# Fresno-Kings-Madera Regional Health Authority

# CalViva Health Commission Meeting Minutes January 16, 2025

#### **Meeting Location:**

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

	Commission Members	yeby i i	
✓	Sara Bosse, Director, Madera Co. Dept. of Public Health	<b>V</b>	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	<b>V</b>	Joe Neves, Vice Chair, Kings County Board of Supervisors
	Joyce Fields-Keene, Fresno County At-large Appointee	1	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	<b>V</b>	Rose Mary Rahn, Director, Kings County Dept. of Public Health
<b>√</b> *	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	<b>√</b>	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)	<b>V</b>	Sia Xiong-Lopez, Equity Officer
✓	Mary Lourdes Leone, Chief Compliance Officer		
1918 <sup>4</sup> , 2010	General Counsel and Consultants		
<b>√</b> *	Jason Epperson, General Counsel		
√= C	ommissioners, Staff, General Counsel Present		
* = C	ommissioners arrived late/or left early	e ugoq.	
• = A	tended 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 1:32 pm. A quorum was present.		_
#2 Roll Call	A roll call was taken for the current Commission Members.		A roll call was taken.

## **Commission Meeting Minutes**

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Cheryl Hurley, Clerk to the Commission	Supervisor Quintero was presented with a plaque and thanked for his service on the FKM RHA Commission from 2017 – 2024. Supervisor Quintero departed the meeting after this presentation, as his service to the Commission ended January 7, 2025.		
#3 Consent Agenda • Commission Minutes dated	All consent items were presented and accepted as read.		Motion: Consent Agenda was approved.
10/17/24. • Finance Committee Minutes dated 9/19/24.			11-0-0-5
<ul> <li>QI/UM Committee Minutes dated 9/19/24.</li> </ul>			(Rogers / Frye)
Public Policy Committee     Minutes dated 9/4/24.			A roll call was taken
Action J. Neves, Vice-Chair	Dr. Hodge arrived at 1:49 pm during Closed Session; not included in vote		
#4 Closed Session	Jason Epperson, General Counsel, reported out of closed session. The Commission met in closed session to discuss items agendized specifically item 4A Conference with Legal Counsel - Existing Litigation, pursuant to Government Code section 54596.9. Fresno County Superior Court Case No. 24CECG02996; item 4B Conference Report Involving Trade Secrets; and item 4C Conference Report Involving Trade Secrets. The Commission discussed those items, and direction was given to staff. There were no other reportable actions, and they recessed from Closed Session at 2:09 pm.		
#5 Draft CY 2025 Rates	The draft CY 2025 rates were received late October 2024. After reviewing and analyzing those rates, it appeared those rates are lower than what the plan		No Motion
Information D. Maychen, CFO	believes to be sufficient. There are numerous factors contributing to those findings. In developing the 2025 draft rates, DHCS used utilization claims data from FY 2023. The problem with that is recently the Plan has seen a substantial increase in utilization in the 2024 utilization data. Specifically related to the Community Supports services that came into effect as part of the CalAIM initiative in 2022. When this program rolled out in 2022, utilization was relatively low, as a		

