**3**	0	0	0	**0**	**4**	0
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	2	1	1	**4**	1	1	0	**2**	0	0	0	**0**	**6**	2
Health Plan Materials - ID Cards-Not Received	0	0	0	**0**	1	1	4	**6**	2	6	0	**8**	0	0	0	**0**	**14**	20
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Behavioral Health	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	2	0	**5**	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	**9**	19
PCP Assignment/Transfer - HCO Assignment - Change Request	1	0	1	**2**	1	0	7	**8**	5	3	0	**8**	0	0	0	**0**	**18**	19
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0

Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
OTHER - Other	0	0	1	**1**	1	2	0	**3**	5	1	0	**6**	0	0	0	**0**	**10**	1
Claims Complaint - Balance Billing from Provider	4	1	1	**6**	0	1	4	**5**	7	1	0	**8**	0	0	0	**0**	**19**	13

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	2	7
Standard Appeals Received	4	5	5	14	9	11	18	38	14	11	0	25	0	0	0	0	77	68
Total Appeals Received	**4**	**5**	**5**	**14**	**10**	**11**	**19**	**40**	**14**	**11**	**0**	**25**	**0**	**0**	**0**	**0**	79	**75**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**98.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	2	10
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	0	4	7	7	16	12	**35**	18	16	0	**34**	0	0	0	**0**	76	66
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**0**	**4**	**7**	**8**	**16**	**13**	**37**	**18**	**16**	**0**	**34**	**0**	**0**	**0**	**0**	**78**	**76**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**5**	**4**	**12**	**8**	**16**	**13**	**37**	**18**	**16**	**0**	**34**	**0**	**0**	**0**	**0**	**75**	**71**
Continuity of Care	0	0	0	0	0	8	0	8	0	0	0	0	0	0	0	0	8	5
Consultation	0	0	0	0	0	2	3	5	6	1	0	7	0	0	0	0	12	3
DME	1	2	0	3	2	3	2	7	6	7	0	13	0	0	0	0	23	13
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	1	2	5	3	0	4	7	1	5	0	6	0	0	0	0	18	22
Other	0	1	1	2	0	1	1	2	2	2	0	4	0	0	0	0	8	6
Pharmacy/RX Medical Benefit	0	1	0	1	0	1	0	1	2	1	0	3	0	0	0	0	5	14
Surgery	0	0	1	1	3	1	3	7	1	0	0	1	0	0	0	0	9	13
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	2	2	1	**5**	2	6	6	**14**	7	6	0	**13**	0	0	0	**0**	32	30
Uphold Rate	**66.7%**	**0.0%**	**25.0%**	**71.4%**	**25.0%**	**37.5%**	**46.2%**	**37.8%**	**38.9%**	**37.5%**	**0.0%**	**38.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**41.0%**	**39.5%**
Overturns - Full	1	3	2	**6**	6	9	7	**22**	10	8	0	**18**	0	0	0	**0**	46	44
Overturn Rate - Full	**33.3%**	**0.0%**	**50.0%**	**85.7%**	**75.0%**	**56.3%**	**53.8%**	**59.5%**	**55.6%**	**50.0%**	**0.0%**	**52.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**59.0%**	**57.89%**
Overturns - Partials	0	0	0	**0**	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	2	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.3%**	**0.0%**	**2.7%**	**5.6%**	**0.0%**	**0.0%**	**2.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.6%**	**2.6%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	3	0
Withdrawal Rate	**0.0%**	**0.0%**	**25.0%**	**14.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**12.5%**	**0.0%**	**5.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.8%**	**0.0%**
Membership	49,987	49,987	47,341		46,869	46,960	283,020		47,677	47,677								**49,899**
Appeals - PTMPM	0.06	-	0.08	0.00	0.17	0.34	0.05	0.00	0.38	0.34	-	0.24	-	-	-	0.00	0.06	0.06
Grievances - PTMPM	0.58	0.42	0.63	0.00	0.77	1.45	0.24	0.00	1.51	1.13	-	0.88	-	-	-	0.00	0.22	0.52

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative	Grievances related to health plan benefit, paln authorization or access issues
Balance Billing	Member billing for Par and Nonpar providers.
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/RX Medical Benefit	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy/RX Medical Benefit	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist

APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals

Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).

Exempt Grievance tab key – Calviva Dashboard	
Column Definitions.	
Date Opened	The date the case was received
SF #	The internal HealthNet system ID code for the CCC representative who documented the call
Rep Name	Name of the CCC associate who took the call
Sup Name	Supervisor of the CCC associate who took the call
Mbr ID	The Calviva Health ID number of the member
SPD	Marked "yes" if the member is part of the "Seniors & Persons with Disabilities" population
Date of Birth	Date of birth of the member
Mbr Name	Name of the member
Reason	The case was categorized as a Calviva Exempt Grievance, hence the reason it's on the report
Preventable	Used if an Exempt Grievance was determined to be preventable
Access to Care	Used if determined Exempt Grievance was related to Access to Care
Issue Main Classification	Case is categorized by type of complaint
Issue Sub Classification	Case is subcategorized by type of complaint
DMHC Complaint Category	Case is categorized based on the DMHC TAR template complaint category
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here
Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it's an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligibilty or lackthereof.
Health Care Benefits	When it's an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
The Outlier Tab	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.

Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #8
Attachment 8.C

Medical Management
Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 8/01/2024 to 8/31/2024

Report created 9/27/2024

Purpose of Report: Summary report on Inpatient and Outpatient Utilization Metrics by Region, County, PPG entity
Reports show inpatient Rates with and without maternity, readmission, TAT Compliance, Care Management Programs

Exhibits:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Azra S. Aslam <Azra.S.Aslam@healthnet.com>
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.con

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 8/01/2024 to 8/31/2024
Report created 9/27/2024

ER utilization based on Claims data	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
	MEMBERSHIP														Quarterly Averages							Annual Averages		
Expansion Mbr Months	119,044	118,421	117,508	116,609		115,570	119,572	119,992	120,073	120,279	120,769	122,044	122,125		116,736	120,103	120,009	117,513	118,378	120,374		118,590	120,053	
Adult/Family/O TLIC Mbr Mos	268,231	266,908	265,208	263,113		262,709	267,059	267,730	267,209	266,454	266,050	266,607	265,991		267,795	271,513	269,846	265,076	265,833	266,571		268,558	266,226	
Aged/Disabled Mbr Mos	49,597	49,395	49,074	48,807		46,270	47,506	47,234	46,940	46,026	46,962	47,175	47,366		45,552	49,671	49,807	49,092	47,003	46,643		48,531	46,935	
	COUNTS																							
Admits - Count	1,995	2,016	2,045	2,222		2,238	2,097	2,137	1,976	2,158	2,133	2,210	2,135		2,072	2,108	2,106	2,094	2,157	2,089		2,095	2,136	
Expansion	635	619	680	696		751	686	663	653	733	734	732	722		600	661	682	665	700	707		652	709	
Adult/Family/O TLIC	878	914	867	944		918	853	935	855	921	890	945	919		897	905	906	908	902	889		904	905	
Aged/Disabled	482	483	498	582		569	558	539	468	504	509	533	494		574	542	518	521	555	494		539	522	
Admits Acute - Count	1,300	1,341	1,364	1,497		1,401	1,422	1,408	1,336	1,422	1,386	1,468	1,394		1,344	1,351	1,421	1,410	1,435	1,381		1,387	1,405	
Expansion	477	498	524	532		547	540	507	512	582	575	579	561		489	537	541	518	531	556		521	550	
Adult/Family/O TLIC	421	439	438	503		449	454	484	442	455	408	461	403		438	436	422	460	462	435		439	445	
Aged/Disabled	402	404	402	462		405	428	417	382	385	403	428	430		417	437	428	423	417	390		426	410	
Readmit 30 Day - Count	214	237	224	251		238	251	237	213	250	262	229	161		242	229	241	237	242	242		237	230	
Expansion	79	89	89	102		93	92	95	85	108	115	93	64		94	88	98	93	93	103		93	93	
Adult/Family/O TLIC	32	38	40	38		37	47	34	47	48	44	37	32		51	44	36	39	39	46		42	41	
Aged/Disabled	103	110	95	111		108	112	108	81	94	103	99	65		97	97	107	105	109	93		102	96	
**ER Visits - Count	13,697	13,708	14,088	14,802		13,698	13,646	14,619	14,711	15,610	14,474	13,761	7,288		13,292	14,760	13,957	14,199	13,988	14,932		14,052	13,476	
Expansion	3,656	3,783	3,560	3,798		3,744	3,509	3,797	3,897	4,094	4,078	4,125	2,275		3,550	3,900	3,930	3,714	3,683	4,023		3,774	3,690	
Adult/Family/O TLIC	8,251	8,176	8,658	9,107		8,141	8,270	8,877	8,879	9,505	8,377	7,683	4,259		8,156	8,903	8,086	8,647	8,429	8,920		8,448	7,999	
Aged/Disabled	1,790	1,749	1,870	1,897		1,813	1,867	1,945	1,935	2,011	2,019	1,953	754		1,586	1,957	1,940	1,839	1,875	1,988		1,830	1,787	
	PER/K																							
Admits Acute - PTMPY	35.7	37.0	37.9	41.9		39.6	39.3	38.8	36.9	39.4	38.3	40.4	38.4		37.5	36.7	38.8	39.2	39.9	38.2		38.2	38.9	
Expansion	48.1	50.5	53.5	54.7		56.8	54.2	50.7	51.2	58.1	57.1	56.9	55.1		50.3	53.7	54.1	52.9	53.9	55.5		52.8	55.0	
Adult/Family/O TLIC	18.8	19.7	19.8	22.9		20.5	20.4	21.7	19.8	20.5	18.4	20.7	18.2		19.6	19.3	18.8	20.8	20.9	19.6		19.6	20.0	
Aged/Disabled	97.3	98.1	98.3	113.6		105.0	108.1	105.9	97.7	100.4	103.0	108.9	108.9		109.9	105.6	103.0	103.3	106.4	100.3		105.4	104.8	
Bed Days Acute - PTMPY	192.5	203.2	215.3	229.5		217.6	206.5	205.7	199.0	198.2	207.1	191.7	183.1		202.9	200.1	202.6	215.9	209.8	201.5		205.3	201.1	
Expansion	302.5	311.2	320.9	310.2		327.7	312.9	303.6	301.9	290.1	347.3	290.0	254.7		298.1	294.0	315.8	314.1	314.6	313.2		305.5	303.3	
Adult/Family/O TLIC	66.1	71.9	67.8	94.5		78.8	74.2	81.8	71.1	80.9	64.2	70.2	68.5		74.2	75.1	68.6	78.0	78.3	72.1		74.0	73.7	
Aged/Disabled	612.1	654.2	759.8	764.2		730.3	682.0	659.0	663.7	636.9	656.7	624.0	642.5		715.6	656.0	655.7	725.8	690.2	652.5		687.5	661.8	
ALOS Acute	5.4	5.5	5.7	5.5		5.5	5.3	5.3	5.4	5.0	5.4	4.7	4.8		5.4	5.4	5.2	5.5	5.3	5.3		5.4	5.2	
Expansion	6.3	6.2	6.0	5.7		5.8	5.8	6.0	5.9	5.0	6.1	5.1	4.6		5.9	5.5	5.8	5.9	5.8	5.6		5.8	5.5	
Adult/Family/O TLIC	3.5	3.6	3.4	4.1		3.8	3.6	3.8	3.6	3.9	3.5	3.4	3.8		3.8	3.9	3.7	3.7	3.8	3.7		3.8	3.7	
Aged/Disabled	6.3	6.7	7.7	6.7		7.0	6.3	6.2	6.8	6.3	6.4	5.7	5.9		6.5	6.2	6.4	7.0	6.5	6.5		6.5	6.3	
Readmit % 30 Day	10.7%	11.8%	11.0%	11.3%		10.6%	12.0%	11.1%	10.8%	11.6%	12.3%	10.4%	7.5%		11.7%	10.8%	11.5%	11.3%	11.2%	11.6%		11.3%	10.8%	
Expansion	12.4%	14.4%	13.1%	14.7%		12.4%	13.4%	14.3%	13.0%	14.7%	15.7%	12.7%	8.9%		15.6%	13.3%	14.4%	14.0%	13.3%	14.5%		14.3%	13.1%	
Adult/Family/O TLIC	3.6%	4.2%	4.6%	4.0%		4.0%	5.5%	3.6%	5.5%	5.2%	4.9%	3.9%	3.5%		5.6%	4.9%	4.0%	4.3%	4.4%	5.2%		4.7%	4.5%	
Aged/Disabled	21.4%	22.8%	19.1%	19.1%		19.0%	20.1%	20.0%	17.3%	18.7%	20.2%	18.6%	13.2%		16.9%	17.9%	20.6%	20.2%	19.7%	18.8%		18.8%	18.4%	
**ER Visits - PTMPY	376.2	378.4	391.5	414.5		387.2	377.2	403.3	406.5	432.9	400.4	378.9	200.8		370.9	401.4	380.9	394.7	389.3	413.3		387.0	373.3	
Expansion	368.5	383.3	363.5	390.8		388.8	352.2	379.7	389.5	408.5	405.2	405.6	223.5		364.9	389.7	393.0	379.2	373.4	401.1		381.8	368.8	
Adult/Family/O TLIC	369.1	367.6	391.8	415.4		371.9	371.6	397.9	398.7	428.1	377.8	345.8	192.1		365.5	393.5	359.6	391.4	380.5	401.6		377.5	360.5	
Aged/Disabled	433.1	424.9	457.3	466.4		470.2	471.6	494.1	494.7	524.3	515.9	496.8	191.0		417.7	472.7	467.5	449.4	478.7	511.5		452.6	456.9	
Services	TAT Compliance Goal: 100%					TAT Compliance Goal: 100%									TAT Compliance Goal: 100%							TAT Compliance Goal: 100%		
Preservice Routine	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	88.0%	100.0%	100.0%		100.0%	100.0%	100.0%	99.1%	100.0%	94.6%				
Preservice Urgent	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	96.0%	94.0%	98.0%	100.0%	100.0%	98.0%		100.0%	99.1%	100.0%	99.1%	98.2%	96.9%				
Postservice	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		96.9%	100.0%	98.9%	100.0%	100.0%	99.1%				
Deferrals - Urgent	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	NA	NA	NA	NA		null	null	null	null	null	null	null	null		null	null	null	null	null	null				
	CCS ID RATE								CCS ID RATE									CCS ID RATE					CCS ID RATE	
CCS %	7.83%	7.72%	7.77%	7.70%		7.56%	7.59%	7.63%	8.57%	8.53%	8.47%	8.50%	8.52%		8.17%	7.91%	7.87%	7.73%	7.59%	8.52%		7.92%	8.17%	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 8/01/2024 to 8/31/2024
Report created 9/27/2024

