FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

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

Phone: 559-540-7840
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www.calvivahealth.org

DATE: July 17, 2023

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, July 20, 2023
1:30 pm to 3:30 pm

Where to attend:

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

Meeting materials have been emailed to you.

Currently, there are **10** 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
July 20, 2023
1:30pm - 3:30pm
Meeting Location(s): **1)** CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

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	**Fresno County At-Large BOS Reappointment** • Joyce Fields-Keene *Action: Ratify reappointment*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D Attachment 4.E Attachment 4.F Attachment 4.G Attachment 4.H Attachment 4.I	**Consent Agenda:** • Commission Minutes dated 5/18/2023 • Finance Committee Minutes dated 3/16/2023 • QI/UM Committee Minutes dated 3/16/2023 • Public Policy Committee Minutes dated 3/1/2023 • Finance Committee Charter • Credentialing Committee Charter • Peer Review Committee Charter • Quality Improvement / Utilization Management Committee Charter • Public Policy Charter *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	
	Information	**A. Conference with Legal Counsel-Existing Litigation** Name of Case: Case #21CV381776	
	Information	B. **Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Equity Officer Per Government Code Section 54957(b)(1)	

	Action	**C. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Executive Officer Per Government Code Section 54957(b)(1)	
6 Information	Attachment 6.A	**Review of Fiscal Year End 2023 Goals** • BL 23-006 Review of Fiscal Year End Goals 2023	J. Nkansah, CEO
7 Action	Attachment 7.A	**Goals and Objectives for Fiscal Year 2024** • BL 23-007 Goals and Objectives FY 2024 *Action: Approve Goals for FY 2024*	J. Nkansah, CEO
8 Information	Attachment 8.A	**Quality Improvement** • HEDIS® MY 2022	P. Marabella, MD, CMO
9 Information	Attachment 9.A	**Case Management** • 2022 Program Evaluation & Executive Summary	P. Marabella, MD, CMO
10 Action		**Standing Reports**	
	Attachment 10.A	**Finance Report** • Financials as of May 31, 2023	D. Maychen, CFO
	Attachment 10.B	**Compliance** • Compliance Report	M.L. Leone, CCO
	Attachment 10.C Attachment 10.D Attachment 10.E Attachment 10.F Attachment 10.G	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Quarterly Summary Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment 10.H	**Executive Report** • Executive Dashboard *Action: Accept Standing Reports*	J. Nkansah, CEO
11		**Final Comments from Commission Members and Staff**	
12		**Announcements**	
13		**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.	
14	**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 September 21, 2023 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

Fresno County At-large Commission
Seat Application

County of Fresno

BOARD OF SUPERVISORS

Chairman	Vice Chairman				
Sal Quintero	**Nathan Magsig**	**Brian Pacheco**	**Steve Brandau**	**Buddy Mendes**	**Bernice E. Seidel**
District Three	District Five	District One	District Two	District Four	Clerk

May 23, 2023

Joyce Fields-Keene
Central California Faculty Medical Group
2625 E. Divisadero Street
Fresno, CA 93721

Subject: Appointment to Fresno-Kings-Madera Regional Health Authority

Dear Ms. Fields-Keene,

We are pleased to inform you that on May 23, 2023, under Chairman Quintero's nomination, you were reappointed by the Board of Supervisors to serve on the **Fresno-Kings-Madera Regional Health Authority** (hereinafter referred to as "authority") for a term expiring on **May 4, 2026**. We thank you for your interest in serving our County.

Statement of Economic Interests (Form 700): You are required to file a Form 700 for your appointed position. Please contact Cheryl Hurley with the authority at (559) 540-7842 for the Form 700, instructions, and where to file the form.

Brown Act Requirements

Newly elected and appointed members of a "legislative body" who have not yet assumed office must conform to the requirements of the Brown Act as if already in office (Govt. Code section 54952.1). Until you hear otherwise, you should immediately begin to refrain from any discussions of authority business, with a quorum of the authority, outside a formal authority meeting. If you have any questions about the Brown Act or your responsibilities and duties under it, please consult your authority's legal counsel.

Fresno County Ordinance Code Section 2.68

Please be aware that Fresno County has an attendance policy for those who are appointed to Boards, Commissions and Committees. You may obtain a copy of this policy from the secretary of the authority, by contacting our office or on our website at https://www.co.fresno.ca.us/departments/clerk-of-the-board-of-supervisors.

State Mandated Ethics Training

California Government Code Section 53235 provides that if a local agency (which includes special districts) provides any type of compensation, salary, or stipend to a member of a legislative body, or provides for reimbursement for actual and necessary expenses incurred by a member of a legislative body in the performance of official duties, then all local agency officials shall receive training in ethics. Such

local agency officials must receive **two hours** of ethics training within one year of commencing service with the local agency and once every two years thereafter. Please consult your authority's staff or legal counsel with questions relating to this requirement.

Should you be required to comply with the ethics training requirement, the Fair Political Practices Commission (FPPC) offers **free online training** at http://localethics.fppc.ca.gov/login.aspx. This course requires that you log onto the FPPC's website, review the course content materials, and take periodic tests to assure retention of the information. For those who choose this option, please be aware that the certificate will record how much time an individual spends to complete the online training. You must complete **at least 2 hours** of training time in order to be compliant with the training requirement. If an individual completes the online training in less than two hours, the certificate will reflect this, indicating that the individual has not completed the required amount of training.

When you complete the training, you will receive a Proof of Participation certificate to sign and submit to whoever maintains the training compliance records for your authority (e.g., the clerk or secretary for the authority). You should keep a copy of the certificate for your records. The authority is required to retain the certificates as public records for at least five years.

On behalf of the Fresno County Board of Supervisors, we wish to extend sincere appreciation for the time and effort you are giving in service to your community and Fresno County.

Sincerely,

Bernice E. Seidel
Clerk of the Board

cc: **Fresno-Kings-Madera Regional Health Authority**

Item #4

Attachment 4.A

Commission Minutes
Dated 5/18/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
May 18, 2023

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	✓	**Michael Goldring**, Valley Children's Hospital Appointee
			Paulo Soares, Commission At-large Appointee, Madera County
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Mary Lourdes Leone**, Chief Compliance Officer
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Amy Schneider**, R.N., Director of Medical Management
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Cheryl Hurley**, Commission Clerk
	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 1:30 pm. A quorum was present.		
#2 Roll Call Cheryl Hurley, Clerk to the Commission	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
#3 Kings County At-Large Commission Seat Appointment Action J. Neves, Co-Chair	The Commission ratified the appointment of Lisa Lewis, Ph.D. for the Kings County BOS appointed At-Large Commission seat.		***Motion**: Ratified appointment of Kings County BOS appointed At-Large seat* *11 – 0 – 0 – 6* *(Rogers / Naz)* *A roll call was taken*
#4 Chair and Co-Chair Nominations for FY 2024 Action J. Neves, Co-Chair	The Commissioners nominated and subsequently re-elected David Hodge, MD as chair and Supervisor Joe Neves as Co-Chair to serve during Fiscal Year 2024.		***Motion**:* *Nominate and Approve Chair:* *11 – 0 – 0 – 6* *(Rogers / Naz)* *Nominate and Approve Co-Chair:* *10 – 0 – 1 – 6* *(Rogers / Naz)* *A roll call was taken*
#5 Consent Agenda • *Commission Minutes dated 3/16/23* • *Finance Committee Minutes dated 2/16/23* • *QI/UM Committee Minutes dated 2/23/23* • *Compliance Report* Action J. Neves, Co-Chair	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *11 – 0 – 0 – 6* *(Rahn / Cardona)* *A roll call was taken*
#6 Closed Session	Jason Epperson, General Counsel, reported out of closed session. The Commission discussed in closed session the items agendized for closed session		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
1) Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility. **2) Government Code section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation.**	discussion as previously read into the record. Items were discussed, direction was given to staff. In addition, a motion was made by Supervisor Rogers, and seconded by Ms. Fields-Keene to adopt as organization-wide holidays Veterans Day and Martin Luther King Day effective calendar year 2024 and moving forward. The motion was adopted unanimously 11-0-0-6. No other reportable action was taken. Closed Session concluded at 1:51 pm.		
#7 CEO Annual Review Ad-Hoc Committee Selection Action J. Neves, Co-Chair	Commission members selected for the CEO Annual Review ad-hoc committee are Dr. Hodge, Dr. Naz, Mr. John Frye.		***Action:*** *Committee members were selected.*
#8 Sub-Committee Members for FY 2024 Information J. Neves, Co-Chair	No changes in Commission members were made for FY 2024 to the following committees, as described in BL 23-004: • Finance Committee • Quality Improvement/Utilization Management Committee • Credentialing Sub-Committee • Peer Review Sub-Committee • Public Policy Committee	*Dr. Naz requested email for information on committees.*	
#9 Community Support Funding Action J. Nkansah, CEO	The Community Support Grant Recommendations were presented to the Commission with funding at $3,925,000 for 2023-2024 fiscal year. The ad-hoc committee reviewed the funding recommendations on March 21, 2023, and voted to move to full Commission for approval.	*Commissioner Bosse raised a question on the CBO list for the two organizations that were selected from Madera, and how the money was distributed*	***Motion****: Approve Community Funding Grant Recommendations* *11 – 0 – 0 – 6* *(Rogers / Quintero)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		between the three counties. The Plan reached out to all previously funded CBOs and asked that they submit an evaluation report. One of the organizations in Madera did not submit their follow-up report to initiate next steps for further grant funding. There are opportunities through sponsorship as well.	
#10 Health Equity Program Description and Work Plan Evaluation • 2022 Executive Summary and Annual Evaluation • 2023 Change Summary and Program Description • 2023 Executive Summary and Work Plan Summary Action P. Marabella, MD, CMO	Dr. Marabella presented the Health Equity 2022 Executive Summary and Annual Evaluation; 2023 Change Summary and Program Description; and 2023 Executive Summary and Work Plan. The Work Plan activities were completed in the following areas: • Language Assistance Services: 78 staff completed Bilingual assessment/re-assessment; Population Needs Assessment was completed with Quality Improvement (QI) and Health Education (HE); and participation in information technology projects to assist vendor record member gender identity, and preferred pronouns and names. • Compliance Monitoring: Investigated and completed follow up on 53 grievances in 2022 with six (6) interventions; and updated all Health Equity Policies. • Communication, Training and Education: Conducted seven (7) Call Center Training sessions; and 107 providers attended implicit bias training: Strengthening Cultural Humility, Dismantling Implicit Bias in Maternal Health. • Health Literacy, Cultural Competency & Health Equity: Completed review of 29 English materials; conducted annual Heritage/CLAS Month with 3,952 attendees; and collaborated on the intervention implementation for the Breast Cancer Screening & Childhood Immunizations PIPs. The 2023 Program Description changes include:	*No comments or questions from Commissioners*	**See #11 for Motion**

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

	• Revised the Mission statement to remove "be an industry leader in ensuring health equity for all members and their communities."
	• Added the following:
	  ○ Improve structural determinants of health equity.
	  ○ Improve neighborhood-level social determinants of health.
	  ○ Improve institutional drivers of health equity.
	  ○ Improve individual & household-level social needs & networks.
	• Edited and expanded on the Health Equity areas.
	• Add Armenian as a language to monitor.
	• Added sex, ethnic group identification, gender identity, medical condition, genetic information, and mental disability or physical disability to cultural competency training.
	• Edited the frequency of the PNA report from annually to every 3 years.
	• Edited and updated the Health Equity Department staff.
	• Included the Chief Health Equity Officer role and responsibilities in this section.
	• Added CalViva Health Equity Officer as a new role section and included responsibilities.
	
	The 2023 Work Plan is consistent with 2022, while incorporating and enhancing the following:
	• Staff assignments updated throughout document.
	• Consolidated Population Needs Assessment activities into one element.
	• Consolidated Provider Training activities.
	• Updated PIP projects and activities for new 2023 PIPs Disparity Project for Childhood Immunizations & Well Child Visits in African American population in Fresno County.
	• Replaced PDSAs with SWOT analysis project for this year Childhood Immunizations.
	• Added Disparity Leadership Program (DLP) project to improve food security for Fresno County.
	
	The Language Assistance Program Annual Evaluation analyzes and compares language service utilization at the end of each calendar year. A year over year		

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	analysis is also performed. The conclusions from the Language Assistance Program annual report are: • Spanish and Hmong continue to be CalViva Threshold Languages. Spanish consistently has the highest volume. • Most interpretation (74%) is done via telephonic interpreters (up from 68% in 2021) • 24% was face-to-face interpretation (down from 28% in 2021) • 2% was Sign language (down from 4% in 2021) • Video Remote Interpreting (VRI) was zero in 2022. Limited English and non-English membership remain high for CVH population and therefore interpreter services are integral to maintaining safe, high-quality care.		
#11 Health Education Program Description and Work Plan Evaluation • Executive Summary • 2022 Annual Evaluation • 2023 Change Summary and Program Description • 2023 Work Plan Action P. Marabella, MD, CMO	Dr. Marabella presented the Health Education Executive Summary, the 2022 Annual Evaluation, the 2023 Change Summary and Program Description, and the 2023 Work Plan. Overall, 10 of 15 key Program Initiatives met or exceeded the year-end goals. Five (5) initiatives with seven (7) objectives did not meet goals. Of the seven (7) objectives, four (4) did not meet the year-end goal; two (2) partially met the year-end goal; and 1 met the year-end goal. The 10 initiatives that were fully met are: 1. Chronic Disease – Asthma 2. Chronic Disease – Diabetes 3. Fluvention & COVID-19 4. Member Newsletter 5. Behavioral Health 6. Pediatric Education 7. Population Needs Assessment 8. Women's Health 9. Compliance 10. Department Promotion The five (5) initiatives that did not meet or partially met were:	*Commissioner Naz questioned a possible Marijuana cessation group.* *Commissioner Rahn asked if there is any plan to interface with some of the home visitation programs in regard to the Perinatal project.*	***Motion**: Approve the Health Equity 2022 Executive Summary and Annual Evaluation, the 2023 Change Summary and Program Description, the 2023 Executive Summary and Work Plan Summary; and the Health Education Executive Summary, 2022 Annual Evaluation, 2023 Change Summary and Program Description, and 2023 Work Plan* *10 – 0 – 0 – 7* *(Cardona / Rogers)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	1. Chronic Disease Education: hypertension 2. Community Engagement 3. Obesity Prevention 4. Perinatal Education 5. Tobacco Cessation The barriers identified are related to low enrollment. Program enrollment will be enhanced through an emphasis on promotion in the CalViva Member newsletter and email campaigns. For Tobacco Cessation a data exchange program will be explored to improve outreach efforts and a nicotine replacement kit program will also be evaluated. Changes to the 2023 Program Description include: 1. Removed references to IHEBA/SHA throughout the document. 2. Deleted Fit Families for Life and Healthy Habits for Healthy People Community Classes description from the Weight Management Programs section. 3. Added: Member Services phone number to the Nurse Advise Line section. Changed title description from myStrength Program to Behavioral Health Education. 4. Added information about Adverse Childhood Experiences (ACEs) education and resources. 5. Added information about MMCD Policy Letter 16-005 Member incentive programs to promote positive health behaviors. 6. Added “and available online” to Member Newsletter section. 7. Added information on MMCD Policy Letter 16-005 Member Incentive Programs. CalViva follows guidance from DHCS Texting Program and Campaign Submission Form and Plan’s Texting Policy to develop, administer and evaluate texting campaigns”. Edited/revised the paragraph. 8. Rearranged Education standards. Deleted Nutrition & Exercise. 9. Other minor edits throughout the document such as updated titles, acronyms, and minor deletions. The 2022 Work Plan initiatives will continue into 2023 with the following enhancements:		