high number of members were not yet aware of these new services, but as promotion of these new services increased over the past two years, utilization has substantially increased. Based off the draft 2025 rate calculations, DHCS will be funding approximately 6% of the cost of the Community Supports services for CY 2025. The Plan requested DHCS review more current utilization data from 2024 to develop the 2025 rates. In addition, when DHCS drafts the rates, they perform a population acuity adjustment to see how severely ill the membership is. DHCS did increase it from the 2024 rates; however, what the Plan has seen in recent claims data is an increase in acuity. The Plan believes that one of the contributing factors are the transitioning population of undocumented immigrants ages 26-49 that began receiving Medi-Cal benefits in January 2024, and also pent-up demand from COVID-19 for medical services which is why Plans are asking DHCS to look at more recent utilization data when applying the acuity adjustment. Plans asked DHCS for transparency in what their rate assumptions are and how many they believe are	QUESTION(S) / COMMENT(S)	
LTC members in that combined rate. Previously, when DHCS made substantial changes to rates, Plans were given forewarning and allowed feedback; in this current case, DHCS made the change without giving Plans the option to provide feedback. CVH provided a comment letter to DHCS voicing concerns; within that letter it was stated that if the concerns are not addressed, the Plan would potentially file a Notice of Dispute which is legal action challenging the rate DHCS has published.  Plan CEOs and Plan CFOs met with DHCS leadership to communicate concerns, and around late December, DHCS revised the CY 2025 rates, noting that DHCS did increase the rates and used more recent claims and utilization data. At this point upon reviewing those revised CY 2025 rates, the Plan does not believe a Notice of		
Dispute will be filed. It appears the rates are more in line with current utilization and projected utilization and medical costs.		
Dr. Marabella presented the new Quarterly CAHPS Root Cause Analysis Report.		Motion: Approve Quarterly CAHPS Root Cause Analysis
physical health at least annually, evaluate member satisfaction for behavioral health at least annually, and aggregate all complaints and appeals into the following required categories:		Report  12 - 0 - 0 - 4  (Neves / Naz)
	LTC members in that combined rate. Previously, when DHCS made substantial changes to rates, Plans were given forewarning and allowed feedback; in this current case, DHCS made the change without giving Plans the option to provide feedback. CVH provided a comment letter to DHCS voicing concerns; within that letter it was stated that if the concerns are not addressed, the Plan would potentially file a Notice of Dispute which is legal action challenging the rate DHCS has published.  Plan CEOs and Plan CFOs met with DHCS leadership to communicate concerns, and around late December, DHCS revised the CY 2025 rates, noting that DHCS did increase the rates and used more recent claims and utilization data. At this point upon reviewing those revised CY 2025 rates, the Plan does not believe a Notice of Dispute will be filed. It appears the rates are more in line with current utilization and projected utilization and medical costs.  Dr. Marabella presented the new Quarterly CAHPS Root Cause Analysis Report.  NCQA accreditation requires that health plans evaluate member satisfaction for physical health at least annually, evaluate member satisfaction for behavioral health at least annually, and aggregate all complaints and appeals into the	LTC members in that combined rate. Previously, when DHCS made substantial changes to rates, Plans were given forewarning and allowed feedback; in this current case, DHCS made the change without giving Plans the option to provide feedback. CVH provided a comment letter to DHCS voicing concerns; within that letter it was stated that if the concerns are not addressed, the Plan would potentially file a Notice of Dispute which is legal action challenging the rate DHCS has published.  Plan CEOs and Plan CFOs met with DHCS leadership to communicate concerns, and around late December, DHCS revised the CY 2025 rates, noting that DHCS did increase the rates and used more recent claims and utilization data. At this point upon reviewing those revised CY 2025 rates, the Plan does not believe a Notice of Dispute will be filed. It appears the rates are more in line with current utilization and projected utilization and medical costs.  Dr. Marabella presented the new Quarterly CAHPS Root Cause Analysis Report.  NCQA accreditation requires that health plans evaluate member satisfaction for physical health at least annually, evaluate member satisfaction for behavioral health at least annually, and aggregate all complaints and appeals into the following required categories:

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	<ul> <li>Access</li> <li>Attitude and Service</li> <li>Billing and Financial Issues</li> <li>Quality of Practitioner Office Site</li> </ul>		A roll call was taken.
	Data is captured through member surveys (CAHPS & ECHO Surveys) annually and analyzed to identify opportunities for improvement, set priorities and decide which opportunities to pursue in the coming year. Once priority areas are identified, then the Plan will implement actions to improve member satisfaction and address the priority issues identified. On a quarterly basis throughout the year, monitoring is performed using Member Complaint and Appeal data categorized in a similar fashion. This allows the Plan to evaluate the success of actions taken in an ongoing manner and identify early any new trends. At the end of the year an evaluation is performed using the same data sources identified above to assess the effectiveness of the actions taken and modify the plan accordingly for future improvements (prior survey results are compared to the new survey results.		
-	<ul> <li>The quarterly monitoring process is:</li> <li>CAHPS Team conducts root cause analysis (RCA) to highlight member pain points.</li> <li>Analysis is based on resolved cases.</li> <li>Conducted on a quarterly basis.</li> <li>To better understand CAHPS results, rate movement, and identify any new areas for improvement.</li> <li>Grievance definition used:</li> <li>An expression of dissatisfaction with any aspect of the operations, activities, or behavior of one's health plan, or its providers, regardless of whether remedial action is requested.</li> <li>Appeal definition used:</li> <li>A request for your health plan to review a decision that denies a benefit or payment.</li> <li>All of the Appeals and Grievances (A&amp;G) data comes from the A&amp;G Ops team.</li> </ul>		