ER utilization based on Claims data	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand					Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand									Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand									
Births	13.7	14.0	13.3	14.1		14.6	12.8	13.8	12.6	13.9	14.8	15.3	15.5		13.7	13.4	14.3	13.8	13.7	-		13.8		
OB % Days	4.8%	5.3%	4.2%	4.1%		1.7%	2.8%	4.1%	4.7%	5.2%	5.1%	8.2%	10.7%		2.0%	3.5%	5.1%	4.5%	2.9%	-		17.0%		
OB % Admits	24.8%	25.0%	23.0%	22.6%		22.1%	21.2%	23.0%	22.6%	23.0%	24.2%	25.0%	26.0%		22.2%	22.9%	24.6%	23.5%	22.1%	-		30.0%		
	Perinatal Case Management					Perinatal Case Management									Perinatal Case Management							Perinatal Case Management		
Total Number Of Referrals	167	170	147	133		320	203	163	280	257	64	131	137		472	598	476	386	686	601		318	1,555	
Pending	0	0	0	0		0	0	0	0	0	0	1	2		0	2	1	21	0	0		3	3	
Ineligible	10	9	8	7		10	21	9	10	9	18	17	13		18	32	10	19	40	37		5	107	
Total Outreached	157	161	139	126		310	182	154	270	248	46	113	122		454	564	465	346	646	564		310	1,445	
Engaged	130	146	130	115		226	137	103	145	160	41	100	103		157	224	183	137	466	346		228	1,015	
Engagement Rate	83%	91%	94%	91%		73%	75%	67%	54%	65%	89%	88%	84%		35%	40%	39%	40%	72%	61%		74%	70%	
Total Cases Managed	476	574	600	599		699	687	603	612	619	505	489	422		344	432	496	410	937	809		702	1487	
Total Cases Closed	58	90	116	127		151	184	136	152	153	119	163	100		136	154	182	180	471	424		150	1,158	
Cases Remained Open	419	478	495	469		547	509	442	439	467	388	318	295		199	263	263	224	442	388		547	318	
	Physical Health Case Management					Physical Health Case Management									Physical Health Case Management							Physical Health Case Management		
Total Number Of Referrals	194	161	114	132		186	275	314	268	343	190	220	274		799	840	612	407	775	801		2,658	2,070	
Pending	0	2	4	19		0	1	0	0	0	3	3	18		0	1	3	25	1	3		29	25	
Ineligible	32	35	16	22		25	23	33	37	79	18	4	25		194	164	101	73	81	134		532	244	
Total Outreached	162	124	94	91		161	251	281	231	264	169	213	231		605	675	508	309	693	664		2,097	1,801	
Engaged	98	81	72	62		78	123	138	119	123	77	102	106		343	422	338	215	339	319		1,318	866	
Engagement Rate	60%	65%	77%	68%		48%	49%	49%	52%	47%	46%	48%	46%		57%	63%	67%	70%	49%	48%		63%	48%	
Total Screened and Refused/Decline	29	12	7	13		36	33	39	29	38	15	25	42		172	132	76	32	108	82		412	257	
Unable to Reach	35	31	15	16		47	95	104	83	103	77	86	83		90	121	94	62	246	263		367	678	
Total Cases Closed	137	107	102	94		118	105	89	76	106	94	109	109		325	415	397	303	312	276		1,440	806	
Cases Remained Open	354	336	302	262		226	252	296	350	376	339	331	324		399	415	354	262	296	339		262	331	
Total Cases Managed	503	441	403	362		360	372	405	435	484	441	450	444		746	848	769	591	622	615		1723	1145	
Complex Case	69	61	60	62		65	59	64	62	65	65	62	51		61	94	95	84	99	86		161	148	
Non-Complex Case	434	380	343	300		295	313	341	373	419	376	388	393		685	754	674	507	523	529		1562	997	
	Transitional Care Services					Transitional Care Services									Transitional Care Services									
Total Number Of Referrals	228	278	277	130		266	291	147	128	238	431	491	610		296	750	827	685	704	797		2,558	2,602	
Pending	0	0	4	13		0	0	0	0	0	0	2	94		0	0	0	17	0	0		17	96	
Ineligible	7	13	19	18		43	40	14	7	6	13	3	17		33	26	28	50	97	26		137	143	
Total Outreached	221	265	254	99		223	251	133	121	232	418	486	499		263	724	799	618	607	771		2,404	2,363	
Engaged	220	256	217	52		101	164	110	88	146	232	318	339		216	673	783	525	375	466		2,197	1,498	
Engagement Rate	100%	97%	85%	53%		45%	65%	83%	73%	63%	56%	65%	68%		82%	93%	98%	85%	62%	60%		91%	63%	
Total Screened and Refused/Decline	0	6	10	14		31	24	3	9	6	24	36	30		7	7	6	30	58	39		50	163	
Unable to Reach	1	3	27	33		91	63	20	24	80	162	132	130		40	44	10	63	174	266		157	702	
Total Cases Closed	212	230	191	79		77	64	138	114	87	97	210	271		195	476	645	500	279	298		1,816	1,058	
Cases Remained Open	69	61	50	12		29	132	107	92	109	233	305	386		19	73	69	12	107	233		12	305	
Total Cases Managed	380	382	310	125		126	204	260	211	245	387	608	725		265	695	901	654	399	587		2,248	1,524	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
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Report created 9/27/2024