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	1. Conduct patient-level evaluation once the Asthma In-Home program ends in July 2023. 2. Vet and onboard new vendor for the Diabetes Prevention Program. 3. Collaborate with community partners to address health disparities in breast cancer screening rates in Fresno, Kings, or Madera County. *Supervisor Rogers stepped out at 2:01 pm; returned at 2:09 pm* *Dr. Naz left the meeting at 2:17 pm; not included in motion*		
#12 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of March 31, 2023:</u> Total current assets recorded were approximately $331.1M; total current liabilities were approximately $204.3M. Current ratio is approximately 1.62. Total equity was approximately $136.9M which is approximately 793% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $3.6M which is approximately $3.3M more than budgeted primarily due to rates on the Plan's money market funds being higher than projected. Premium capitation income actual recorded was approximately $1B which is approximately $122.4M more than budgeted primarily due to rates and enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $862.9M which is approximately $117.7M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $41.6M, which is approximately $2.8M more than budgeted due to higher than budgeted enrollment. Dues and Subscriptions expense actual recorded was approximately $207K which is approximately $53K more than budgeted due to the Local Health Plans of California (LHPC) one-time additional assessment related to their work in renewing the MCO tax and allocating dollars to reinvest back into Medi-Cal as opposed to the State general fund. All other expense line items are below or close to what was budgeted.	*No questions or comments from Commissioners for Finance Reports.*	***Motion**: Standing Reports Approved* *9 – 0 – 0 – 8* *(Rogers / Boss)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Net income recorded was approximately $8.9M, which is approximately $5.9M more than budgeted primarily due to Interest income being approximately $3.3M higher, and rates and enrollment being higher than budgeted. <u>FY 2024 Proposed Budget:</u> On March 16, 2023, the FY 2024 budget was reviewed and approved by the Finance Committee to move to Commission for recommendation of full review and approval. Projected enrollment for FY 2024 is anticipated to gradually decline due to the disenrollment process that began April 2023. During April 2023, counties are going to focus on auto ex-parte renewals, which are renewals for members that can be automatically renewed as counties leverage state, local and federal databases to verify pertinent information, i.e., IRS, FTB, etc. This accounts for approximately 25-30% of renewals. In May 2023, anything that falls out of that process will fall under the normal process of sending out the renewal packets. Late June 2023, the State will process disenrollments for true disenrollments. The plan will begin to see members fall off in July 2023. This disenrollment process will go through June 30, 2024, and will be based off the member's eligibility month. The gradual decline in enrollment takes into account any members that may shift to Kaiser, as Kaiser moves into the Plan's service area beginning January 2024 based off their contract with DHCS. It also takes into account any new members that may come into the Plan as a result of the undocumented immigrants ages 26-49 moving into Medi-Cal managed care January 2024. The enrollment projection also considers any members the Plan may gain or lose as a part of the Dual Special Needs Program (D-SNP) going live 2024. Medical revenue is projected to be approximately $1.26B which is approximately $110.8M more than budgeted primarily due to an increase in rates and a slight increase in enrollment in comparison to FY 2023's budget. Interest income is projected to be $3.6M which is approximately a $3.3M more than budgeted in FY 2023 due to the increase in rates on the money market funds.		

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	Medical Cost expense is projected to be approximately $1.13B which is approximately $133.6M more than budgeted in FY 2023 due to rates being higher and a slight increase in enrollment. Salary, wages, and benefits expense is projected to be approximately $4.5M which is approximately a $955K increase primarily due to hiring additional staff such as the Health Equity Officer, as required per DHCS 2024 contract. Furthermore, projecting to hire additional staff to account for new programs moving in to Medi-Cal management care such as D-SNP, NCQA accreditation, and long-term care to name a few. Consulting expense is projected to be $400K which is $100K more than budgeted in FY 2023 due to ramping up efforts to being NCQA accredited. Grants expense is projected to be approximately $3.9M which is $640K less than budgeted in FY 2023 due to certain short-term or start-up funding requested by community-based organizations which have been fully funded. Insurance expense is projected to be approximately $404K which is approximately $207K more than budgeted in FY 2023 due to adding a cyber insurance policy in addition to increasing insurance premiums. License expense is projected to be approximately $1.4M which is about $224K more than budgeted in comparison to FY 2023 due to the license fee being based off enrollment as of March each year. The Plan's enrollment as of March 2023 is higher than March 2022. Recruitment expense is projected to be approximately $112K which is approximately $76K more than budgeted in FY 2023 due to the use of recruiting agencies to identify qualified candidates for the positions mentioned in the Salary & Wage category. MCO taxes were projected to be $66.5M which was based off the State's initial budget in January, noting that the State communicated the use of the prior MCO tax structure which ended December 2022. In that previous MCO tax structure, it		

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	had a lower tax rate in the beginning then escalates up as the years go by, which explains the $25M decrease in comparison to FY 2023. Governor Newsom has since presented the May revised State budget and included in that revised budget was a revised MCO tax proposal noting that they are looking to substantially increase the MCO taxes. Based on the new proposal, the MCO tax would almost quadruple, which would increase the Plan's budgeted MCO taxes to $500M compared to the $66.5M originally budgeted. The State is looking to make this retroactive to April 2023, which is nine months earlier than originally projected. The reason behind the substantial increase is due to the State facing a $31.5B budget deficit. The Federal government has also communicated to DHCS they are looking to tighten the rules around the MCO tax program which would essentially decrease it. The new revised MCO tax proposal must pass the California state legislature by June 15, 2023. By June 30, 2023, the State must send the revised proposal to CMS for approval. If passed as proposed, the budget may need revision. Ongoing monitoring is taking place. Capital Expenditure budget is $400K which is $150K more than budgeted for FY 2023 primarily due to upcoming vacancy in the building and budgeting for any improvements requested by new tenant(s). Net Income is projected to be approximately $8.8M which is approximately a $4.2M increase in comparison to FY 2023 primarily due to interest income increasing by approximately $3.3M, and rates increasing. **Medical Management**		
• **Medical Management** P. Marabella, MD, CMO	<u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through April 2023 beginning with an explanation regarding how staff obtain data or information from Members and providers via phone, fax, email or online and how it's rolled up into the dashboard and other narrative reports. Each grievance submitted by or for a Member is categorized according to standardized criteria and is reflected in the appropriate area on the monthly dashboard. The last tab in each Excel file includes a list or log identifying each member who submitted a grievance that	*No questions or comments from Commissioners for Appeals & Grievances Dashboard.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	month with their demographic information, assigned provider, county, language spoken, the specifics of their grievance and how it was resolved. This represents hundreds of lines in the log when all grievance types are compiled but each one is reflected on the dashboard to allow for the identification of trends over time and opportunities for improvement. In addition, Dr. Marabella stated that comments and questions from Commissioners are encouraged. • Grievances received overall for Q1 2023 increased when compared to the previous year. • Quality of Service Grievances increased when compared to the previous two months. The "Other" and "Transportation – Access" categories have both increased when compared to the previous year. • Quality of Care Grievances remained consistent and most related to delay in PCP care. • Exempt Grievances had a significant decrease when compared to the previous year. "Transportation-No Show" showed improvement. However, it appears this grievance type may have shifted from Exempt over to QOS rather than truly declining. • Appeals for Q1 2023 remained consistent with previous quarters. "Advanced Imaging" has improved (decreased). <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through Q1 2023. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through March 31, 2023, which demonstrates that rates have remained steady when compared to the previous year. Membership has begun to level off and is expected to decline as redeterminations begin. Utilization remained steady through quarter 1. Turn-around times are at 100% compliance with standards this reporting month, except for routine deferrals. The issue associated with this failure has been	*No questions or comments from Commissioner for the Key Indicator Report.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	addressed and follow up completed. Case Management results have shown increased referrals and demonstrate positive outcomes. <u>QI & UMCM Quarterly Report – Q1 2023</u> Dr. Marabella provided the QI & UMCM Q1 2023 update. Two QI/UMCM meetings were held in Quarter 1: one on February 23, 2023, and one on March 16, 2023. The following guiding documents were approved at these meetings: 1. QI/UM Committee Charter 2023 2. 2022 Quality Improvement End of Year Evaluation 3. 2023 Quality Improvement Program Description 4. 2023 Quality Improvement Work Plan 5. 2022 Utilization Management/Case Management End of Year Evaluation 6. 2023 Utilization Management Program Description 7. 2023 Case Management Program Description 8. 2023 Utilization Management/Case Management Work Plan In addition, the following general documents were approved at these meetings: 1. Pharmacy Provider Updates 2. Medical Policies The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard, Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Reporting, the MHN Performance Indicator Report for Behavioral Health Services, and the Blood Lead Screening Report. Additional Quality Improvement reports were also reviewed as scheduled during Q1. The Utilization Management & Case Management reports reviewed were the Key Indicator Report, Inter-rater Reliability Results for Physicians and Non-Physicians, Case Management and CCM Report, the PA Member Letter Monitoring Report, and other reports scheduled during Q1.	*No questions or comments from Commissioner for the Quarterly QI & UMCM Report.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Pharmacy quarterly reports included Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, Inter-rater Reliability Review Report and Quality Assurance Results. HEDIS® Activity: In Q1, HEDIS® related activities focused on data capture for measurement year 2022 (MY22). Managed Care Medi-Cal health plans will have 15 quality measures that they will be evaluated on for MY2022 and the Minimum Performance Level (MPL) is the 50th percentile. Activities included: 1. Finalized and submitted the 2023 HEDIS® Roadmap by January 31, 2023. 2. MY2022 HEDIS® data gathering from clinics and providers throughout the three-county area with final submission to DHCS and HSAG by June 1st, 2023. 3. Completed Annual HEDIS® Audit on 3/8/23. 4. Initial reports are in review for evaluation of compliance with MCAS measures. Current improvement projects are: 1. Breast Cancer Screening (BCS) PIP (Performance Improvement Project) concluded 12/31/22. Final Report submitted 04/28/23. Awaiting HSAG feedback. 2. Childhood Immunizations (CIS-10)– PIP Immunization birth to 2 years concluded 12/31/22. Final Report submitted 04/21/23. Awaiting HSAG feedback. 3. Well-Child & Childhood Immunization SWOT in progress with three (3) strategies in the implementation phase. Initial report submitted 02/28/23 with DHCS approval. Two New PIP Projects to be initiated in September 2023. 1. One clinical – Well-Child Visits in the African American population in Fresno County and		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	2. One Non-clinical - Improve referrals to Community Supports programs (Sobering Centers, Day Habilitation programs) within 7 days of visiting an emergency department (ED) for members with a Substance Use Disorder (SUD)/Serious Mental Health (SMH) diagnosis and seen in ED for the same diagnosis. No significant compliance issues have been identified. Oversight and monitoring processes will continue. **Executive Report** Enrollment through March 31, 2023, continues to increase as a result of the public health emergency (PHE); total enrollment is currently at 437,493. CVH Market Share % for February and March has improved. DHCS has not provided a replacement report to address the discontinued reports which provided data to MCPs around Default, Share of Choice %, and Voluntary Disenrollments. There are no significant issues or concerns to report as it pertains to IT Communications and Systems. Workstation and spam filer upgrades are currently in process. The Plan is assessing a new security information and event manager for better stability and maintenance. In reference to the Call Center and Website activities, there has been an increase in users calling into the Member and Transportation Call Centers, as well as an increase in users visiting the CVH website. No other significant issues or concerns. Q1 2023 numbers are available. No significant issues or updates for Provider Network and Engagement Activities. For Claims Processing and Provider Disputes, Q4 2022 numbers are now available. Management is working with Administrator regarding performance for PPG 2 and PPG 3. All other areas met goal.	*Commissioner Cardona inquired about the number of members transitioning to Kaiser. CFO Daniel Maychen responded and reported the Plan completed an analysis and for FY 2024 estimates approximately 5,000 may be enrolled in Kaiser but will not all occur in one month. Kaiser membership would increase month by month.* *CEO Jeff Nkansah responded in Fresno, Kings, and Madera Counties, Kaiser currently does not have an existing Medi-Cal presence so the transition of Medi-Cal members to Kaiser will look different in Fresno, Kings, and Madera Counties than other Counties where Kaiser has*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	With regard to Madera Community Hospital, the Plan continues to monitor activity related to MCH. The Plan reviewed claims utilization at the alternative hospitals for Claims year 2022, as well as our current claims experience for Q1 2023. A majority of the claims experience for 2022 at MCH, many of these services were provided in 2022 at Fresno Hospitals. In 2023, as expected, the Plan sees no claims experience at MCH, and all services have been redirected to the alternative hospitals, primarily Fresno County hospitals. While membership is being redirected to Fresno County hospitals, it is dispersed among them, and not heavily redirected to one over the others in a trend that is significantly different than the previous years' experience. *Kerry Hydash left meeting @ 2:45 pm*	*an active Medi-Cal presence.* *No questions or comments from Commissioners regarding MCH.*	
#13 Final Comments from Commission Members and Staff	Supervisor Quintero thanked the staff at CVH for the work put into the FKM RHA Commission meetings.		
#14 Announcements	None.		
#15 Public Comment	None.		
#16 Adjourn	The meeting was adjourned at 3:01 pm. The next Commission meeting is scheduled for July 20, 2023, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #4