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	<ul> <li>Year-over-Year comparison for Q3 Appeals &amp; Grievances volume by County (2023 to 2024):</li> <li>There was an increase in the appeals volume in Q3 2024 for Fresno (45.6%), Kings (100%), and Madera (200%) counties, which resulted in a higher PTMPY rate compared to 2023 Q3.</li> <li>There was an increase in the volume of grievances (12.2%) in Fresno County. Kings and Madera counties showed a decrease of 28.3% and 36.9% respectively compared to 2023 Q3.</li> </ul>		
	<ul> <li>2024 Q1 – Q3 Trends for Appeals &amp; Grievances volume comparison by County:</li> <li>Appeals showed an increase in volume of 29.2% in Fresno County, 20% in Kings County, and a decrease of 21% in Madera County compared to Q2.</li> <li>Overall, grievance volume for Q3 showed a slight decrease compared to Q2 in Fresno (1.64%) and Madera (28%) counties. Kings County stayed the same as Q2.</li> </ul>		·
	<ul> <li>Year over Year comparison for Q3 Top Appeal &amp; Grievance trends by Classification Codes (2023 to 2024):</li> <li>In 2024 Q3, there was a 60.2% increase in appeals for Not Medically Necessary classification code compared to 2023 Q3.</li> <li>For grievances, there was a decrease in 3 of the top 5 grievances: 5.4% in Access to Care, 30.1% Balanced Billing, and 22% Quality of Care – PCP compared to 2023 Q3.</li> <li>Administrative Issues and transportation grievances had an increase of 85% and 17.2% respectively compared to last year, same quarter.</li> </ul>	Commissioner De Le Torre asked what the overturn rate is on Appeals?  Dr. Marabella stated the overturn rate has been higher than desired as most of the Appeals have	
	<ul> <li>Quarter over Quarter 2024 Top Appeal &amp; Grievance trends by Classification Codes:</li> <li>In 2024 Q3, there was a 19.8% increase in appeals for Not Medically Necessary classification code compared to 2024 Q2.</li> <li>For grievances, an increase was noted in 3 of the top 5 grievances in volume, 11.4% in Access to Care, 2.7% Administrative Issues, 36% Transportation compared to 2024 Q1.</li> <li>There was a decrease of 34.8% in Balance Billing and 6.1% in Quality of Care - PCP grievances in 2024 Q3 compared to 2024 Q2.</li> </ul>	to do with Advanced Imaging and the problem with Imaging is incorrect or insufficient information being submitted by the requesting provider. Once correct information is submitted it's overturned.	