ER utilization based on Claims data	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
	Behavioral Health Care Management					Behavioral Health Care Management									Behavioral Health Care Management							ehavioral Health Care Managemen		
Total Number Of Referrals	40	26	40	38		78	94	73	68	138	81	115	121		235	166	128	104	245	287		633	768	
Pending	0	0	0	0		0	0	0	0	0	0	0	9		0	0	0	0	0	0		0	9	
Ineligible	3	1	5	10		7	5	2	2	5	6	2	6		21	16	10	16	14	13		63	35	
Total Outreached	37	25	35	28		71	89	71	66	133	75	113	106		214	150	118	88	231	274		570	724	
Engaged	36	25	21	12		37	73	52	35	65	52	73	78		139	108	100	58	162	152		405	465	
Engagement Rate	97%	100%	60%	43%		52.0%	82.0%	73.0%	53.0%	49.0%	69%	65%	74%		65%	72%	85%	66%	70%	55%		71%	64%	
Total Screened and Refused/Decline	1	0	1	4		2	2	1	7	10	1	1	4		6	12	4	5	5	18		27	28	
Unable to Reach	0	0	13	12		32	14	18	24	58	22	39	24		69	30	14	25	64	104		138	231	
Total Cases Closed	41	34	26	27		35	27	31	55	60	36	62	50		154	122	128	87	93	151		491	356	
Cases Remained Open	106	95	89	75		64	119	142	121	127	141	145	160		149	138	106	75	142	141		75	145	
Total Cases Managed	149	129	118	104		113	150	176	182	193	184	217	233		307	264	237	170	237	297		572	540	
Complex Case	15	12	15	15		14	11	10	10	15	13	17	14		13	17	20	18	19	19		32	35	
Non-Complex Case	134	117	103	89		99	139	166	172	178	171	200	219		294	247	217	152	218	278		540	505	