Attachment 4.B

Finance Committee Minutes
Dated 3/16/23

CalViva Health
Finance
Committee Meeting Minutes

March 16, 2023

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

	Finance Committee Members in Attendance		CalViva Health Staff in Attendance
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Office Manager
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Accounting Manager
	Paulo Soares		
	Joe Neves		
✓	David Rogers		
✓	John Frye		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:32 am, a quorum was present.	
#2 Finance Committee Minutes dated February 16, 2023 Attachment 2.A Action, D. Maychen, Chair	The minutes from the February 16, 2023 Finance meeting were approved as read.	Motion: *Minutes were approved* *4 – 0 – 0 – 2* *(Frye / Rogers)*
#3 Financials as of January 31, 2023 Action	Total current assets recorded were approximately $241.9M; total current liabilities were approximately $118.8M. Current ratio is approximately 2.04.	Motion: *Financials as of January 31, 2023 were approved* *4 – 0 – 0 – 2*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
D. Maychen, Chair	Total equity as of January 31, 2023 was approximately $133.1M which is approximately 816% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $2.4M which is approximately $2.2M more than budgeted primarily due to rates on the Plan's money market funds being higher than projected. Premium capitation income actual recorded was approximately $755.5M which is approximately $48.2M more than budgeted primarily due to rates and enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $622.3M which is approximately $46.2M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $32M, which is approximately $1.6M more than budgeted due to higher than budgeted enrollment. All other expense line items are below or close to what was budgeted. Net income recorded for the first seven months of FY 2023 was approximately $5.2M which is approximately $3.2M more than budgeted due to rates and enrollment being higher than budgeted, in addition interest income being approximately $2.2M higher than originally projected. The $3.2M MCO tax gain communicated during the February 2023 Finance meeting was to be recouped by DHCS in calendar year Q1 2023; however, per DHCS, the date of the MCO tax gain recoupment has now been revised to calendar year Q3 2023 (i.e., next fiscal year). As a result, to capture the MCO tax recoupment in the current fiscal year, the Plan booked an accrual for the MCO tax gain recoupment in the January 2023 financials, which is why net income has declined in comparison to previous financials presented.	*(Frye / Rogers)*
#4 Fiscal Year 2024 – Proposed	There was a minor revision to Enrollment for the FY 2024 basic budget	Motion: *Approve Budget*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Budget • Budget Assumptions • Proposed Budget	assumptions. This was due to using the most recent enrollment numbers from February 2023 to use as a benchmark to project out the enrollment for FY 2024. In addition, a revision to enrollment was made to increase the projected disenrollment numbers to be more conservative. As a recap, for projected enrollment for FY 2024 is anticipated to gradually decline due to the disenrollment process beginning April 2023. Enrollment is expected to drop off beginning July 2023 due to the time it takes the Counties and State to work through the disenrollment process. The gradual decline in enrollment accounts for any new member the Plan will acquire related to the undocumented immigrants ages 26-49 which is projected to be effective 2024. Any additional members the Plan receives as a part of the D-SNP program going live 2024. Also taking into account any members lost to Kaiser when they become effective 2024 based on their contract with DHCS. Medical revenue is projected to be approximately $1.3B which is approximately a $110.8M more than budgeted primarily due to an increase in rates and a slight increase in enrollment in comparison to FY 2023's budget. Interest income is projected to be approximately $3.6M which is approximately a $3.3M more than budgeted in FY 2023 due to the increase in rates on the money market funds. Medical Cost expense is projected to be approximately $1.13B which is approximately $133.5M more than budgeted in FY 2023 due to rates being higher and a slight increase in enrollment. Salary and wage expense is projected to be approximately $4.5M which is approximately a $955K increase primarily due to hiring additional staff such as the Health Equity Officer, required per DHCS 2024 contract. Furthermore, projecting to hire additional staff to account for new	*Assumptions and Proposed Budget to move to Commission for final approval* *4 – 0 – 0 – 2* *(Frye / Rogers)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	programs moving in to Medi-Cal management care such as D-SNP, NCQA accreditation, and long-term care to name a few. Consulting expense is projected to be approximately $400K which is $100K more than budgeted in FY 2023 due to ramping up efforts to being NCQA accredited. Grants expense is projected to be approximately $3.9M which is $640K less than budgeted in FY 2023 due to certain short-term or start-up funding requested by community based organizations which have been fully funded. Insurance expense is projected to be approximately $404K which is approximately $207K more than budgeted in FY 2023 due to adding a cyber insurance policy in additional to increasing insurance premiums. License expense is projected to be approximately $1.4M which is about $224K more than budgeted in comparison to FY 2023 due to the license fee being based off enrollment as of March each year. The Plan's enrollment as of March 2023 is higher than March 2022. Recruitment expense is projected to be approximately $112K which is approximately $76K more than budgeted in FY 2023 due to the use of recruiting agencies to identify qualified candidates for the positions mentioned in the Salary & Wage category. MCO taxes projected to be $66.5M which is approximately $25M less than budgeted in FY 2023 primarily due to the California state budget for 2024, noting that they are projecting to renew the MCO tax beginning January 2024; the previous MCO tax expired in December 2022. The reason for the decline is due to the State indicating they are looking to keep same MCO tax structure that was previously in place. In	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	that MCO tax structure, in the initial years, it had a lower tax rate, causing the decline in MCO taxes in FY 2024 vs FY 2023. Capital Expenditure budget is $400K which is $150K more than budgeted for FY 2023 primarily due to a vacancy in the building and budgeting for any improvements requested by new tenant(s). Net Income is projected to be approximately $8.8M which is approximately a $4.2M increase in comparison to FY 2023 primarily due to interest income increasing by approximately $3.3M, and rates increasing.	
#5 Announcements	Harold Nikoghosian has resigned from the Commission and Finance Committee. The Plan is actively recruiting for his replacement.	
#6 Adjourn	Meeting was adjourned at 11:45 am	

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

Dated: May 18, 2023

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 5/18/23

Item #4

Attachment 4.C

QIUM Committee Minutes
dated 3/16/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
March 16th, 2023

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.**, CalViva Chief Medical Officer, Chair	✓**	**Amy Schneider, RN,** Director of Medical Management Services
✓	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Iris Poveda,** Medical Management Specialist
	Raul Ayala, MD, Adventist Health, Kings County	✓	**Norell Naoe,** Medical Management Administrative Coordinator
✓	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers		**Zaman Jennaty,** Medical Management Nurse Analyst
✓ *	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**Rajeev Verma, M.D.,** UCSF Fresno Medical Center	✓	**Maria Sanchez**, Compliance Manager
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**	✓	**Patricia Gomez,** Senior Compliance Analyst
	Guests/Speakers		
✓			

✓ = in attendance
* = Arrived late/left early
** = Via Telephone

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.	
#2 **Approve Consent Agenda** - Committee Minutes: February 23, 2023 - Specialty Referrals Report (Q4) - Standing Referrals Report (Q4) - Initial Health Assessment (IHA) Quarterly Report (Q3) - SPD HRA Outreach (Q4) - NIA/Magellan (Q4) - Pharmacy Provider Updates (Q4)	The February 23rd, 2023, QIUM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. A link for Medi-Cal Rx Contract Drug List was available for reference. *Dr. Ramirez arrived at 10:37 AM.	Motion: *Approve* Consent Agenda - Committee Minutes: February 23, 2023 - Specialty Referrals Report (Q4) - Standing Referrals Report (Q4) - Initial Health Assessment (IHA) Quarterly Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Medical Policies Provider Updates (Q4) (Attachments A-H) **Action** Patrick Marabella, M.D Chair		(Q3) - SPD HRA Outreach (Q4) - NIA/Magellan (Q4) - Pharmacy Provider Updates (Q4) - Medical Policies Provider Updates (Q4) (Verma/Lee) 5-0-0-1
#3 **QI Business** - Appeals & Grievances Dashboard and Turn Around Time Report (January) - Appeals & Grievances Validation Audit Summary (Q3) (Attachments I-J) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turn Around Time Report** were presented through January 2023. ➢ There was a total of 101 grievances this month which has remained consistent over time. ➢ The majority were Quality of Service related: 13 Access-Prior Authorization delays; 10 Administrative; 11 others. Monitoring to continue. ➢ Quality of Care Grievances also remained consistent compared to previous months. ➢ Exempt Grievances had a notable decrease compared to previous months. PCP delay for Prior Authorizations Specialty Referrals will continue to be monitored. ➢ There were eight (8) Transportation Provider No Shows. Transportation Grievances are expected to decrease over the next several months as tracking and oversight are implemented and monitored. ➢ 29 Total Appeals with 10 cases related to Advanced Imaging. ➢ Uphold and Overturn rates were upside down this month, this demonstrates that once providers are asked to clarify their requests, they receive approval. Tests are ordered	Motion: *Approve* - A&G Dashboard and Turn Around Time Report (January) - A&G Validation Audit Summary (Q3) (Cardona/Ramirez) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	appropriately, just not documented completely when initially submitted. The **Appeals & Grievances Validation Audit Report Q3** was presented. CVH conducts weekly A&G case validations to ensure each Grievance or Appeal case contains the appropriate documentation and evidence necessary for standard and expedited Quality of Service (QOS), Quality of Care (QOC), and Appeal cases. ➢ A decrease is noted in the number of cases monitored this quarter due to the use of sampling rather than 100% case review. 85% of cases met compliance standards when initially submitted. ➢ All documents identified to be missing from the cases were obtained and added to complete the file before closing. ➢ There were twenty-one (21) cases with missing documents, with thirty-five (35) documents missing in total. Two (2) acknowledgment letters were sent beyond the mandated 5-day time frame.	
#3 **QI Business** - MHN Performance Indicator Report for Behavioral Health Services (Q4) (Attachment K) **Action** Patrick Marabella, M.D Chair	The **MHN Performance Indicator Report for Behavioral Health Services Q4** provides a summary of an array of indicators to evaluate the behavioral health services provided to CalViva members. Fifteen out of the fifteen metrics met or exceeded their targets this quarter. ➢ Q4 CVH membership was 418,917 with a 2.3% utilization rate. ➢ Behavioral Health Providers (BHP) Open Practice rate was at 96% with a member-to-BHP ratio of 302:1 (Target is at least 5000:1) ➢ Appointment Access standards were met for the two (2) Emergent and ten (10) Urgent cases. ➢ All ABA and non-ABA prior authorization requests met timeliness and accuracy standards for approvals and denials. ➢ There were three (3) Potential Quality Issues (PQI) cases, and zero (0) Untoward Events. All Provider Disputes were resolved within timeliness standards, resulting in a 100% compliance rate. Approximately half of the disputes were from two (2) providers, both were regarding incorrect documentation on unrelated issues. The providers were educated on the correct procedures.	Motion: *Approve* - MHN Performance Indicator Report for Behavioral Health Services (Q4) (Ramirez/Lee) 5-0-0-1
#3 **QI Business** - Performance Improvement Project Updates – SWOT	The **Performance Improvement Projects Update – SWOT** was presented. The CVH Medical Management team is leading a QI project to address Childhood Immunizations and Well-Child Visits in Fresno and Kings counties. This CIS-10 HEDIS® measure evaluates the percentage of children who complete their immunizations by the age of 2 during the measurement year, and the	Motion: *Approve* - Performance Improvement Project Updates –

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment L) **Action** Patrick Marabella, M.D Chair	W30 HEDIS® measure evaluates Well-Child Visits in the first 30 months of life. Three strategies and action items for the SWOT are as follows: ➢ Retrieve the Hep B immunization data given to newborns in the hospitals. ➢ Increase the conversion of sick visits to well-care visits for children under 30 months of age. ➢ Identify five high-volume pediatric providers to partner with CVH to ensure all children under the age of 2 years receive needed immunizations at any provider visits. Committee members agreed that it is difficult to provide all immunizations to the under 2 population as many families don't bring their children in for well-care visits, which becomes increasingly difficult the more children a family has. Another barrier is the CAIR registry: inconsistency with patient data and access to records between facilities makes it hard to track immunization history. National standardization of routine immunizations should be implemented.	SWOT (Verma/Ramirez) 5-0-0-1
#3 **QI Business** - Blood Lead Screening Quarterly Report (Q3) (Attachment M) **Action** Patrick Marabella, M.D Chair	The **Blood Lead Screening Quarterly Report Q3** was presented and describes clinical guidelines for blood lead screening, reporting requirements related to blood lead screening and, emphasizes the importance of parents/caregivers receiving anticipatory guidance related to blood lead poisoning prevention, blood lead level testing, and follow-up services from providers. ➢ The Q3 Blood Lead Level Screening Report shows CalViva Health's performance on blood lead level screenings and anticipatory guidance monitoring from Q1 - Q3 2022. o Q3 compliance for CPT Code (lead screening only) ranged from: • 97.2% (Q3) – 97.5% (Q1) in members 6-17 months of age • 59.9% (Q3) – 59.8% (Q2) in members 18-30 months of age • 99.3% (Q3) - 99.4% (Q1) in members 31-72 months of age o Q3 Documentation of Anticipatory Guidance using Codes was very low in all age groups.: ➢ Beginning Q1 2023, providers are being educated to document anticipatory guidance by using CPT codes along with preventative medicine counseling codes. We anticipate higher compliance for anticipatory guidance beginning of the Q1 2023 report. ➢ Additional barriers in Q1 2023 include the California Lead Poisoning Prevention Branch (CLPPB) of the California Department of Public Health (CDPH) declaring filter paper testing for lead in children is not an acceptable testing methodology. Filter paper testing has been the current economical methodology of testing amongst our providers. CVH working towards finding an acceptable testing methodology.	Motion: *Approve* - Blood Lead Screening Quarterly Report (Q3) (Verma/Cardona) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - QI/UM Committee Charter 2023 (Attachment N) **Action** Patrick Marabella, M.D Chair	The **2023 QI/UM Committee Charter** was presented for annual review and this year includes edits to meet NCQA Accreditation standards. Additions or changes include: ➢ Purpose: o QIUM Committee role in the oversight and guidance for Health Equity (HE); and evaluation of the results of delegated, nondelegated, and collaborative QI and UM activities. ➢ Committee Focus: o Review of annual CM Program Evaluation. o Monitors key clinical and service performance indicators for QI, UM, HE, and Credentialing/Recredentialing activities (e.g., access & availability, over/under utilization, key UM and CM indicators, behavioral health, population health, A&G, HEDIS®, and CAHPS® measure results, provider satisfaction surveys, disease management, and public health programs activities, timeliness standards, etc.) o Analyze and evaluate the results of QI & HE activities. o Monitor the effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social determinants of health (SDoH), and community needs and makes ongoing recommendations. o Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission. Also ensuring that the Plan complies with state, federal, contractual, and NCQA requirements. ➢ Composition: o Added: QIUM Committee will be composed of external participating physicians. ➢ Subcommittees and Work Groups reporting to QI/UM: o Clarified the QIUM Committee reporting structures to include two subcommittees, Credentialing and Peer Review each with its own Charter. o There are three workgroups which consist of CVH and HN staff/leadership. • QI/UM Work Group ▪ A&G Work Group • Access Workgroup	Motion: *Approve* - QI/UM Committee Charter 2023 (Ramirez/Lee) 5-0-0-1
#4 **QI Business** - Quality Improvement Annual	The **2023 Quality Improvement Program Description** was presented. Annual updates this year include edits to meet NCQA Accreditation standards:	Motion: *Approve* - Quality