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	<ul> <li>Trending Appeals by Category:         <ul> <li>In 2024 Q3, appeals appear steady compared to last year, same time, in two out of the four categories. Diagnostic –CAT Scan had an increase of 166.6% compared to 2023 Q3.</li> </ul> </li> <li>As for 2024 Q2 &amp; Q3 appeals, there was an increase of 42.1% in the category of Diagnostic – MRI. Other – Self Injectable Medication and Outpatient – Procedure appeals returned after skipping 2024 Q2 (0 cases) with an increase of 180% and 175% compared to 2024 Q1.</li> </ul> <li>Trending Grievances by Category:         <ul> <li>Most of the trending grievances had a decrease in 2024 Q3 compared to 2023 Q3.</li> <li>Prior Authorization Delay (13.7%), Transportation Missed Appointment (70.2%), and Inappropriate Payment Demand (participating providers) (30.6%) had a decrease in volume compared to 2023 Q3.</li> <li>The trending grievances that had a noted increase are PCP Referral for Services of 200% and Health Plan of 420% compared to 2023 Q3.</li> <li>Prior Authorization Delay and Inappropriate Payment Demand (participating providers) volume showed an improvement of 15.3%, Referral Process of 57.1%, and Inappropriate Payment Demand (participating providers) of 27.1% in Q3 compared to Q2.</li> <li>There was an increase in grievance volume in PCP Referral for Services of 114.2% and Delay in Referral by PCP of 116.6% from previous quarter.</li> </ul> </li>		
	<ul> <li>Actions and next steps include:         <ul> <li>Live and recorded Provider Training Webinars started in July 2024 to address Prior Authorizations and e-consults.</li> <li>Best Practices Tip Sheet was released in September 2024 with guidelines developed for Prior Authorizations on how to avoid processing delays and improve member satisfaction.</li> </ul> </li> <li>Corrective Action Plans (CAPs) for PPGs with low scores in the PAAS and PAHAS surveys to improve timeliness of appointments with PCPs and Specialists.</li> </ul>		

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	<ul> <li>Isolated appeals cases had discussion with Plan leadership on issues and opportunities to improve members' experience with PPG leaders.</li> <li>Future activities include analyzing CAHPS results and A&amp;G quarterly data at the CalViva A &amp; G Work Group to identify priority opportunities and establish interventions to address identified issues and improve member satisfaction.</li> </ul>		
#7 Standing Reports	Finance Financials as of September 30, 2024		Motion: Standing Reports Approved
Finance Reports	Titialiciais as of September 30, 2024		10-0-0-6
Daniel Maychen, CFO	As of September 30, 2024, total current assets recorded were approximately \$494.8M; total current liabilities were approximately \$338.4M. Current ratio is approximately 1.46. Total net equity as of the end of September 2024 was approximately \$166.2M, which is approximately 643% above the minimum DMHC required TNE amount.		(Frye / Neves)  A roll call was taken.
	As of the end of September interest income actual recorded was approximately \$2.9M, which is approximately \$1.6M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately \$502.9M which is approximately \$41M more than budgeted due to enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately \$342.2M which is approximately \$39.9M more than budgeted due to enrollment being higher than projected.		David Luchini left meeting at 3:06 pm, not included in vote.  Dr. Naz left meeting at 3:09 pm, not included in vote.
	License expense actual recorded was approximately \$373K which is approximately \$16K more than budgeted due to DMHC's license fee assessment rate being higher than projected. Recruitment expense was approximately -\$549 due to a timing issue and a credit back from a job posting.		
	Total net income for the first three months of FY 2025 actual recorded was approximately \$4.5M, which is approximately \$2.8M more than budgeted primarily due to interest income being approximately \$1.6M higher than projected and enrollment being higher than projected.		

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TO CONTROL OF CONTROL	Compliance Report		
Compliance     M.L. Leone, CCO	Year to date there have been 357 Administrative & Operational regulatory filings for 2024; 46 Member Materials filed for approval; 149 Provider Materials reviewed and distributed, and 119 DMHC filings.		
	There have been 33 potential Privacy & Security breach cases reported year to date, with three (3) being high risk.		
	Since the 10/17/2024 Compliance Regulatory Report to the Commission, there were seven (7) new MC609 cases filed, with a year to date total of 24. There are 29 cases that remain open and under investigation.		
	<ul> <li>The 7 new cases encompassed:</li> <li>3 of the cases involved hospice care providers who had duplicate and overlapping hospice services.</li> <li>1 case involved a participating provider for excessive billing and upcoding.</li> <li>1 case involved a participating provider for unnecessary drug testing and illegal remuneration.</li> <li>1 case involved a non-participating provider receiving payment for services outside of their current active CLIA.</li> <li>1 case of a provider with possible services not rendered or was a possible "phantom" provider.</li> </ul>		
	The Annual Oversight Audits currently in progress since last reported include UMCM, Access & Availability, and Call Center. Audits completed were ER (CAP required), Privacy & Security (CAP required), Provider Network (CAP required), Claims (CAP required), Health Education (no CAP), Continuity of Care (no CAP), Fraud, Wate & Abuse (no CAP), and Pharmacy (no CAP).		
	Regarding the 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 (4 for behavioral health and 5 for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is		