	First Year of Life Care Management					First Year of Life Care Management									First Year of Life Care Management							First Year of Life Care Management		
Total Number Of Referrals	26	28	18	27		32	29	47	35	29	22	56	34		0	8	60	73	108	86		141	284	
Pending	0	0	0	0		0	0	0	0	0	0	1	0		0	0	0	0	0	0		0	1	
Ineligible	0	0	2	1		1	1	0	0	1	0	0	2		0	1	0	3	2	1		4	5	
Total Outreached	0	28	16	26		31	28	47	35	28	22	55	32		0	7	60	70	106	85		137	278	
Engaged	0	28	16	21		31	28	47	35	28	22	47	32		0	3	60	65	106	85		128	270	
Engagement Rate	0%	100%	100%	81%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.0%	100.0%		0.0%	43.0%	100.0%	93.0%	100.0%	100.0%		93.0%	97.0%	
Total Screened and Refused/Decline	0	0	0	2		0	0	0	0	0	0	3	0		0	2	0	2	0	0		4	3	
Unable to Reach	0	0	0	3		0	0	0	0	0	0	5	0		0	2	0	3	0	0		5	5	
Total Cases Closed	0	8	4	4		2	8	10	9	8	11	11	12		0	0	3	16	20	28		19	71	
Cases Remained Open	0	74	91	108		140	160	196	218	243	254	289	308		0	3	56	108	196	254		108	289	
Total Cases Managed	0	88	95	113		143	169	207	232	250	265	301	321		0	3	62	125	217	282		128	381	

Item #8

Attachment 8.D

Medical Management
QIUM Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick C. Marabella, MD Chief Medical Officer
Amy R. Schneider, RN Senior Director Medical Management

COMMITTEE DATE: October 17th, 2024

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 3 2024(Oct 2024)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Care Management and Population Health Management performance, programs, and regulatory activities in Quarter 3 of 2024.

I. Meetings

Two QI/UM meetings were held in Quarter 3, in July and September. On July 18th and September 19th, 2024, the QI/UM Committee met, and the following **guiding documents** were approved:

1. 2023 Care Management Program Evaluation
2. 2024 QI & Health Education Work Plan Mid-Year Evaluation
3. 2024 UMCM Work Plan Mid-Year Evaluation
4. Health Disparities Analysis and Actions Report 2024

In addition, the following **general documents** were adopted/approved at the meetings:

1. Medical Policies
2. Clinical Practice Guidelines
3. Pharmacy Provider Updates
4. Quality Improvement Policies & Procedures Annual Review
5. Prior Authorization Requirements (Aug 2024)

The following **Oversight Audit Results** were presented and accepted at the July meeting:

1. 2023 Continuity of Care
2. 2023 Emergency Services

New presentation at the QI/UM Committee:

1. **Continuity & Coordination of Medical Care** This new component of our Population Health Management program was presented and discussed at the July meeting.
   Purpose & Goals of this Project include the following:
   - Facilitate care coordination and communication among providers and the health plan.
   - Evaluate performance results that quantify continuity & coordination of medical care.
   - Identify opportunities to improve continuity and coordination based upon results.

Results of monitoring by County were presented for Postpartum Care, Eye Exams for Diabetics, Pharmacotherapy for Opioid Use Disorder, and All Cause Readmissions. CalViva performed well on all measures except Pharmacotherapy for Opioid Use Disorder where all three (3) counties were below the goal.

Barriers to successful care coordination were identified and strategies for improvement established. Results will be re-evaluated next year to assess the effectiveness of interventions.

II. QI Reports - The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard & Quarterly A & G Reports** provide a summary of all grievances in order to track volumes, turn-around times and case classifications. A year-to-year evaluation of the first 6 months was also presented.
   - **a.** The total number of grievances received through July 2024 increased in volume in comparison to 2023 results.
   - **b.** Quality of Service (QOS) cases represented the greatest volume overall and demonstrated an increase from the prior year.
   - **c.** Quality of Care (QOC) cases were lower this year compared to last, however they have gradually increased month over month so far this year. This trend was seen last year as well.
   - **d.** Trends continue for Balanced Billing issue. However, we did see a decline is Transportation-related issues overall and a decline in "provider no shows". Both issues continue to be addressed through action plans.
   - **e.** Total Appeals have increased compared to Q2 2023.
   - **f.** A new A & G Report was added this year in response to a regulatory Corrective Action Plan (CAP) called the "Call Center Inquiry Calls Audit". This report was developed to ensure all member expressions of dissatisfaction are properly identified and processed as grievances to ensure proper handling, routing, and resolution. Q1 & Q2 2024 reports have been presented and continue to be refined.
2. **Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.
   PQI reviews may be initiated by a member, non-member, or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review.
   a. In quarter 2 most member generated cases were scored at level zero (64), followed by level one (13) and then level two (8). There were no (0) level 3 or 4 cases, and one (1) Behavioral Health member generated PQI. One (1) Physical Health non-member generated PQI in Q2 scored as level 3. There were no (0) Behavioral Health non-member generated PQIs. There were follow up actions completed for thirty-five (35) lower severity cases in Q2.
3. The **Lead Screening Quarterly Report** is a Quarterly Assessment of Blood Lead Screening in Children compliance to ensure that CalViva members receive blood lead level testing and follow-up when indicated and that parents/caregivers receive anticipatory guidance related to blood lead poisoning prevention from providers. This is a HEDIS® measure requiring that we meet or exceed the 50th percentile. Currently only Madera County is meeting the 50th percentile.
   a. Q1 2024 rates were reported and found to be approximately 10% lower than Q4 2023, this is due to the cumulative effect of the measure throughout the calendar year.
   b. Documentation of anticipatory guidance using established codes remains very low.
   c. Improvement efforts are focused on increasing Point of Care testing. Lead analyzer equipment and kits have been purchased by the Plan for twenty-eight (28) providers in Fresno County and five (5) in Madera County. Screening rates are expected to improve; however, documentation of anticipatory guidance still needs to be addressed.