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Program Description 2023 - Quality Improvement Annual Work Plan 2023 (Attachments O-P) **Action** Patrick Marabella, M.D Chair	➢ Updated HN Medical Management Department to Population Health and Clinical Operations (PHCO). ➢ Updated Initial Health Assessment to Initial Health Appointments. ➢ Revised Health Promotion Program descriptions for 2022. ➢ Revised MemberConnections' responsibilities to expand role in Member Engagement. ➢ Changed Transition Care Management (TCM) to Transitional Care Services (TCS). ➢ Removed MHN references and replaced them with Behavioral Health Administrator. ➢ Added information that delegated activities are reports to the CalViva QIUM Committee. ➢ Revised committee description to include chairperson, delegated and nondelegated activities, and representatives from CalViva and HNCS departments. ➢ Revised description to separate out the Credentialing and Peer Review Subcommittees. ➢ Staff Resources and Accountability – Added Org Chart for Med Mgt. ➢ The A&G section was moved and revised to a workgroup description. ➢ Chart revised to include CalViva Workgroups. ➢ Updated the Chief Medical Officer description to include a chairperson and oversight of QIUM Program information. ➢ Other minor edits The **2023 Quality Improvement Annual Work Plan** was presented with a new format to standardize and better delineate processes and outcomes. This year includes edits to meet NCQA Accreditation standards: ➢ 8 Key areas of QI Work and initiatives include: I. Behavioral Health (MCAS Measures) • FUA-30 –Follow up after ER visits for substance abuse. • FUM-30—Follow up after ER visits for mental health. II. Chronic Conditions (MCAS Measures) • Respiratory -AMR—Asthma Medication Ration • Heart – CBP—Control Blood Pressure • Diabetes – CDC>9—HgbA1c to below 9 III. Maternal/Women's Health (MCAS measures) • Perinatal Care—Prenatal (PPC-pre) and Post-partum (PPC-post) o Reduce disparities for Afro-American Women. IV. Member Engagement and Experience	Improvement Annual Program Description 2023 - Quality Improvement Annual Work Plan 2023 (Ramirez/Verma) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Initial Health Appointment (IHA) is under 120 days.
	• CAHPs Improvement
	  o Access to Care
	  o Customer Service
	  o Doctor Communication
	  o Care Coordination
	  o Overall Rating Measures
	V. Hospital Quality/Patient Safety
	• Hospital Reportable Data Scorecard
	  o CAUTI: Catheter-associated urinary tract infection
	  o CLABSI: Central line-associated bloodstream infection
	  o C. DIFF: Clostridium difficile infection
	  o MRSA: Methicillin-resistant Staphylococcus aureus
	  o SSI-COLON: Surgical site infections – Colon Surgery
	  o NTSV C-sections: Nulliparous term singleton vertex
	VI. Pediatric
	• Well Child Visits-(W30-6+)
	• Childhood Immunization-MCAS (CIS10; W30)
	  o CIS-10 Immunization Child <2 years old
	  o Well Child Visits
	  o SWOT Methodology
	VII. Preventative Health
	• Cancer Screening
	  o BCS, Breast Cancer Screening
	  o CCS, Cervical Cancer Screening
	  o CHL, Chlamydia Screening
	• Childhood Blood Lead Screening and Anticipatory Guidance
	VIII. Provider Engagement
	• Quality EDGE – Evaluating Data to Generate Excellence
	  o Increase MCAS year over year by 10%.
	• Provider Access, Availability, and Service
	  o Improve Provider Appointment Access Survey (PAAS) and Provider	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	After-Hours Availability Survey (PAHAS). Committee Members discussed the different Diabetic HgbA1c level measures such as < 7 for pediatrics, and < 8 or > 9 for adults. The National Committee on Quality Assurance (NCQA) includes several other Diabetic measures in its manual as well. The metric CVH is focused on currently is an attempt to address the highest-risk adult members with an HbA1c above 9. This measure follows NCQA guidelines and is a required measure for the Managed Care Accountability Set mandated by DHCS. We support all members in lowering their HbA1c level to below 7. Additional discussion occurred about challenges with obtaining current patient contact information to encourage members to complete preventive screenings. The Plan will increase the utilization of MemberConnections staff and Community Health Workers to improve outreach into the community to capture correct contact information. Roughly 35% of member contact information received from the state is inaccurate according to previous CalViva QI studies. This is a continuing problem for our HEDIS® projects. With the unwinding of the Public Health Emergency and reinstatement of member eligibility redeterminations, members are required to update their contact information. It is anticipated we will see some improvement in contact information through this process.	
#5 **UM/CM Business** - Key Indicator Report & TAT report (January) - Case Management and CCM Report (Q4) - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2022 - PA Member Letter Monitoring Report (Q4) - MedZed Report Integrated Care Management Report (Q4)	The **Key Indicator Report and Turn Around Time Report** through January were presented. Membership continues to rise but may decrease with the unwinding of the Public Health Emergency and redetermination process. ➢ Utilization for all risk types decreased in January 2023 compared to last year but is consistent with December 2022 figures. ➢ Turn- around Times were met in all areas in January 2023. ➢ Case Management results remained robust in the Perinatal and Integrated categories and remained consistent in all others. The **Case Management and CCM Report Q4** summarizes the case management, transitional care management, MemberConnections, Palliative care, and Emergency Department (ED) diversion activities for 2022 through the fourth quarter and utilization-related outcomes through the third quarter of 2022. CM continued to support member education related to COVID-19 and provided vaccine information during outreach. ➢ Decreased referrals to some programs. Fewer Concurrent Review (CCR) referrals due to the increase in Flu, RSV, and COVID cases. ➢ CM outcomes improved for Q3; Admissions and Readmissions decreased; ED Claims	Motion: *Approve* - Key Indicator Report & TAT report (January) - Case Management and CCM Report (Q4) - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2022 - PA Member Letter Monitoring Report (Q4) - MedZed Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments Q-U) **Action** Patrick Marabella, M.D Chair	decreased; Total health care costs reduced for members participating in Case Management. Next Steps: ➢ Preparing for the implementation of the "First Year of Life" Program and referrals. ➢ Exploring the opportunity to move Care Management into a Regional model, to align with UM and allow staff to become more familiar with the region they cover. **InterQual Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2022** was presented. UM staff use InterQual® Clinical Decision Support Criteria along with other evidence-based medical policies, clinical support guidelines, and technical assessment tools approved by the Medical Advisory Council to assist clinical reviewers in reviewing medical criteria, with consistency. All UM staff and physicians undergo InterQual® training upon hire and annually, complete a "Summary of Changes" course that is conducted by InterQual® instructors. ➢ The UM Department: 94% pass rate on all modules. ➢ The Medical Affairs Department: 96% pass rate on all modules ➢ 2023 IRR continues with monthly InterQual® (initial) and InterQual® Refresher training, as needed. The **PA Member Letter Monitoring Report Q4** monitors Notice of Action (NOA) letters including Prior Authorizations, Concurrent, and Post Service denials. Findings are discussed with the entire UM Management Directors monthly. All metrics are expected to meet the standard of 100% compliance. The Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. ➢ There was a total of 12- unique denial letters and 4 unique deferral letters impacted by letter opportunities. ➢ Denial and Deferral LTR Codes 48, 49, & 60 will continue to be monitored. In follow-up, Medical Management implemented staff/physician coaching focused on the use of clear and concise language and no medical jargon. Committee Member discussion followed regarding the importance of clear and concise language in communications to members and best communication practices. **MedZed Integrated Care Management Report Q4** monitors the volume and engagement of members referred to MedZed Care Management Program. The program is designed as a bridge and supports members to achieve care plan goals and reengage with traditional care (assigned PCP).	Integrated Care Management Report (Q4) (Cardona/Lee) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ Q4 average engagement rate = 56% which increased this quarter due to a change in referral frequency from quarterly to monthly. ➢ The average engagement rate will increase over time due to increasing outreach efforts.	
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q4) - Pharmacy Operations Metrics (Q4) - Pharmacy Top 25 Prior Authorizations (Q4) - Pharmacy Inter-Rater Reliability Results (IRR) (Q4) - Quality Assurance Results for Pharmacy (2022) (Attachments V-Z) **Action** Patrick Marabella, M.D Chair	The **Pharmacy Executive Summary Q4** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. ➢ Pharmacy Operations Metrics •Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q4. •Overall, TAT for Q4 was 96.4%. PA TAT was slightly lower in Q4 than in Q3. •PA volume was stable in Q4 compared to Q3. No outliers were found in Q4. The **Pharmacy Operations Metrics Q4** provides key indicators measuring the performance of the PA Department in service to CalViva Health members. Pharmacy prior authorization (PA) metrics were within 5% of the standard for Q4 at 96.4%. The turnaround time (TAT) expectation is 100% with a threshold of 95%. The **Pharmacy Top 25 Prior Authorizations Q4** identifies the most requested medications to the PA Department for CVH members and assesses potential barriers to access of medications through the PA process. The top ten (10) denials of the quarter by percentage and total number are consistent with recent quarters except for a few placement variations. More variance is seen in the top 15th to 25th. Since reporting on medical benefit-only drugs is new this year, trending and analysis will continue to identify patterns. The **Pharmacy Inter-Rater Reliability Results Q4** were presented. A sample of 10 prior authorization denials per month is reviewed quarterly to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold of 90%. ➢ The overall score was 85.83% with most issues related to criteria application, letter language, and questionable denial. ➢ Criteria Application continues to be the main issue in Q4. In five cases, improper Criteria Application likely led to improper approval decisions by pharmacy technician reviewers. A more detailed review and QA on cases in Q4 has been performed and results have been shared with PA management to address this concern.	Motion: *Approve* - Pharmacy Executive Summary (Q4) - Pharmacy Operations Metrics (Q4) - Pharmacy Top 25 Prior Authorizations (Q4) - Pharmacy Inter-Rater Reliability Results (IRR) (Q4) - Quality Assurance Results for Pharmacy (2022) (Verma/Lee) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **Quality Assurance Results for Pharmacy 2022** evaluate the consistency and accuracy with which MedPharm Pharmacy staff apply prior authorization criteria in decision-making and communicate the decisions to providers and patients. The overall target is a score of 95% or better in all areas with a threshold cumulative score requirement of 90% or greater for all quarters in the calendar year to be compliant. ➢ The average criterion applied appropriately for 2022 was 73%. ➢ Detailed results have been shared with the leadership of the MedPharm team to ensure consistent, accurate, and timely reviews are being performed. As part of the oversight responsibilities, health plan pharmacy leadership will continue to escalate findings not meeting the target and threshold to the prior authorization management team to improve the quality of the reviews as well as expectations of the plan in the review of the medical benefit pharmacy requests.	
#7 **Policy & Procedure Business** - Pharmacy Policy Review 2023 (Attachment AA) **Action** - Patrick Marabella, M.D Chair	The **Pharmacy Policy & Procedure Review 2023** grid was presented. With the implementation of Medi-Cal Rx, several policy changes were required: ➢ Eight policies were reviewed and remain in effect after Medi-Cal Rx implementation to address the medical benefit drugs. This included, for example, Program Metrics Review, Specialty Pharmacy Program, and Drug Utilization Review. o Policy (RX-001) had a reference deleted (RX-110) since it was retired due to MediCal Rx Program. ➢ Four policies (RX-104, 113,119 &129) were retired that are no longer pertinent due to the Carve-Out.	Motion: *Approve* - Pharmacy Policy Review 2023 (Verma/Lee) 5-0-0-1
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Attachments BB) **Action** Patrick Marabella, M.D Chair	The **Credentialing Sub-Committee Quarterly Report** was presented. The Credentialing Sub-Committee met on February 23, 2023. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. ➢ Reports covering Q3 were reviewed for delegated entities. ➢ Q4 reports were reviewed for MHN and Health Net. ➢ The 2023 Credentialing Sub-Committee annual policy and procedure review was completed with one retired policy, one new policy, and five policies updated with minor or no changes. The policies were revised as follows: o New policy CR-109 Ongoing Monitoring of Sanctions-Complaints was provided for committee review.	Motion: *Approve* - Credentialing Subcommittee Report (Ramirez/Lee) 5-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ The Appeals Process policy was revised to add a health and safety precautions statement to assure the comfort levels of all fair hearing participants. ○ Policy CR-190 Medi-Cal Termination Appeals Process was retired and combined into CR-140. ➢ There was one Adverse Action case for the Q4 Credentialing Report from Health Net.	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report (Attachments CC) **Action** Patrick Marabella, M.D Chair	**Peer Review Sub-Committee Quarterly Report** was presented. The Peer Review Sub-Committee met on February 23, 2023. ➢ The county-specific Peer Review Sub-Committee Summary Reports for Q4 were reviewed for approval. No significant cases to report. ➢ The 2023 Peer Review Sub-Committee annual policy and procedure review was completed with one policy reviewed without changes and one policy with more significant changes was provided to the committee to review. Both policies were approved. ➢ The Q4 Peer Count Report was presented at the meeting with a total of three cases reviewed. The outcomes for these cases are as follows: ○ Two cases closed and cleared. No cases pending closure for Corrective Action Plan compliance or cases with outstanding CAPs. ○ One case is pended for further information. ➢ Follow-up was initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue.	Motion: *Approve* - Peer Review Subcommittee Report (Cardona/Lee) 5-0-0-1
#9 **Compliance Update** - Compliance Regulatory Report (Attachment DD)	Mary Lourdes Leone presented the **Compliance Report.** **Oversight Audits.** The following annual audits are in-progress: Credentialing, Fraud, Waste & Abuse, and the Member Call Center. No oversight audits have been completed since the last Commission report. **Fraud, Waste, & Abuse Activity.** Since the last report, there have been two MC609 cases filed. One case was regarding a participating PCP who is routinely billing high-level Evaluation and Management (E/M) services at a rate that is significantly higher than peers. The other case was referred to the Plan by the California DOJ regarding a DME provider of pulmonary equipment. **2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit.** The Plan is still awaiting the DMHC's final determination on our 2021 CAP response. **Department of Health Care Services ("DHCS") 2023 Medical Audit - CAP.** On 1/3/23, the Plan received DHCS' written notice scheduling the Department's medical audit of the Plan for the week of April 17, 2023. The 2023 audit will also include two additional "focus audits", one related to	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Behavioral Health and the other to Transportation. The Plan submitted all Pre-Audit document requests on 3/3/23 and is currently responding to DHCS' requests for specific sample case files used in the Department's audit verification process. **Department of Health Care Services ("DHCS") 2022 Medical Audit.** The Plan received the DHCS' CAP request on November 30, 2022. The CAP identified three audit findings: two concerned lack the documentation related to the provision of blood lead screening of young children and one related to a lack of documentation of a Physician Certification Statement (PCS) form for a member's request for non-emergency medical transportation (NEMT). Based on the Plan's monthly submission of its CAP activities, the DHCS has accepted as completed the two associated with the blood lead screening. The Plan will continue to file a monthly report on the transportation findings until the DHCS accepts the Plan's actions as having been satisfactorily completed. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** The Plan is awaiting DMHC's Preliminary Report. **California Advancing and Innovating Medi-Cal (CalAIM).** On 2/15/23, the Plan submitted an updated Model of Care (MOC) to DHCS in preparation for the new ECM population of focus (POF) that goes live on 7/1/23, specifically Children and Youth. The Plan is awaiting DHCS approval of the MOC. **Member Handbook/Evidence of Coverage.** On 3/3/23, the Plan received DHCS' 2023 EOC Errata A which includes the following updates: • Language regarding the California Cancer Equity Act • The removal of the word "brief" under Cognitive health assessments The Plan is required to provide the Errata A to members electronically or by mail by May 1, 2023, and post a copy on its website no later than May 1, 2023. **DHCS 2024 Operational Readiness Work Plan & Contract.** The Plan has completed the monthly filings to DHCS of the various policies and other required documents through January 2023 and has received approvals on most but is still responding to additional DHCS information requests for some of the items. The Plan is on schedule to continue the required monthly filings through August 2023. **Public Policy Committee.** The Public Policy Committee last met on 3/1/23. The meeting was held at CalViva's Administrative Office location. The following reports were presented: the 2022 Health Education Executive Summary and Work Plan Mid-Year Evaluation; 2022 Health Equity Executive	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Summary and Work Plan Mid-Year Evaluation; 2022 Summary and Language Assistance Program Mid-Year Evaluation; the Quality Improvement and HEDIS Update MY 2021; and the Q3 Quarterly Grievance Report. There were no recommendations for referral to the Commission. The next meeting will be held on June 7, 2023, at 11:30 am in the Plan's Administrative Office.	
#10 **Old Business**	None.	
#11 **Announcements**	Next meeting May 18th, 2023	
#12 **Public Comment**	None.	
#13 **Adjourn**	Meeting was adjourned at 11:58 pm	