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	required to submit monthly updates on all CAP activities. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 1/10/25.		
	Regarding the DHCS 2024 Medical Audit, on 10/3/2024, DHCS sent out the 2024 Audit Report and CAP request. There were two deficiencies. The Plan has since submitted updates on 11/1/24 and 12/1/24. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 2/1/25.		
	Regarding the DMHC 2025 Medical Follow-Up Audit, on 1/6/25, the Plan received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. All requested documents must be submitted by 2/5/25.		
	Regarding the 2023 Annual Network Certification, on 11/15/24, the Plan received DHCS written notice that the Plan was deemed compliant and had passed the 2023 ANC with no deficiencies.		
	Regarding the 2023 Subnetwork Certification, on 12/10/24, the Plan received written notice that all deficiencies had been corrected and closed the 2023 SNC.		
	Regarding the 2024 Subnetwork Certification Landscape Analysis, on 9/25/2024, the Plan received the 2024 SNC preliminary request for the Landscape Analysis and submitted a response on 10/25/2024. On 1/3/2025, the Plan submitted the 2024 SNC deliverable certifying subnetwork compliance with network adequacy and access standards.		
	With regard to Population Health Management, MCPs are required to submit the PHM Strategy Deliverable to DHCS annually. The purpose of the annual PHM Strategy Deliverable is for MCPs to demonstrate their engagement in local health jurisdictions' (LHJs) community health assessments (CHAs) and community health improvement plans (CHIPs) and provide other updates on the MCP's		

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CONT. AT THE COMMENT OF T	implementation of the PHM Program to inform DHCS' monitoring efforts. CalViva is required to submit its PHM Strategy deliverable by 11/22/24.		
	With regard to the Non-Discrimination Notice, the Plan has posted to the CalViva website its revised Non-Discrimination Notice (NDN). The revisions were made to be compliant with the Office for Civil Rights (OCR) Final Rule under section 1557 of the Affordable Care Act (ACA) as published in the Federal Register on May 6, 2024. The NDN was required to be updated anywhere it is used no later than November 2, 2024. The Plan has posted the revised notice on its website and in the lobby of its administrative office.		
	With regard to the Notice of Privacy Practices, The Plan has revised its NOPP to include additional language specific to how a member's race, ethnicity, language, sexual orientation, and gender identity will be protected, and additional language on how the Plan processes a member request Confidential Communications. This has been included in the Plan's DHCS/DMHC-approved 2025 Member Handbook and will be posted to the Plan's website.		
	Since the last update to the Commission, the Plan has executed two additional MOUs with Kings County: The Kings County Department of Behavioral Health DMC MOU, and the Kings County Department of Public Health WIC MOU.	-	
	The Public Policy Committee met on December 4, 2024. The following reports were presented:  2024 Work Plan Mid-Year Evaluation  2024 Executive Summary and Work Plan Mid-Year Evaluation		
	<ul> <li>2024 Summary and Language Assistance Program Mid-Year Report</li> <li>MY 2023 Quality Improvement &amp; HEDIS Update</li> <li>Q3 2024 Appeal and Grievance Report</li> <li>A&amp;G Dashboard review by Dr. Marabella</li> </ul>		
	Additionally, the PPC was given a presentation on Social Determinants of Health and asked to provide feedback on the Plan's goals for mitigating social risks. A review of the online portal "Community Connect" powered by Findhelp was given to demonstrate how members' social needs are assessed, and also how members		