4. **Additional Quality Improvement Reports** approved include Facility Site and Medical Record Review Report, Behavioral Health Performance Indicator Report, Initial Health Appointment Quarterly Report, Provider Preventable Conditions, County Relations Report, Member Incentives Program report, Performance Improvement Updates (PIPs), and others scheduled for presentation at the QI/UM Committee during Q3.

III. Access Reports – The following is a summary of the access related reports and topics reviewed. These reports may come from the Access Work Group or other access-related information.

1. Access Work Group minutes from March 26th, June 13th and June 27th, 2024, were reviewed and approved.
2. The **Access Work Group Q3 Summary Report** was presented. This report provides a summary of Work Group activities since the last report. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. A variety of reports were presented and discussed at the workgroup including, but not limited to, reports on access related grievances, network adequacy and capacity, Call Center metrics, Triage & Screening results, Telehealth and more. Several standing reports related to the annual DMHC Timely Access Reporting (TAR) filing were discussed and brought back for final approval due to their length and complexity. Updates were provided on Network Certifications and other regulatory filings.

3. **Additional Access Related Reports** approved include the Specialty Referral Report, Provider Office Wait Time Report, and the Standing Referral Report.

IV. UMCM Reports - The following is a summary of the reports and topics reviewed:

1. **The Key Indicator Report (KIR) & Concurrent Review Report** provided data through July 31st, 2024, and Q2 respectively. A summary was reviewed with the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through Q2 2024. Quarterly comparisons were reviewed with the following highlights:
    - **Membership** fluctuated in the first six months of the year but appears to be leveling off.
    - For **Acute Admissions** (adjusted PTMPY), all three populations (Expansion, TANF and SPD) increased compared to 2023.
    - **Bed Days** (adjusted PTMPY) have declined for all three populations.
    - **Acute Length of Stay** (adjusted PTMPY) decreased for all three populations.
    - **ER Visits** (adjusted PTMPY) demonstrate random variation through Q2 without significant trends.
2. **The Care Management and CCM Report** provides a summary of the various case management and care coordination services offered to CalViva members. The programs include physical health case management, perinatal case management, behavioral health case management, transitional care services (the entry point for most CM programs) and the First Year of Life is a new program this year. Reports for Q1 and Q2 were presented in July and September respectively. The **outcome measures** include Readmission rates, ED utilization, Pre-term deliveries for the OB population, Member satisfaction, and Overall Healthcare costs. Positive results were seen for all outcome measures.

3. The **Enhanced Care Management (ECM) & Community Supports Performance Report for** Q1 and Q2 were presented in July and September respectively. This report summarizes key features of the CalAIM Program, DHCS' initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system and program and payment reform. Enhanced Care Management (ECM) and Community Supports (CS) provide a menu of services that can serve as cost-effective alternatives to standard covered Medi-Cal services.
   Between January through June 2024, there has been a steady increase in both ECM and CS uptake, including authorizations and claims submissions.
    - As of June 2024, of the 8,059 members assigned to Enhanced Care Management (ECM) in the three CVH counties, 1,251 are enrolled, accounting for a 15.5% enrollment rate (goal is 25%).
    - For Community Supports (CS) services, a total of 14,271 authorizations were submitted between January to June 2024, with 78,173 total claims count.
        - 92% for services related to Medically Tailored Meals/Medically Supported Foods
        - 4% for Housing Transition/Housing Sustaining/Housing Deposits Services
        - 3% for Day Habilitation Services, and
        - 0.6% for Personal Care and Homemaker Services.

The top three barriers to enrollment are 1) Lack of accurate or available member contact info 2) Difficult to find members for referral into program 3) Lack of awareness by members and providers about the program.

Next steps include but are not limited to:

1) **Data intervention** through one-on-one follow ups with individual ECM providers.
2) **Internal PHCO team to systematically screen, engage and refer** members into ECM and CS services.
3) **2024 ECM provider incentive program** that encourages both ECM and CS enrollment, including a new measure around increasing community referrals.

4. **Additional UMCM Reports** include Concurrent Review IRR Report, TurningPoint, MedZed Report, Evolent Report (NIA), CCS Report, SPD HRA Report, Top 10 Inpatient Diagnoses MY2023, PA Member Letter Monitoring report and others scheduled for presentation at the QI/UM Committee during Q3.

V. Pharmacy Quarterly Reports

The following is a summary of the reports and topics reviewed: Pharmacy reports include Executive Summary, Operation Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR) which were all reviewed. Since the implementation of Medi-Cal Rx in January of 2022, pharmacy activities are focused on Medical Benefit drugs.

1. Pharmacy prior authorization metrics were within 5% of standard for the second quarter.
2. PA metrics remained consistent in Q2 compared to Q1 with an overall Turn-around Time of 98.4%.
3. PA volumes decreased slightly in Q2.
4. Second quarter top medication requests were consistent with quarter 1.
5. Inter-rater Reliability results met the 90% threshold for action. 95% goal not met; the overall score was 95.83%. Criteria application was the most common issue in Q2 followed by clear and concise language in member letters, and questionable denial Vs approval for one (1) case. Results were shared with PA Managers.

VI. HEDIS® Activity

In Q3, HEDIS® related activities were focused on analyzing the results for MY2023 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile.

The final HEDIS® results for CalViva for MY 2023 (RY24) were received. A review of these results noted the following:

- **Fresno County** did not meet the Minimum Performance Level (MPL) of the 50th percentile for the following measures: Asthma Medication Ratio, Follow up after ED Visit for Mental Health/SUD, Childhood IZ, Lead Screening in Children, and Well-Care Visits (W30-15 & W30-30).
- **Kings County** did not meet the MPL of the 50th percentile for the following measures: Asthma Medication Ratio, Follow up after ED Visit for Mental Health/SUD, Childhood IZ, Adolescent IZ, Lead Screening in Children, Child and Adolescent Well-Care Visits, and Well-Care Visits (W30-15 & W30-30).
- **Madera County** met the MPL of the 50th percentile for all measures except Follow up after ED Visit for Mental Health/SUD.