NEXT MEETING: May 18th, 2023

Submitted this Day: May 18 2023

Submitted by: Amy Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #4

Attachment 4.D

Public Policy Committee Minutes
dated 3/1/23

Public Policy Committee
Meeting Minutes
March 1, 2023

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
✓	Lisa Sanchez, Kings County Representative		**Staff Members**
✓	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations
✓	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, Senior Compliance & Privacy/Security Specialist
		✓	Maria Sanchez, Compliance Manager
			Patrick Marabella, MD, CMO
			Amy Schneider, RN, Director, Medical Management
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:33 am. A quorum was present.	A roll call was taken.
#2 Meeting Minutes from December 7, 2022 **Action** Joe Neves, Chair	The December 7, 2022, meeting minutes were reviewed.	**Motion:** Approve December 7, 2022, Minutes 8-0-0-1 (D. Phillips / J. Neves)

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#3 Enrollment Dashboard **Information** Maria Sanchez, Compliance Manager	Maria Sanchez presented the enrollment dashboard through December 2022. Membership as of December 31, 2022, was 418,051. CalViva Health maintains a 68.23% market share. It is anticipated that enrollment will decrease as the public health emergency ends. Moving forward the Default numbers, the County Share of Choice %, and the Voluntary Disenrollments numbers will no longer be available as the State has stopped providing that information. The State is working on an alternative way to provide Plans with this information in the future.	**No Motion**
#4 Annual Report **Information** Courtney Shapiro, Director, Community Relations & Marketing	The Annual Report is a mandated report and is for the benefit of stakeholders, community partners, and elected officials, and is posted on the CVH website for public viewing. Each PPC member was provided a hard copy of the annual report.	**No Motion**
#5 Committee Membership Update **Information** Courtney Shapiro, Director, Community Relations & Marketing	Public Policy Committee membership has been updated as follows: New members: Maria Arreola, At-Large member for a term of one year. Lisa Sanchez, Kings County, for a term of one year. Renewals: Kristi Hernandez moved from the At-Large position to a Fresno County position with a term of three years. Norma Mendoza, Madera County, was renewed for a three-year term. David Phillips, UHC representative, was renewed for a three-year term.	**No Motion**
#6 Appeals, Grievances and Complaints **Information**	For Q4 2022 there was 1 Coverage Dispute (Appeal), 82 Disputes Involving Medical Necessity (Appeals), 79 Quality of Care, 116 Access to Care, and 121 Quality of Service, for a total of 399 appeals and grievances. The total for calendar year 200 was 1,621 which was a decrease from calendar year 2021. The majority of which are from Fresno County.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Maria Sanchez, Compliance Manager	The turn-around time compliance for appeal and grievance cases was as follows: • Standard Grievances: 100% • Expedited Grievances: 100% • Standard Appeals: 100% • Expedited Appeals: 99% There was a total of 553 Exempt Grievances received in Q4 2022. Of the total grievances and appeals received in Q4, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 99 • Appeals: 4 • Exempt: 15 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 Administrative, Access-Other, and Transportation-Access. The majority of quality of care (QOC) grievance cases were categorized as PCP Delay, Specialist Care and PCP Care. The top categories of appeal cases were related to Advanced Imaging, Surgery, and Pharmacy.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	The top categories for exempt grievances were Health Plan Material-ID Cards Not Received, PCP Assignment/Transfer Health Plan Assignment Change Request, and PCP-HCO Assignment - Change Request.	
#7 Regulatory Audit Status • 2020 DHCS Audit Monthly CAP • 2022 DHCS Audit CAP • 2022 DMHC Audit **Information** Mary Lourdes Leone, Chief Compliance Officer	The 2020 DHCS Audit Monthly CAP was accepted and approved by DHCS in February 2022, however DHCS only notified the Plan in January 2023. The recently completed 2022 DHCS Audit CAP resulted in three findings; two of which had to do with blood-lead screening in children, and the third had to do with transportation. The Plan has submitted two monthly responses in reference to the CAP. The Plan will continue to submit monthly responses until DHCS confirms all findings have been addressed adequately. The 2022 DMHC Audit was completed in the Fall of 2022; the preliminary report of findings is pending.	
#8 Health Education **Information** Steven Si, Senior Compliance Privacy/Security Specialist	A total of 1,747 CalViva Health members participated in six-member incentive programs during Q3- Q4 2022. In total, $44,350.00 worth of gift cards; $1,260 equivalent value in bags of rice; and $665 worth in digital weight scales were given to CalViva Health members. Of the award recipients: 86% were from Fresno County, 8% from Kings County, 5% from Madera County, and for 1% the county was unknown. There was an increase in the percentage of total member incentive awards given of 66% (+612) for Q3-Q4 2022. Next steps include: • Breast Cancer Screening (BCS) PIP: Provider Engagement will continue with BCS events throughout 2023.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Strength Weaknesses, Opportunities, and Threats (SWOTs) process for Well-Child (W30) and Childhood Immunizations (CIS-10). • COVID-19 and CDC H-9: these two programs have been closed out. • Diabetes Prevention Program: currently searching for a new Diabetes Prevention vendor. • Child and Adolescent Well Care Visits (WCV): continue to focus on point (POC) of care incentives.	
#9 Annual Compliance Report **Information** Mary Lourdes Leone, Chief Compliance Officer	The Member Service Call Center received 110,473 calls, of which 109,176 were answered. Overall service level was 93%. The Member Service Call Center for Mental Health received 4,560 calls, of which 4,504 were answered. Overall service level was 88%. There were 2,768 welcome calls made to new members in 2022. The Provider Network remains stable. In 2022, contracted providers were sent approximately 214 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 17 informational letter templates for contracted providers and 5 forms intended for provider use. In 2022, 45 communications were reviewed by the Plan. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2022 Member Handbook/Evidence of Coverage (EOC) was made available to members by posting to the CalViva Health website for downloading.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	In 2022 the Plan completed eight (8) Delegation Oversight Audits for Health Net in the areas of Access & Availability, Claims, Continuity of Care, Provider Disputes, Utilization Management, Fraud, Waste & Abuse, Emergency Services, and Provider Network. Corrective action plans (CAPs) were required for two of the functional areas, Claims and Utilization Management. CAPS have been completed and approved for all categories. For calendar year 2022, the Plan had a total of 1,626 Grievances and Appeals, of which 1,637 were resolved with 99.88% turn-around-time. The number of cases resolved for Seniors & Persons with Disabilities (SPDs) was 474 with a 100% turn-around-time. The number of cases resolved for Exempt Grievances was 2,429 with a 100% turn-around-time. The 2022 Regulatory audits and Corrective Action Plans (CAPs) included: • 2020 DHCS Audit CAP • 2022 DHCS Audit • DHCS -2020-2021 EQR Performance Evaluation • DHCS 2022 Encounter Data Validation (EDV) Study • 2022 DHCS Annual Network Certification (ANC) • DHCS MOT Corrective Action Plan (CAP) • Measurement Year (MY) 2021 DMHC Timely Access Report (TAR) • March 2021 DMHC 18-Month Follow-Up Audit • September 2022 DMHC Triennial Audit • March 2022 DMHC Routine Financial Exam New or expanded benefits or programs consist of: • Enhanced Care Management (ECM) and Community Supports (CS) • Community Health Worker (CHW) Services • Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) • Long Term Care (LTC) • MMCE Phase II	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Doula Services • Cognitive Health Assessment • Medi-Cal Expansion In 2023, the Plan anticipates developing new policies and implementing/revising existing processes as a result of the initiatives described above, as well as new regulatory guidance and laws becoming effective in 2023. The Plan will continue its efforts to implement ECM/CS in Fresno, Kings and Madera counties by submitting updated Models of Care (MOCs) that include updated reports of new POFs transitioning into ECM and expanding provider capacity for CS. In 2023, the Compliance Program will also continue to focus on meeting the regulatory requirements associated with the upcoming execution of the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and implementing a Dual-Eligible Special Needs Program (D-SNP) in our service area. In 2023, CalViva will once again be audited by DHCS, and will continue to submit all required documentation in fulfillment of the Operational Readiness Contract. The Plan expects increased regulatory oversight and monitoring of health plan activities, in the following areas: • Provider network adequacy and certification requirements for direct and delegated networks • Timely Access • Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) • Behavioral Health • Encounter data quality and timeliness • Clinical Quality Improvement (MCAS measures) • Member Grievances/Appeals	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#10 2023 CalViva Health Member Handbook/Evidence of Coverage **Information** Mary Lourdes Leone, Chief Compliance Officer	The new CVH Member Handbook/Evidence of Coverage was posted to the CalViva Health website January 1, 2023. A printed format is available to members by request.	
#11 CalAIM Update – Enhanced Care Management, Community Supports Information Elizabeth Campos	DHCS has developed a multi-year initiative which is intended to improve the quality of life and health outcomes of our Medi-Cal population by implementing a broad delivery system program, and payment reform across Medi-Cal program. The two programs within CalAIM that support Medi-Cal members are Enhanced Care Management (ECM), and Community Supports (CS). ECM is a benefit and is intended to be rendered in person. The role of the ECM provider is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. The ECM core service components include: Comprehensive Assessment & Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member & Family Supports, and Coordination of Referral to Community & Social Support Services. Community Supports is medically appropriate and cost-effective alternatives to state plan services. These services provide considerable flexibility for plans to go beyond services defined in the Medicaid state plan to address social needs. Community Supports assists with things such as: housing navigation, housing deposits, housing tenancy & sustaining services, meals & medically tailored meals, asthma remediation, environmental accessibility, nursing facility transition/diversion to assisted living facilities, RCFE and ARF, community transition services/nursing facility transition to a home, day habilitation, personal care, respite, sobering centers, recuperative care, and short-term post hospitalization housing. Each program, ECM and CS, has a referral process which is made to educate members, refer members to the correct program, and connect them with a Provider.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#12 Promotores Health Network and Collaboration with Alzheimer's Association update **Information** Adela Corona	Adela Corona provided an in-depth update on community promotores activities.	
#13 Announcements	Jeff Nkansah, CEO for CalViva Health, reported the State is beginning to unwind flexibilities with regard to COVID-19 restrictions. Medi-Cal redeterminations will begin again in April and will be based on redetermination dates. The State is working to coordinate Medi-Cal Medicare dual eligibles; questions can be directed to Courtney Shapiro, Director of Community Relations & Marketing. Courtney Shapiro shared information in reference to CalViva's Youth Recreation Fund. There are funds available from the FY 2023 budget. Anyone interested can complete an application that is found on the CalViva Health website. CalViva will be participating in the backpack give away on August 5, 2023, at Grizzlies Stadium. David Phillips with United Health Centers (UHC) announced their new President/CEO, Justin Preas. UHC opened a new site in Visalia, and a new optometry center in downtown Fresno. UHC has six urgent care locations in Fresno, Mendota, and Kerman. Norma Mendoza announced the Health Fair in Mendota took place on February 23, 2023. There were 62 CalViva members in attendance.	
#14 Public Comment	None.	
#15 Adjourn	Meeting adjourned at 1:11 pm.	

NEXT MEETING **June 7, 2023, in Kings County**
11:30 am - 1:30 pm

Submitted This Day: June 7, 2023,

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

Approval Date: June 7, 2023

Approved By: _____
Joe Neves, Chairman

Item #4

Attachment 4.E

Finance Committee Charter

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
FINANCE COMMITTEE

I. Purpose

A. The purpose of the Finance Committee is to provide a committee structure to monitor and evaluate the financial status of the Fresno-Kings-Madera Regional Health Authority (RHA) from a regulatory compliance and general operating standpoint and to advise RHA on matters which are within the purview of the Finance Committee.

II. Authority

A. The Finance Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority (RHA) Commission in an advisory capacity.

III. Definitions

A. Fresno-Kings-Madera Regional Health Authority (RHA) Commission -
The Fresno-Kings-Madera Regional Health Authority (referred to as the RHA), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Responsibilities

A. The Commission's Finance Committee will discuss, advise and make recommendations to the Commission on the following areas:
1. Compliance with all financial statutory, regulatory, and industry standard requirements
2. Medi-Cal managed care rate and impact to the Regional Health Authority
3. Budgets prior to submission to the Commission
4. Unaudited financial statements prepared by staff
5. Compensation and benefit levels for staff
6. Selection of an independent auditing firm.

V. Committee Membership:

A. Composition
1. The RHA Commission Chairperson shall appoint the members of the Committee.
2. The Finance Committee shall consist of at least three (3) Commission members, the Chief Executive Officer, and the Chief Financial Officer.
    2.1. Chairperson: Chief Financial Officer.
    2.2. The Committee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership

1. Commissioner Committee members' terms will be established by the RHA Commission Chairperson on an annual basis at the start of each fiscal year.

C. Vacancies
1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
1. All members of the Committee shall have one vote each
2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings

A. Frequency
1. The frequency of the Finance Committee meeting will be at least quarterly
2. The Committee Chairperson or RHA Commission may call additional meetings as necessary
3. A quorum consists of at least 51% of the membership
4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Minutes
1. Minutes will be kept at every Finance Meeting by a designated staff member. Signed, dated, summary minutes are kept. Minutes are available for review by regulatory entities.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review.