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	and providers can utilize Community Connect to refer members to various social service resources and programs. The next PPC meeting will be held on March 5, 32025, 11:30am-1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.		
Medical Management	Medical Management		
P. Marabella, MD, CMO	Appeals and Grievances Dashboard		
	Dr. Marabella presented the Appeals & Grievances Dashboard through Q3 2024.		
	<ul> <li>The total number of grievances through Q3 2024 remains high when compared to previous YTD. The Quality-of-Service category represents the highest volume of total grievances.</li> <li>For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Access-Other, Administrative, and Interpersonal. Balanced Billing continues to be an issue and is being addressed. Transportation Access has improved.</li> <li>The volume of Quality of Care (QOC) cases remains consistent when compared to previous YTD.</li> <li>The volume of Exempt Grievances remains consistent when compared to previous YTD.</li> <li>Total Appeals volume has significantly increased when compared to previous YTD. The majority being Consultation, DME, Advanced Imaging, and Other (SNF-Long Term Care related). Uphold and overturn rates remain consistent.</li> </ul>		
	Key Indicator Report		
	Dr. Marabella presented the Key Indicator Report (KIR) through Q3 2024.		
	A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through Q3 2024.		

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	<ul> <li>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:         <ul> <li>For Bed Days (adjusted PTMPY), there is a steady decline compared to previous year.</li> <li>Acute Length of Stay (adjusted PTMPY) also shows a decline.</li> </ul> </li> <li>Readmission rates have declined with the assistance of Case Management.</li> </ul>		
	Case Management (CM) engagement rates are up, and all areas continue to improve.		
	QIUM Quarterly Summary Report		
	Dr. Marabella provided the QI, UMCM, and Population Health update for Q4 2024. Two meetings were held in Quarter 4, one on October 17 <sup>th</sup> , 2024, and one on November 21 <sup>st</sup> , 2024.		
	The following program documents were approved: 1. 2024 Health Equity Work Plan Mid-Year Evaluation & Executive Summary 2. 2024 Health Equity Language Assistance Program Mid-Year Report 3. Quality Improvement Health Equity Transformation Program 2024		
	In addition, the following general documents were adopted/approved at the meetings:  1. Medical Policies Update		
	<ol> <li>Pharmacy Provider Updates</li> <li>Public Health Policies &amp; Procedures Annual Review</li> <li>Utilization Management &amp; Care Management Policies and Procedures Annual Review</li> </ol>		
	5. 2024 Preventive Health Guidelines for Members		
	The following Oversight Audit Results were presented and accepted at the October meeting:  1. 2024 Appeals and Grievances Oversight Audit		
	1. 2024 Appeals and Grievances Oversight Addit		

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	The following Quality Improvement Reports were reviewed: Appeals and Grievance Dashboard & Quarterly Reports for Q3 2024; Behavioral Health Performance Indicator Report; and Facility site & Medical Record & PARS Review Report. Additional Quality Improvement reports from Q2 & Q3 were reviewed as scheduled during Q4.		
	The following Access Reports were reviewed: Provider Appointment Availability (PAAS) & After-Hours Access Survey (PAHAS) Results, Access Workgroup Quarterly Reports for Q4, and the Access Work Group minutes from July 30th, 2024. Other Access-related reporting included the Standing Referrals Report, Provider Office Wait Time, and Specialty Referrals Report.		
	The Utilization Management & Case Management reports reviewed were the Key Indicator Report & UM Concurrent Review Report. Additional UMCM reports were reviewed as scheduled during Q4.		
	Pharmacy quarterly reports reviewed were Pharmacy Executive Summary, Operation Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR).		
	The Q4 HEDIS® 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 and initiating or enhancing activities to address opportunities for improvement.		
	Quality Improvement Activities included two Performance Improvement Projects, the Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative, the Lean Equity Improvement Projects, and the Comprehensive Improvement Project.		
	No significant compliance issues have been identified. Oversight and monitoring processes will continue.		
	Credentialing Sub-Committee Quarterly Report		