There are two new HEDIS® Measures that MCPs will be held accountable to meet the MPL for in 2024 and these are as follows:

- Topical Fluoride for Children, and Developmental Screening in the First Three Years of Life.

VII. Quality Improvement Activities

1. Two Performance Improvement Projects:

A. **Clinical Disparity PIP** - Improve Infant Well-Child Visits in the Black/African American(B/AA) Population in Fresno County.

- First Annual Report submitted to HSAG/DHCS on 9/11/24. Awaiting feedback.
- Continuing Intervention #1 to refer all B/AA pregnant or newly delivered members to Black Infant Health (BIH) adding member incentives for attending.

- Developing 2nd intervention to focus on specific actions BIH will initiate to support WCV completion.

B. **Non-Clinical PIP** - Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue.
   - First Annual Report submitted to HSAG/DHCS on 9/25/24. Awaiting feedback.
   - Implementing two interventions at Saint Agnes Medical Center:
     - Staff Training on appropriate Coding to document services provided.
     - Cultural Competency focusing on the Hispanic Population to increase Follow up.

2. ***Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative*** *April 2024 through March 2025.* In progress. Working with Clinica Sierra Vista (CSV) and IHI to improve WCV for *Hispanic Children 0-15 months* in Fresno County through testing of interventions related to Provider/Caregiver Experience, Equitable Scheduling and Community Resources.
   - **Intervention #1** Equity & Transparent, Stratified and Actionable Data - **complete.**
   - **Intervention #2** Understanding Provider and Patient/Caregiver Experiences – **complete**
   - **Intervention #3 Reliable & Equitable Scheduling Processes –** in progress. We are currently testing an intervention focused on educating caregivers about the importance of WCVs.

3. ***Lean Equity Improvement Projects*** *in Kings (Child Domain) and Madera (Behavioral Health Domain) assigned in April 2024*. A-3 Project Summaries submitted first progress report to DHCS 09/30/24. Awaiting feedback.

4. ***Comprehensive Improvement Project*** *in Fresno County (Child & Behavioral Health Domains) assigned in April 2024.* Fishbone Diagram followed by Plan for Improvement submitted and approved by DHCS. First progress report on Initial Strategies and Action Items due to DHCS 10/18/24.

VIII. Findings/Outcomes

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of utilization management, care management, population health and the quality and safety of care provided to CalViva members. No significant compliance issues have been identified. Oversight and monitoring processes will continue.

Item #8

Attachment 8.E

Executive Dashboard

	2023	2023	2023	2023	2023	2024	2024	2024	2024	2024	2024	2024	2024
Month	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**
CVH Members													
Fresno	353,005	350,061	348,373	346,709	345,319	343,493	347,888	348,065	348,349	347,954	347,975	349,399	348,729
Kings	39,697	39,366	38,824	38,583	38,436	38,232	38,901	38,877	38,831	38,563	38,404	38,370	38,254
Madera	48,375	48,124	47,588	47,150	46,762	46,717	48,656	48,684	48,579	48,666	48,888	49,258	49,373
Total	441,077	437,551	434,785	432,442	430,517	428,442	435,445	435,626	435,759	435,183	435,267	437,027	436,356
SPD	50,616	50,476	50,222	49,987	49,899	47,393	47,212	47,029	46,869	46,763	46,841	47,066	47,185
CVH Mrkt Share	67.44%	67.46%	67.51%	67.59%	67.65%	67.15%	66.84%	66.83%	66.81%	66.83%	66.85%	66.90%	66.92%
ABC Members													
Fresno	156,328	155,030	154,141	152,908	151,942	151,485	155,843	155,594	155,721	155,374	155,027	155,215	154,520
Kings	25,952	25,737	25,319	25,075	24,901	25,311	25,600	25,550	25,522	25,234	25,053	24,915	24,819
Madera	30,642	30,333	29,752	29,339	29,018	28,693	29,862	29,595	29,230	28,949	28,785	28,665	28,541
Total	212,922	211,100	209,212	207,322	205,861	205,489	211,305	210,739	210,473	209,557	208,865	208,795	207,880
Kasier													
Fresno						3,562	3,998	4,627	5,075	5,467	5,931	6,269	6,645
Kings						2	54	67	87	98	102	113	121
Madera						574	673	800	884	918	987	1,054	1,098
Total						4,138	4,725	5,494	6,046	6,483	7,020	7,436	7,864
Default													
Fresno	55.25%	64.51%	55.31%	52.18%	54.90%	48.76%	57.21%	55.65%	57.56%	59.38%	64.17%		
Kings	61.54%	56.71%	63.12%	65.00%	58.18%	62.64%	53.82%	55.67%	56.78%	57.36%	57.76%		
Madera	55.58%	64.21%	55.26%	58.30%	56.41%	55.86%	54.76%	61.60%	65.92%	72.97%	77.26%		
County Share of Choice as %													
Fresno	65.32%	48.06%	66.31%	65.72%	51.27%	66.82%	59.92%	62.71%	62.52%	62.40%	64.25%		
Kings	50.51%	65.47%	66.67%	61.84%	69.21%	65.78%	62.47%	63.07%	65.75%	67.10%	65.56%		
Madera	63.87%	57.35%	63.79%	66.57%	57.79%	69.02%	58.71%	60.62%	65.83%	58.80%	62.24%		

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Security Risk	**2**	Description: Average security risk for all hosts. 5 = High Severity. 1 = Low Severity
	Business Risk Score	**24**	Description: Business risk is expressed as a value (0 to 100). Generally, the higher the value the higher the potential for business loss since the service returns a higher value when critical assets are vulnerable.
	Average Age of Workstations	**3.6 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems.		