C. Structure

The meeting agenda will consist of:
1. Approval of minutes
2. Standing Items
3. Activity Reports
4. Data Information Reports
5. Ad-hoc Items

VII. Committee Support

A. The Chief Financial Officer/staff will provide Committee support, coordinate activities and perform the following as needed:
1. Regularly attend meetings
2. Assist Chairperson with preparation of agenda and meeting documents
3. Perform or coordinate other meeting preparation arrangements
4. Prepare minutes

APPROVAL:

RHA Commission Chairperson  **Date:** ~~7/21/2022~~ 7/20/2023

David Hodge, MD
Commission Chairperson

Item #4

Attachment 4.F

Credentialing Committee Charter

Fresno-Kings-Madera Regional Health Authority
Credentialing Subc-Committee Charter

I. Purpose:

A. The purpose of the Credentialing ~~Sub-C~~Subcommittee is to give input on the credentialing and re-credentialing policies used by CalViva Health ("CalViva" or the "Plan") and its Operating Administrator (Health Net) and monitor delegated credentialing/recredentialing activities. Delegated entities performance and compliance with credentialing standards will be monitored and evaluated on an ongoing basis by CalViva's Chief Medical Officer ("CMO"), the Chief Compliance Officer ("CCO"), and CalViva's Credentialing ~~Sub-C~~Subcommittee.

II. Authority:

A. The Credentialing ~~Sub-C~~Subcommittee serves as a ~~sub-c~~Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Credentialing ~~Sub-C~~Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding credentialing and recredentialing, policies, processes, and standards.
B. Has final decision-making responsibility to monitor, sanction, suspend, terminate or deny practitioners or organizational providers.
C. Provide oversight of delegated credentialing and recredentialing functions.
D. Report sanctions for quality of care issues to the appropriate licensing authority including 805 reporting requirements.
E. Provide quarterly summary reports of Credentialing activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's credentialing and recredentialing criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
   1. The RHA Commission shall appoint the members of the ~~Sub-C~~Subcommittee.

2. The ~~Sub-C~~Subcommittee is chaired by the CalViva CMO.
3. ~~Sub-C~~Subcommittee size is determined by the Commission with the advice of the CMO.
4. The ~~Sub-C~~Subcommittee is composed of participating physicians including external participating practitioners who are also serving as members of the QI/UM Committee.
   a. ~~Sub-c~~Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
   b. Membership shall consist of primary care providers and specialists to reflect our provider network.
   d. The ~~Sub-C~~Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner ~~Sub-C~~Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of ~~Sub-C~~Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the ~~Sub-C~~Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the ~~Sub-C~~Subcommittee meetings will be at least quarterly.
   2. The ~~Sub-C~~Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the ~~Sub-C~~Subcommittee members.
   2. ~~Sub-C~~Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes

1. Minutes will be kept at every ~~Sub-C~~Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide ~~Sub-C~~Subcommittee support, coordinate activities, and perform the following as needed:

A. Regularly attend ~~Sub-C~~Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of ~~Sub-C~~Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157
4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)
5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Item #4

Attachment 4.G

Peer Review Committee Charter

Fresno-Kings-Madera Regional Health Authority
Peer Review Subc~~-C~~ommittee Charter

I. Purpose:

A. The ~~Sub-C~~Subcommittee processes and activities have been established to achieve an effective mechanism for the Plan's continuous review and evaluation of the quality of care delivered to its enrollees, including monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies by the development of corrective action plans, and initiating remedial actions and follow-up monitoring where necessary and appropriate. Through the Plan's peer review protected activities, the Plan aims to assure its enrollees receive acceptable standards of care and service.

B. To provide a peer review committee structure for the consideration of patterns of medically related grievances that the Chief Medical Officer (CMO) determines require investigation of specific participating providers and to provide peer review of practitioners or organizational providers experiencing problematic credentialing issues, performance issues or other special circumstances.

II. Authority:

A. The Peer Review ~~Sub-C~~Subcommittee serves as a ~~sub-c~~Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Peer Review ~~Sub-C~~Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding peer review policies, processes, and standards.
B. Reviews potential quality incidents referred by the QI/UM Committee that might involve the conduct or performance of specific practitioners or organizational providers and should be further investigated.
C. Report sanctions for quality-of-care issues to the appropriate licensing authority including 805 reporting requirements.
D. Establish and maintain a process for provider appeal of provider sanctions including a process of conducting fair hearings for providers who are sanctioned for issues related to quality of care.

E. Provide quarterly summary reports of Peer Review activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's peer review criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
   1. The RHA Commission shall appoint the members of the ~~Sub-C~~Subcommittee.
   2. The ~~Sub-C~~Subcommittee is chaired by the CalViva CMO.
   3. ~~Sub-C~~Subcommittee size is determined by the Commission with the advice of the CMO.
   4. The ~~Sub-C~~Subcommittee is composed of participating physicians including external participating providers who are also serving as members of the QI/UM Committee.
      a. ~~Sub-c~~Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      b. Membership shall consist of primary care providers and specialists to reflect our provider network.
      c. Participating Practitioners from other specialty areas shall be retained as necessary to provide peer review input.
      d. The ~~Sub-C~~Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner ~~Sub-C~~Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of ~~Sub-C~~Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the ~~Sub-C~~Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the ~~Sub-C~~Subcommittee meetings will be at least quarterly.
   2. The ~~Sub-C~~Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.

3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the ~~Sub-C~~Subcommittee members.
   2. ~~Sub-C~~Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every ~~Sub-C~~Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide ~~Sub-C~~Subcommittee support, coordinate activities and perform the following as needed:

A. Regularly attend ~~Sub-C~~Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of ~~Sub-C~~Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157

4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)
5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Item #4

Attachment 4.H

Quality Improvement /
Utilization Management Committee

Fresno-Kings-Madera Regional Health Authority
Quality Improvement/Utilization Management Committee Charter

I. Purpose:

A. The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, Health Equity, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

B. The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of delegated, nondelegated, and collaborative QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

II. Authority:

A. The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The QI/UM Committee's responsibilities include but are not limited to the following activities.

A. Review and recommend approval to the RHA Commission of the program documents listed below:
   1. Annual QI Program Description
   2. Annual QI Work Plan
   3. Annual QI Program Evaluation
   4. Annual UM Program Description
   5. Annual CM Program Description
   ~~5.~~6. Annual CM Program Evaluation
   ~~6.~~7. Annual UM/CM Work Plan
   ~~7.~~8. Annual UM/CM Program Evaluation;
   ~~8.~~9. Annual Health Education Program Description
   ~~9.~~10. Annual Health Education Work Plan
   ~~10.~~11. Annual Health Education Program Evaluation

~~11.~~12. Annual ~~Culture and Linguistics~~Health Equity ("HE~~C&L~~") Program Description
~~12.~~13. Annual ~~Culture and Linguistics~~Health Equity Work Plan
Annual ~~Culture and Linguistics~~ Health Equity Program Evaluation
~~13. Population Health Management Program~~

14.

B. Reviews quarterly reports of Work Plan progress for the programs listed above;
C. Monitors key clinical and service performance indicators for QI, UM, HE and Credentialing/Recredentialing activities (e.g., access & availability, over and under utilization, key UM and case management indicators, behavioral health, population health, appeals and grievances, HEDIS® and CAHPS® measure results, provider satisfaction surveys, disease management and public health programs activities, timeliness standards etc.);
D. Analyze and evaluate the results of QI and Health Equity activities;
~~C.~~E. Monitor effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social determinants of health (SDoH), and community needs and makes ongoing recommendations;
~~D.~~F. Provide oversight and review reports of delegated UM and Credentialing/ Recredentialing functions and collaborative QI functions;
~~E.~~G. Reviews summarized grievance reports for medically related issues and administrative quality concerns;
~~F.~~H. Reviews analysis of potential quality incident reports (developed from grievances/complaints, utilization management, utilization reports suggesting over or under utilization);
~~G.~~I. Oversees and monitors CalViva's participation in the Department of Health Care Services ("DHCS") required Quality Improvement Projects ("QIPs");
~~H.~~J. Approve and oversee conduct of special QI studies as warranted;
I. Brings general medically-related concerns to the attention of the Plan's Operating Administrator (Health Net);
J. Advises on the conduct of provider and member satisfaction surveys and submits its review to the Commission;
K. Reviews the results of clinical outcome studies, identifies gaps and reports findings to the Commission;
L. Forwards to the Credentialing /Peer Review Sub-Committee potential quality incidents that might involve the conduct of specific providers and should be further investigated;
M. Receives reports from the Credentialing/Peer Review Sub-Committee;
N. Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission.
O. Ensure that the Plan is in compliance with state, federal, ~~nd~~ contractual and NCQA requirements for QI, UM, HE and Credentialing.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Committee is chaired by the CalViva Chief Medical Officer ("CMO").
   3. Committee size is determined by the RHA Commission with the advice of the CMO.
   4. The QI/UM Committee will be composed of:
      4.1. Participating health care providers, including external participating physicians, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network.
      4.2. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners.
      4.3. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      4.4. Participating Practitioners from other specialty areas shall be retained as necessary to provide specialty input.
      4.5. For purpose of meeting a quorum, the RHA Commission Chair may appoint an alternate member, who is also a provider member of the RHA Commission, to serve as a voting member of the committee.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Committee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
   1. All members of the Committee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the QI/UM Committee meetings will be at least quarterly.
   2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.
   4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Notice

1. The meeting date will be determined by the Chairperson with the consensus of the Committee members.
2. Committee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
1. Minutes will be kept at every Committee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the Committee's recommendations.

VII. ~~VII.~~ Committee Support:
~~VII. Subcommittees and Reporting Committees~~

The Plan Medical Management department staff will provide Committee support, coordinate activities and perform the following as needed:
A. Regularly attend Committee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and improvement discussions,
E. Ensure a quarterly summary of Committee activity and Committee recommendations is prepared for submission to the RHA Commission.

VIII. ~~VIII.~~ Subcommittees and Work Groups reporting to QI/UM:

A. ~~A.~~ QI/UM ~~-~~Committee has two ~~four~~ Ssubcommittees and three work groups:
1. ~~1.~~ Credentials Sub-Committee and Peer Review Sub Committee each with own charter
~~1.~~ ~~2.~~ QI/UM Operational Work Group consists of CalViva and Health Net staff/leadership. The QI /UM Operational Work Group has one sub group:
2.
- Appeals and Grievances Work Group consists of CalViva~~CVH~~ and Health Net~~N~~ staff ~~-~~to review, track, trend appeals and grievances and reports to QI/UM Operational Work Group

~~3.~~ Access Work Group reports information reviewed by CalViva~~CVH~~ and Health Net~~N~~ staff regarding access and availability of services to QI/UM Committee
3.

~~The QI /UM Operational Work group has one subcommittee :~~
~~1. Appeals and Grievances Work Group with CVH and HN staff to review, track, trend AG and reports to QI/UM Operational WG~~

~~VIII~~ IX. Authority

A. Health & Safety Code Sections 1370, 1370.1
B. California Code of Regulations, Title 28, Rule 1300.70
C. DHCS Contract, Exhibit A, Attachments 4 and 5
D. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Item #4

Attachment 4.I

Public Policy Committee Charter

Fresno-Kings-Madera Regional Health Authority
Public Policy Committee Charter

I. Purpose:

A. The purpose of the Public Policy Committee is to provide a committee structure for the consideration and formulation of CalViva Health ("CalViva" or the "Plan") policy on issues affecting members. Subscribers and enrollees shall be afforded an opportunity to participate in establishing the public policy of the Plan.

II. Authority:

A. The Public Policy Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission. This authority is described in the RHA Bylaws.

III. Definitions:

A. **Public Policy** means acts performed by the Plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the Plan's facilities to provide health care services to them, their families, and the public. (Rule 1300.69)

B. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health.
   1. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. On April 15, 2010, the RHA Commission adopted the name "CalViva Health" under which it will also do business.

IV. Committee Focus:

A. The Public Policy Committee's recommendations and reports will be regularly and timely reported to the Commission. The Commission shall act upon these reports and recommendations and the action taken by the Commission will be recorded in the minutes of the Commission's meetings.
B. Principal Responsibilities:
   1. Review a quarterly summary report regarding the specific nature and volume of complaints received through the grievance process and how those complaints were resolved
   2. Make recommendations concerning the structure and operation of the Plan's grievance process including suggestions to assist the Plan in ensuring its' grievance process addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities.
   3. Review and evaluate member satisfaction data
   4. Advise on health education and cultural and linguistic service needs through review of a population needs assessment, demographic, linguistic, and cultural information related to the Plan's population in order to make recommendations regarding:

4.1. Linguistic needs of populations served and identify any enhancements or alternate formats that Plan materials may need.
4.2. Policies needed for increasing member access to services where there may be barriers resulting from cultural or linguistic factors.
4.3. Changes needed to the provider network to accommodate cultural, linguistic, or other ethnic preferences.
4.4. Improvement opportunities addressing member health status and behaviors, member health education, health disparities and gaps in services.

5. Advise on problems related to the availability and accessibility of services
   5.1. Review data/other Plan information and make recommendations for policy or Plan/provider network changes needed related to Americans with Disabilities Act (ADA) requirements or to minimize barriers and increase access for members with disabilities (e.g. identifying potential outreach activities, etc.).
6. Review member literature and other plan materials sent to members and advise on the effectiveness of the presentation.
7. Make recommendations or suggestions for member outreach activities, topics or articles/information for publication on the member website, in member education materials or newsletters, etc.
8. Recommend review/revision and/or development of policies and procedures to the RHA Commission or other Plan committees as appropriate based on the Committee's review of grievance, member satisfaction, and other Plan data.
9. Review financial information pertinent to developing the public policy of the Plan.
10. Other matters pertinent to developing the public policy of the Plan.

V. Committee Membership:

A. Composition

The RHA Commission Chairperson shall appoint the members of the Committee. The Public Policy Committee shall consist of not less than seven (7) members, who shall be appointed as follows:

1. One member of the RHA Commission who will serve as Chairperson of the Committee;
2. One member who is a provider of health care services under contract with the Plan; and
3. All others shall be members (must make-up at least 51% of the committee members) entitled to health care services from the Plan.
   3.1. Public Policy enrollee members shall be comprised of the following:
      3.1.1. Two (2) enrollees from Fresno County
      3.1.2. One (1) enrollee from Kings County
      3.1.3. One (1) enrollee from Madera County
      3.1.4. One (1) At-Large enrollee from either Fresno, Kings, or Madera County

3.2. Two (2) Community Based Organizations (CBO) representatives shall be appointed as alternate Public Policy Committee members to attend and participate in meetings of the Committee in the event of a vacancy or absence of any of the members appointed as provided in subsection 3.1 above.

3.2.1. The alternates shall represent different Community Based Organizations (CBO) that serve Fresno, Kings, and/or Madera Counties and provide community service or support services to members entitled to health care services from the Plan.

3.2.2 Two (2) alternates from the same CBO shall not be appointed to serve concurrent terms.

3.3. The enrollee members and CBO representatives shall be persons who are not employees of the Plan, providers of health care services, subcontractors to the Plan or contract brokers, or persons financially interested in the Plan.