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	The Credentialing Sub-Committee met on October 17, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. The 2025 Credentialing Sub-Committee meeting dates were presented and approved. Reports covering the second quarter for 2024 were reviewed for delegated entities and third quarter 2024 for Health Net including Behavioral Health.		
	The 2024 Adverse Events report for Q3 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. There was one (1) case identified in Q3 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no reconsiderations or fair hearings during the third quarter of 2024. There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of appointment availability. There were no (0) cases identified outside of the ongoing monitoring process this quarter.		
	The Access & Availability Substantial Harm Report Q3 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 third quarter 2024 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).		
	Credentialing Adverse Actions for Q3 for CalViva Credentialing Sub-Committee from Health Net Credentialing Committee was presented. There were two (2) cases presented for discussion for July, August, and September for CalViva Health. One (1) case was placed on pending status awaiting the Medical Board of California's decision and one (1) case was placed on annual monitoring for compliance with the Medical Board of California's orders.		
	Ongoing monitoring and reporting will continue.		

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	Peer Review Sub-Committee Quarterly Report		
	The Peer Review Sub-Committee met on October 17th, 2024. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2024 were reviewed for approval. There were no significant cases to report. The 2025 Peer Review Sub-Committee meeting dates were presented and approved.		
	The 2024 Adverse Events Report for Q3 was reviewed. This report provides a summary of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CalViva CMO requests to be forwarded to the Peer Review Committee. There were nine (9) cases identified in Q3 that met the criteria for reporting and were submitted to the Peer Review Committee. Six (6) of these cases involved a practitioner and three (3) cases involved organizational providers (facilities). Of the nine (9) cases, three (3) were tabled, one (1) was deferred, one (1) was closed to track and trend with a letter of concern, and four (4) were closed to track and trend. Five (5) cases involved Seniors and Persons with Disabilities (SPDs), and none (0) involved Behavioral Health. There were no (0) incidents involving appointment availability resulting in substantial harm to a member or members in Q3. There were no (0) cases that met the Peer Review trended criteria for escalation. There were no (0) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) There were thirty-four (34) 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 Q3 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	severity level. Eighteen (18) cases were submitted to the Peer Review Committee in Q3 2024. There was one (1) incident found involving appointment availability issues without significant harm to a member. Two (2) cases were determined to be related to significant harm to a member but 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 Q3 2024.		
	Quarter 3, 2024 Peer Count Report was presented at the meeting with a total of eighteen (18) cases reviewed. There were eleven (11) cases closed and cleared. There were three (3) cases tabled for further information. Two (2) cases were pending closure for CAP compliance and one (1) case was deferred. One (1) case with CAP outstanding/continued monitoring. There were no (0) cases closed/terminated.		
	Follow up will be initiated to obtain additional information for tabled cases and ongoing monitoring and reporting will continue.		
	Executive Report		
Executive Report	Executive Dashboard		
J. Nkansah, CEO	Enrollment as of September 2024 is 435,615.		
	Kaiser enrollment as of November is approximately 9,000 and is approaching what their membership was at the time CVH had a relationship with them in 2017.		
	In 2025, Kaiser will accept Auto Assignment activity up to 5,900 members; however, Kaiser will not take on auto assignments in Fresno, Kings, or Madera counties.		
	Regarding Information Technology Communications & Systems, the average age of workstations is decreasing as older workstations are being updated. The cybersecurity assessment is in progress with the final report to follow.		

## **Commission Meeting Minutes**

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding the Call Center and CVH Website, efforts remain ongoing to allow Members a self-service option to gain access to their Member ID Card through the CalViva Health Website. Scheduled implementation by Q1 2025.		
	Regarding Provider Activities, Claims Processing, and Provider Disputes, there are no significant issues or concerns.		
#8 Final Comments from Commission Members and Staff	None.	****	
#9 Announcements	None.		
#10 Public Comment	None.		
#11 Adjourn	The meeting adjourned at 3:10 pm. The next Commission meeting is scheduled for February 20, 2025, in Fresno County.		

Submitted this Day: 2.20.25
Submitted by: Mery Hurley

Clerk to the Commission