Member Call Center CalViva Health Website		**Year**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
		Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	(Main) Member Call Center	**# of Calls Received**	**35,660**	**34,897**	**34,897**	**34,875**	**41,520**	**36,270**
		# of Calls Answered	**35,418**	**34,625**	**34,595**	**34,533**	**41,114**	**36,104**
		Abandonment Level (Goal < 5%)	**0.70%**	**0.80%**	**0.90%**	**1.00%**	**1.00%**	**0.50%**
		Service Level (Goal 80%)	**94%**	**87%**	**88%**	**83%**	**85%**	**98%**
	Behavioral Health Member Call Center	**# of Calls Received**	**813**	**940**	**860**	**1,436**	**940**	**864**
		# of Calls Answered	**808**	**930**	**848**	**1,426**	**936**	**859**
		Abandonment Level (Goal < 5%)	**0.60%**	**1.10%**	**1.40%**	**0.70%**	**0.40%**	**0.60%**
		Service Level (Goal 80%)	**91%**	**89%**	**89%**	**95%**	**97%**	**94%**
	Transportation Call Center	**# of Calls Received**	**12,407**	**12,107**	**12,554**	**8,239**	**9,469**	**13,007**
		# of Calls Answered	**12,394**	**12,083**	**12,466**	**8,181**	**9,384**	**12,942**
		Abandonment Level (Goal < 5%)	**0.10%**	**0.00%**	**0.50%**	**0.50%**	**0.60%**	**0.40%**
		Service Level (Goal 80%)	**94%**	**93%**	**87%**	**86%**	**79%**	**86%**
	CalViva Health Website	**# of Users**	**54,000**	**42,000**	**40,000**	**45,000**	**54,000**	**53,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (60%)**	**Mobile (60%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**
		Session Duration	**~ 2 minutes**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website. Q2 2024 numbers were presented during 9/19/24 Commission Meeting.							

Provider Network & Engagement Activities	**Year**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**
	Month	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**156**	**156**	**156**	**157**	**156**	**156**	**158**
	PCP	**396**	**396**	**397**	**401**	**406**	**409**	**418**
	PCP Extender	**391**	**392**	**421**	**433**	**413**	**413**	**442**
	Specialist	**1468**	**1468**	**1471**	**1477**	**1485**	**1531**	**1563**
	Ancillary	**266**	**278**	**279**	**283**	**285**	**302**	**312**
	Year	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Behavioral Health	**472**	**507**	**593**	**598**	**592**	**353**	**652**
	Vision	**30**	**37**	**104**	**110**	**104**	**108**	**116**
	Urgent Care	**11**	**12**	**14**	**14**	**16**	**16**	**16**
	Acupuncture	**4**	**4**	**4**	**4**	**3**	**3**	**3**
	Year	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	% of PCPs Accepting New Patients - Goal (85%)	**97%**	**97%**	**97%**	**98%**	**96%**	**94%**	**94%**
	% Of Specialists Accepting New Patients - Goal (85%)	**97%**	**98%**	**98%**	**98%**	**98%**	**97%**	**98%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**96%**	**96%**	**97%**	**96%**	**93%**	**96%**	**97%**
	Year	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**
	Month	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
	Providers Interactions by Provider Relations	**472**	**432**	**328**	**584**	**628**	**498**	**638**
	Reported Issues Handled by Provider Relations	**10**	**7**	**10**	**12**	**7**	**9**	**4**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**13**	**86**	**28**	**71**	**64**	**93**	**39**
	Interventions Deployed for PCP Quality Performance Improvement	**13**	**86**	**28**	**71**	**64**	**93**	**39**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network. Updated data was received from the Provider Relations/Provider Engagement team. Numbers were updated from the 9/19/24 Commission Meeting for Feb 2024 - Aug 2024.							

Claims Processing	**Year**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	95% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	94% / 95% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / NA NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 99% NO	100% / 100% NO	87% / 100% NO	76% / 100% NO	1% / 93% NO	
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	90% / 94% YES	82% / 91% YES	91% / 97% NO	95% / 98% NO	99% / 99% NO	94% / 97% YES	88% / 99% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 100% YES	90% / 100% YES	83% / 98% YES	68% / 92% NO	47% / 89% YES	79% / 93% YES	99% / 100% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 99% NO	100% / 100% NO	99% / 100% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99%/100% NO	99%/100% NO	99% / 100% NO	100% / 100% YES	99% / 100% YES	98% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	64% / 100% NO	95% / 100% NO	79% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure					100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q2 2024 numbers are available. Management is working with PPG 2 and PPG 8 on improving performance. Reporting has ended for PPG 1. They are no longer a part of the CalViva network. All other areas met performance/goal.							

Provider Disputes	**Year**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	96%	98%	99%	99%	99%	98%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	78%	98%	89%	
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	84%	11%	31%	81%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	85%	71%	40%	66%	65%	70%	93%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	99%	41%	55%	90%	97%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	100%	43%	65%	85%	98%	97%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	47%	63%	97%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	N/A	100%	67%	95%	100%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	99%	99%	100%	97%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)					N/A	100%	100%
Message from the CEO	Q2 2024 numbers are available. Management is working with PPG 3 on improving performance. Reporting is ending for PPG 1. They are no longer a part of the CalViva network. All other areas met performance/goal.							