3.4. In selecting the enrollee members and/or CBO representatives of the Committee, the RHA Commission Chairperson shall generally consider the makeup of the Plan's Medi-Cal enrollee population including Seniors and Persons with Disabilities (SPD), and such factors such as ethnicity, demography, occupation, and geography. Any such selection or election of enrollee members or a CBO representative shall be conducted on a fair and reasonable basis.

B. Term of Committee Membership
1. The Commissioner member may be appointed for a three (3) year term and his/her term will be coterminous with their seat on the Commission.
2. The provider member may be appointed for a three (3) year term.
3. Subscriber/enrollee members' and CBO representative terms shall be of reasonable length (one, two, or three years) and shall be staggered or overlapped so as to provide continuity and experience in representation.
4. At the conclusion of any term, a Committee member may be reappointed to a subsequent three-year term.

C. Vacancies
1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
1. All members of the Committee shall have one vote each.
2. When attending a meeting in place of a regular member, an alternate member shall be entitled to participate in the same manner and under the same standards as a regular member, to the extent that the alternate member is not otherwise disqualified from participating in discussion and voting on an item due to a conflict of interest.

VI. Meetings:

A. Frequency
   1. The frequency of the Public Policy Committee meetings will be quarterly.
   2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership
   4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Place of Meetings
   1. The Committee Chairperson will determine the place of the Committee meetings.

C. Notice
   1. At the end of each Public Policy Committee meeting, the next meeting date will be determined by consensus unless a pre-arranged schedule has been established.
   2. Committee members will be notified in writing in advance of the next scheduled meeting.

D. Minutes
   1. Minutes will be kept at every Public Policy Committee meeting by a designated staff member.
   2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the Committee's recommendations.

VII. Committee Support:

A. The Plan Director of Community Relations and designated Plan staff will provide Committee support, coordinate activities and perform the following as needed:
   1. Regularly attend Public Policy meetings.
   2. Prepare agenda and meeting documents.
   3. Perform or coordinate other meeting preparation arrangements.
   4. Prepare minutes and capture specific "suggestions or recommendations" for reporting to the RHA Commission and Quality Improvement/Utilization Management Committee.
   5. Initiate and follow-up on action items and suggestions until completed and ensure that feedback is provided to the Committee to "close the loop".
   6. Compliance staff will include a summary of Public Policy Committee activity and Committee recommendations in Compliance Reports to the RHA Commission.
   7. Submit Public Policy Committee meeting minutes to the RHA Commission.

VIII. Other Requirements:

1. The Plan's Evidence of Coverage (EOC) includes a description of its system for member participation in establishing public policy.
2. The Plan will also furnish an annual EOC to its members with a description of its system for their participation in establishing public policy and will communicate material changes affecting public policy to members.

IX. Authority

1. Health & Safety Code Section 1369
2. California Code of Regulations, Title 28, Rule 1300.69
3. RHA Bylaws

APPROVAL:

RHA Commission Chairperson David S. Hodge ~~9/15/2022~~

Date:

: David Hodge, MD

~~6/1/22~~

Item #6

Attachment 6.A

Review of Fiscal Year End 2023 Goals

BL 23-006

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

Phone: 559-540-7840
Fax: 559-446-1990
www.calvivahealth.org

DATE: July 20, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Review of Goals and Objectives for Fiscal Year End 2022

BL #: 23-006

Agenda Item 6

Attachment 6.A

DISCUSSION:

Category	Goal	Review
Market Share	Maintain market share	Market share continues to be impacted by the "Default Formula" adopted and applied for this period and freeze in Medi-Cal disenrollment(s) due to the COVID-19 Public Health Emergency.
Medical Management / Quality Improvement	Continue the Childhood Immunization PIP with special immunization events, as well as continuing the Disparity PIP for Breast Cancer Screening in Southeast Asian women with testimonial videos and mobile mammography events.	Successfully completed both the Childhood Immunization PIP and the Breast Cancer Screening Disparity PIP and submitted to DHCS and HSAG.
Funding of Community Support Program	Administer the Community Investment Funding Program	13 Provider recruitment grants awarded with 11 Providers recruited.
Tangible Net Equity (TNE)	Continue to meet DMHC minimum TNE requirements meanwhile continuing to provide grants to the community which helps improve access and quality health care.	Met DMHC TNE requirements and provided various grants to the community in which we operate.
Direct Contracting	Maintain current direct contracts to align with TNE requirements	Maintained current direct contracts.
Community Outreach	Continue to participate in local community initiatives.	Participated in Cradle to Career, See 2 Succeed Vision Program, Fresno Community Health Improvement Partnerships (FCHIP), The Children's Movement of Fresno (TCM Fresno), Group Prenatal Care Embrace, Back 2 School Backpack event, Reading Heart Advisory Group, Help Me Grow, Coalition for Digital Health, and 150+ CBO Sponsorships.
State and Federal Advocacy	Continue to advocate Local Initiative Plan interest.	Continued as a Local Health Plan Association and Mid State MGMA Board Member.
2024 Medi-Cal Contract Readiness	Initiate and complete activities for Operational Readiness to be compliant with DHCS contractual requirements effective January 1, 2024	All 2024 Medi-Cal Contract Readiness deliverables were successfully submitted per the Department of Health Care Services' schedule and remain on track for final approval by September 2023.
Health Plan Accreditation	Initiate activities to achieve NCQA Health Plan Accreditation by 2025 and NCQA Health Equity Accreditation by 2026	Survey for NCQA Health Plan Accreditation will begin with submission of the organization's survey tool scheduled for Tuesday, May 7, 2024.

Item #7

Attachment 7.A

Fiscal Year 2024 Goals & Objectives

BL 23-007

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

Phone: 559-540-7840
Fax: 559-446-1990
www.calvivahealth.org

DATE: July 20, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Goals and Objectives for Fiscal Year 2024

BL #: BL 23-007
Agenda Item 7
Attachment 7.A

DISCUSSION:

Category:	Goal:
Market Share	Maintain market share
Medical Management / Quality Improvement	Initiate a SWOT project to improve (1)Well Child Visits by converting sick visits to well visits and (2)Childhood Immunizations in Fresno County by working with hospitals to get new born immunization data. Also complete planning and initiate a Clinical PIP to improve Well Child Visits and Nonclinical PIP to improve Follow up visits for Substance Abuse and Mental Health visits to the ER.
Funding of Community Support Program	Administer the Community Investment Funding Program
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirements.
Direct Contracting	Maintain current direct contracts to align with TNE requirements
Community Outreach	Continue to participate in local community initiatives.
State and Federal Advocacy	Continue to advocate Local Initiative Plan interest.
2024 Medi-Cal Contract Readiness	Obtain the Department of Health Care Services' approval of all Contract Readiness deliverables and execute the Contract by December 31, 2023.
Health Plan Accreditation	Maintain activities to achieve NCQA Health Plan Accreditation by 2025 and NCQA Health Equity Accreditation by 2026.
Diversity, Equity, and Inclusion	Promote diversity in recruiting and hiring. Offers training to employees on cultural competency, bias or inclusion.

Item #8

Attachment 8.A

Quality Improvement
HEDIS® MY 2022

MY 2022 HEDIS® Results

CalViva Health RHA Commission and
QI/UM Committee Meetings
July 20th, 2023

MPL = Minimum Performance Level(50th percentile)
HPL = HIGH Performance Level (90th percentile)

RY 2019-2023 HEDIS Results - CalViva Health

	Acronym	Type	HEDIS Measure	Measure Status	Fresno					Kings					Madera					MPL	HPL
					2023	2022	2021	2020	2019	2023	2022	2021	2020	2019	2023	2022	2021	2020	2019	2023	2023
1	BCS	A	Breast Cancer Screening	Existing	52.14	49.11	52.64	55.26	51.12	58.61	56.64	58.24	57.30	56.21	61.03	56.63	59.15	62.44	58.05	50.95	61.27
2	CCS	H	Cervical Cancer Screening	Existing	57.08	63.04	60.16	63.50	59.57	58.95	64.17	68.39	70.07	*84.54*	61.58	64.42	66.49	*65.21*	*63.40*	57.64	66.88
3	CHL	A	Chlamdyia Screening	Existing	58.86	59.88	57.81	61.26	N/A	62.15	55.98	59.85	64.48	N/A	59.38	63.15	52.85	*55.42*	N/A	55.32	67.84
4	CIS-10	H	Childhood Immz - Combo 10	Existing	27.49	35.04	32.12	33.82	N/A	23.84	31.87	29.93	33.09	N/A	48.42	49.64	50.37	*46.96*	N/A	34.79	49.76
5	FUM	A	Follow-Up After ED Visit for Mental Health Illness-30 days	New	25.47	N/A	N/A	N/A	N/A	70.07	N/A	N/A	N/A	N/A	52.00	N/A	N/A	N/A	N/A	54.51	70.01
6	FUA	A	Follow-Up After ED Visit for Substance Abuse-30 days	New	18.48	N/A	N/A	N/A	N/A	31.79	N/A	N/A	N/A	N/A	18.32	N/A	N/A	N/A	N/A	21.24	32.38
7	HBD	H	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	New	37.47	N/A	N/A	N/A	N/A	30.05	N/A	N/A	N/A	N/A	35.93	N/A	N/A	N/A	N/A	39.90	30.90
8	CBP	H	Controlling High Blood Pressure	Existing	61.73	56.83	52.07	62.03	60.34	71.81	65.10	63.99	64.43	72.37	67.49	67.29	65.21	69.77	69.10	59.85	69.19
9	IMA-2	H	Immunizations for Adolescents: Combination 2	Existing	39.17	37.23	43.55	38.69	38.69	29.68	32.66	29.44	35.04	30.58	53.00	50.49	53.06	54.88	53.55	35.04	48.42
10	LSC	H	Lead Screening in Children	New	49.88	N/A	N/A	N/A	N/A	53.77	N/A	N/A	N/A	N/A	66.42	N/A	N/A	N/A	N/A	63.99	79.57
11	PPC-Pre	H	Prenatal Care	Existing	89.62	86.11	89.05	92.21	85.56	87.76	91.70	91.24	95.38	62.89	90.37	88.15	92.21	91.48	85.94	85.40	91.89
12	PPC-Pst	H	Postpartum Care	Existing	84.23	81.60	78.35	78.83	70.83	84.18	87.34	84.67	86.13	73.68	87.04	80.00	80.29	81.51	63.54	77.37	84.18
13	WCV	A	Child and Adolescent Well-Care Visits	Existing	48.14	46.30	47.00	N/A	N/A	39.56	38.80	37.00	N/A	N/A	57.71	55.20	52.00	N/A	N/A	48.93	62.70
14	W30-6+	A	Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visits	New	50.01	48.80	N/A	N/A	N/A	53.48	55.56	N/A	N/A	N/A	56.71	65.06	N/A	N/A	N/A	55.72	67.56
15	W30-2+	A	Well-Chid visits for age 15 Months to 30 Months- Two or more Well-Child Visits	New	62.69	61.86	N/A	N/A	N/A	55.59	54.43	N/A	N/A	N/A	75.65	73.23	N/A	N/A	N/A	65.83	78.07

LEGEND	
YELLOW	Result below DHCS MPL for that RY (IP)
GREEN	Result above DHCS HPL for that RY
ITALICS	DHCS not holding plans to MPL for this measure in RY2015
*	Denominator fewer than 30
N/A	No Rate available (not reported)

Upcoming and Retired Measures			
Acronym	Type	HEDIS Measure	Measure Status
AMR	A	Asthma Medication Ratio	Upcoming
TFL-CH	A	Topical Fluoride for Children	Upcoming
DEV	A	Developmental Screening in the First Three Years of Life	Upcoming
CDC-H9	H	HbA1c Poor Control (>9.0%)	Retired
WCC-BMI	H	Weight Assessment and Counseling - BMI Percentile	Retired
WCC-N	H	Counseling for Nutrition	Retired
WCC-PA	H	Counseling for Physical Activity	Retired
W15	H	Well-Child Visits in the First 15 Months of Life	Retired
W34	H	Well Child Visits in 3-6th Years of Life	Retired
AWC	H	Adolecent Well-Care Visits	Retired

- Overall, 64% (29/45) of measures met or exceeded the MPL
- Six (6) of 45 (13%) at the HPL
- Sixteen (16) of 45 (36%) missed the MPL.

Discussion & Questions

Item #9
Attachment 9.A

Case Management
2022 Program Evaluation
& Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Carrie-Lee Patnaude, Director Care Management

COMMITTEE DATE: July 20, 2023

SUBJECT: CalViva Care Management Program Evaluation 2022 Executive Summary

Summary:

Care Management (CM) processes have been consistent, and evaluation/monitoring of CM metrics continue to be a priority. Case Management monitors the effectiveness of programs in order to better serve our members. We maintained above 90% on our Satisfaction Surveys and in our quality audits. We increased the amount of members managed in our CM programs in 2022 and outcomes showed decrease in readmissions and ED use, and greater adherence to Prenatal and Postpartum visits in the perinatal care management program. What we aim to improve on in 2023, besides supporting CalAIM activities, is to Regionalize Care Management program and staff to better support member needs.

Purpose of Activity:

CalViva Health has delegated responsibilities for care management (CM) activities to Health Net Community Solutions. CalViva Health's CM activities are handled by qualified staff in Health Net's State Health Program (SHP) division.

The Care Management Program is designed for all CalViva Health members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely and effective manner.
CalViva Medical Management staff maintains clinical oversight of services provided through review/discussion of routine reports and regular oversight audits.

The 2022 CM Program Evaluation encompasses a review of care management programs through the documentation of current and future strategic initiatives and goals. The evaluation tracks key performance metrics and provides for an assessment of our progress and identifies critical barriers.

Analysis/Findings/Outcomes:

I. Cases Managed

The goal to increase cases managed in 2022 over 2021 was met. Overall, 1.04% of the total population was managed in 2022 amongst physical health and behavioral health CM and the perinatal CM program. The average population of members in 2022 was 419,272. The overall percentage of population managed in Physical Health CM was 0.64%. Behavioral Health demonstrated 0.19%. The population managed in Perinatal CM was 0.21%.

II. Monitoring audits for compliance with regulatory standards

The Plan completed file reviews and audits as planned in 2022. As a result, it was identified that each program met the goal of 90% or greater audit scores in 2022. Additional training and individual coaching were completed in 2022 for staff with below goal scores.

III. Care Management Outcomes

a. Physical Health and Behavioral Health Outcomes

Measures of effectiveness for care management are evaluated using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM. Measures of effectiveness include the following indicators: Readmission rates; Ed Utilization' Overall health care costs.

Claims data demonstrated a reduction in readmissions for the care managed members, 3.8% decrease (pre 42.5% vs post 38.7%) in readmission rate based on claims. There was also a reduction in ED utilization for this population by 204 ED visits and a reduction of 534 ED visits per 1,000 members per year. Comparing health care costs demonstrated a reduction in inpatient claims of 584, a decrease of 5,220 for outpatient services, and a 392 increase for pharmacy.

b. Perinatal Outcomes

The Perinatal CM program was evaluated based on the member's compliance with completing their first prenatal visit within the first trimester and their post-partum visit. In addition, the rate of pre-term delivery of high-risk members managed was evaluated.

Members in the Perinatal CM program demonstrated a 3.9% percentage increase in compliance with completing the first prenatal visit in their first trimester and a 9.5% percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program. There were 2.1% fewer pre-term deliveries for high-risk members managed than high-risk members not managed.

IV. Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. The goal for member satisfaction is > than 90%. All survey questions had responses scoring over 90%.

There were no grievances related to care management in 2022. The goal for member complaints/grievances < 1/10,000 members was met.

V. Summary and Priorities

In 2022, the key accomplishments for CM were:

- Continued COVID-19 outreach activities.
- Successful coordination for CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Successful transition of Rx carve out to the State and use of Magellan's Rx system.
- Filled open CM positions.

What we are trying to accomplish next year:

- Increase caseload per CM to align with goals.
- Support CalAIM activities, prepared for additional Populations of Focus.
- Support CalAIM Community Supports programs and increased offerings.
- Manage more members across CM programs.
- Enhance Transitional Care Management program in preparation for the DHCS PHM Roadmap.
- Regionalize Care Management program and staff to better support member needs.

Care Management Program Evaluation 2022

Table of Contents

Care Management Program Evaluation - 2022

I. Overview

Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. Health Net is a managed care organization. Health Net attained NCQA accreditation in 2019; demonstrating the Plan's commitment to excellence.

Health Net provides Care Management to CalViva members. Care Management services were available for over 417,634 assigned CalViva members in Fresno, Kings, and Madera counties in 2022.

In 2022, our focus was on strategic initiatives and Population Health Management activities, while continuing to further relationships across departments and with community partners. CalViva continued to support our members, providers, community partners, and associates in the response to the COVID-19 pandemic. Activities included associates continuing to work from home, expansion of telehealth services, webinars for our providers, member outreach, and education.

CalViva Health is dedicated to improving access to care and providing quality health care to families in the Fresno, Kings, and Madera County area. We provide the right care at the right place and the right time.

Beliefs

- "We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities."

Purpose of Self-Assessment

The purpose of the self-assessment is to provide information about our Care Management (CM) Program and evaluate the effectiveness of the program. Performance is measured against internal and established external standards of care. This self-assessment is reflective of 2022 and findings were used to establish goals for 2023.

II. Program Infrastructure and Evaluation

Medical Management Committees

Oversight and operating authority of CM activities is delegated to CalViva's Quality Improvement Utilization Management Committee (QIUM) and ultimately to the CalViva's

Commissioners. The annual review and revision of the CM Program Description and the annual CM Program Evaluation are presented to the QIUM Committee for review and approval.

Care Management Program

The CM Program is a collaborative process of assessment, planning, coordinating, monitoring, and evaluation of the services required to meet an individual's needs. Care Management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of CM is the provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. The care manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner. In order to optimize the outcome for all concerned, CM services are best offered in a climate that allows direct communication between the Care Manager, the member (or designated representative), and appropriate service personnel. This communication focuses on maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. Coordination of care and services is a key function of CM across the continuum, including acute, chronic, complex, and special needs cases.

Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The care manager must ensure appropriate referrals are made for the member to the appropriate provider or community resource, even if these services are outside of the required core benefits of the health plan. The care manager shall ensure each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable. The Plan shall ensure each member's privacy is protected during all communications with external parties. Transfer of protected health information (PHI) will be conducted by phone, secure fax or secure email in order to ensure maintenance of member privacy at all times with only the minimal necessary information being shared.

Behavioral Health (BH) Program

When a member has behavioral health needs that fall into the mild to moderate service category (as identified by state criteria All Plan Letter 13-021) the plan manages the ongoing care and coordination of services. If a member has behavioral health care needs that requires more intensive treatment, and meets specialty mental health criteria, the plan works jointly with the local county behavioral health department to facilitate a referral and works together to ensure continuity of care for the shared member.

Members who have co-morbid conditions requiring coordination of care to manage both behavioral health and physical health issues are provided integrated care services. In these

instances, a physical health and a behavioral health professional work together to jointly develop a single plan of care that addresses the full needs of the individual.

During 2022, meetings were held with all 3 county mental health plans to discuss collaboration and coordination of care. Each of the 3 county mental health plans were informed of the services available to CalViva Helath members including care management, transportation, and how to access Member Services. During these outreach visits, data-sharing and collaboration plans were presented to promote coordination between mild-moderate and severe members. As a result, data sharing plans are in place with all 3 county mental health plans to ensure a warm transfer between shared members and to reduce challenges or barriers in obtaining appropriate behavioral health services.

Continued participation in this process strengthened relationships and provided opportunity to maintain current points of contact with the intent to facilitate access to appropriate levels of service. Of major importance was maintaining the standards regarding releases of information and data collection that protect the rights of the members under HIPAA guidelines and provides the information required for continuity and quality of care that was developed in prior years. Through the application of clinical and financial information the plan will be able to move forward collaboratively with other agencies to target specific interventions for the members and decrease duplication of services and enhance overall service provision to members. The shared communication among plan partners enables us to advance population health and better trend the needs of the population cross service type.

Care Management Referrals

Members for CM were identified through a variety of sources including the concurrent review process, reports such as the Notification of Pregnancy, Health Risk Screening, Sickle Cell, High Dollar, Pharmacy, Impact Pro, and Population Health Management, as well as providers and preferred provider group (PPG), county entities, and member self-referrals. Overall, the volume of referrals for 2022 was 4,657 for CM programs. The volume of referrals for physical health demonstrated an average of 150 per month for the entire year. The volume of referrals to behavioral health averaged 97 per month for the year and 152 per month for the Perinatal Care Management program. Care management cases requiring clinical expertise were managed by licensed care managers and cases only requiring assistance with psychosocial needs such as housing, finance, and other resources were managed by program specialists with social work experience.

The data for the Care Management program is divided into three categories: Physical Health, Behavioral Health, and Perinatal Care Management.

Physical Health

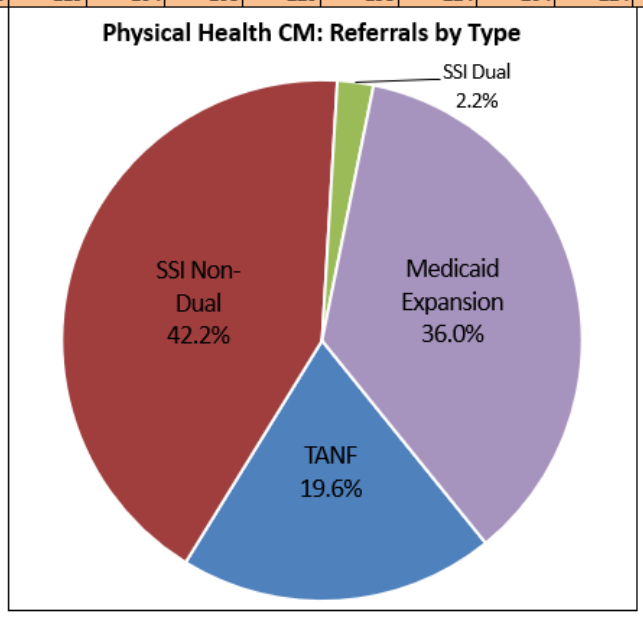
- Referrals by Type:
  - Total number of referrals for 2022 was 1,1962.
  - 44.4 % for Seniors and Persons with Disabilities (SPD) dual and non-dual members.

- 36 % of the members referred were Medi-Cal Expansion.
- 19.6 % of the members referred were TANF.

Table A. Physical Health CM Referrals by Type

CAL VIVA Physical Health Care Management Referrals By Type: 1/1/2022 - 12/31/2022

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	11	18	22	26	28	41	32	42	49	54	30	32	**385**
SSI Non-Dual	51	38	52	66	60	100	93	104	63	73	58	69	**827**
SSI Dual	2	4	6	5	3	6	5	3	5	4	0	1	**44**
Medicaid Expansion	25	26	39	37	47	76	68	75	87	93	72	61	**706**
TOTAL REFERRALS	**89**	**86**	**119**	**134**	**138**	**223**	**198**	**224**	**204**	**224**	**160**	**163**	**1,962**

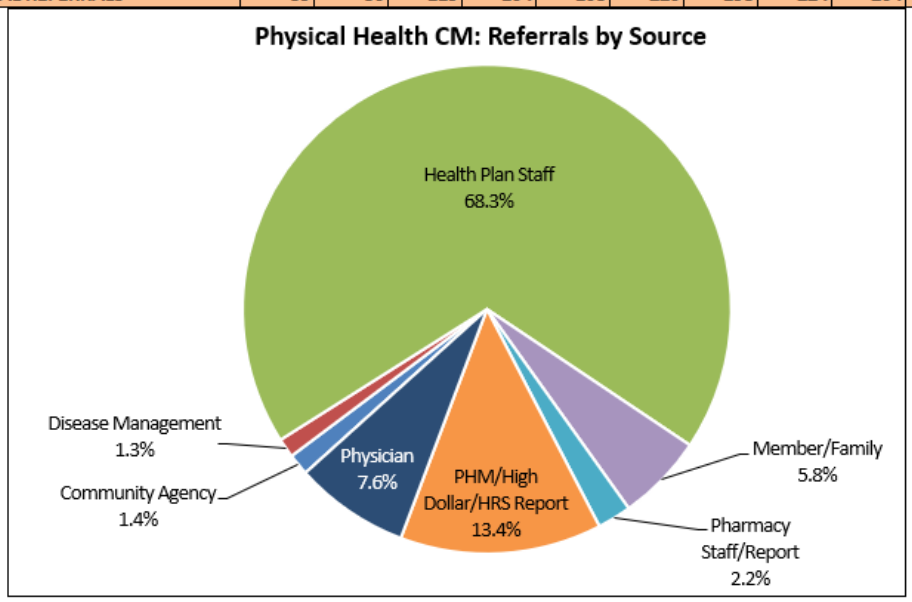


- Referral sources:
  - 68.3% of referrals came from within the Health Plan.
  - 13.4 Reports/PHM/HRS.
  - 7.6% Physician.
  - 5.8% Member and Family.
  - 2.2% Pharmacy.
  - The remainder of physical health referrals were from a variety of sources – Disease Management and Community Agencies.

Table B. Physical Health CM Referrals by Source

CAL VIVA Physical Health Care Management Referrals By Source: 1/1/2022 - 12/31/2022

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	1	1	7	2	1	0	1	3	0	4	3	5	**28**
Disease Management	1	3	1	2	3	4	3	2	3	0	2	1	**25**
Health Plan Staff	49	56	72	91	91	143	116	135	153	188	129	118	**1,341**
Member/Family	9	8	12	12	6	13	15	8	9	12	2	7	**113**
Pharmacy Staff/Report	5	1	1	2	14	9	2	4	4	1	1	0	**44**
PHM/High Dollar/HRS Report	12	8	16	4	14	35	49	50	21	11	17	25	**262**
Physician	12	9	10	21	9	19	12	22	14	8	6	7	**149**
TOTAL REFERRALS	**89**	**86**	**119**	**134**	**138**	**223**	**198**	**224**	**204**	**224**	**160**	**163**	**1,962**



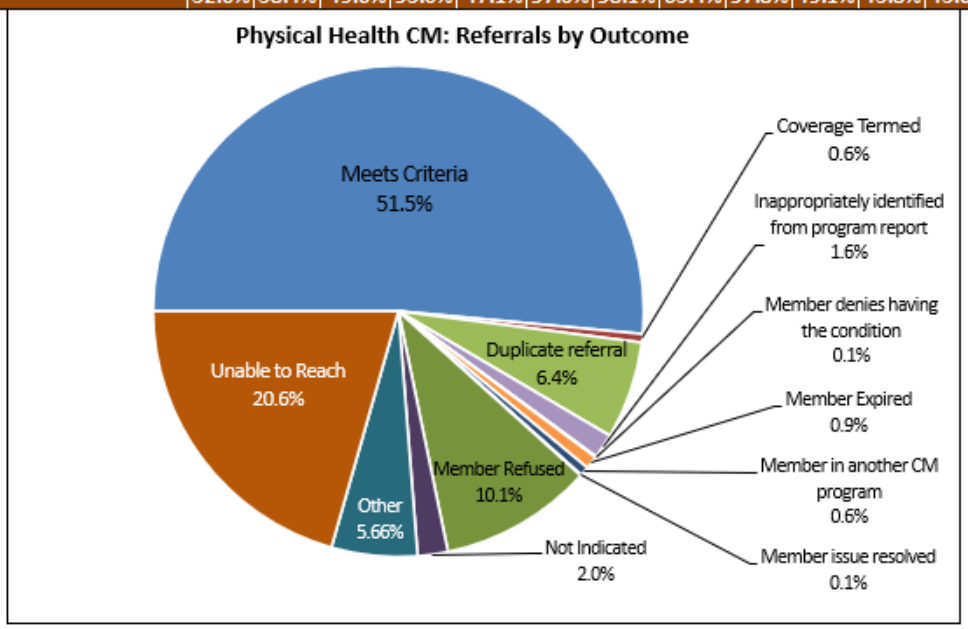
- Referral Outcome:
  - 51.5% meet criteria and agreed to CM.
  - 20.6% of the members were unable to be reached.
  - 10.1% of the members/representatives refused CM.
  - 17.8% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, other (including members requesting information only not a referral to CM), coverage termination, duplicate referrals, expired, member issue resolved.
  - 92% of members who met criteria and initially agreed to CM resulted in an open case.

Table C. Physical Health CM Referral Outcome

CAL VIVA Physical Health Care Management Referrals By Outcome: 1/1/2022 - 12/31/2022

Member issue resolved

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Meets Criteria	29	33	59	71	65	127	115	142	118	110	70	71	**1,010**
Coverage Termed	1	1	1	1	1	0	2	0	1	3	0	0	**11**
Duplicate referral	2	9	11	10	6	9	8	17	19	21	6	8	**126**
Inappropriately identified from prog	1	1	1	3	1	1	1	1	0	4	2	16	**32**
Member denies having the condition	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Member Expired	1	1	0	4	1	4	1	0	2	2	1	0	**17**
Member in another CM program	1	0	2	1	2	1	2	0	1	1	0	1	**12**
Member issue resolved	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Member Refused	6	3	13	12	23	24	20	19	23	22	16	17	**198**
Not Indicated	2	3	4	3	4	2	6	3	3	4	2	3	**39**
Other	12	6	5	1	7	9	11	6	4	5	20	25	**111**
Unable to Reach	34	29	23	27	28	46	32	36	33	52	43	21	**404**
TOTAL REFERRALS	**89**	**86**	**119**	**134**	**138**	**223**	**198**	**224**	**204**	**224**	**160**	**163**	**1,962**
%Meets Criteria	**32.6%**	**38.4%**	**49.6%**	**53.0%**	**47.1%**	**57.0%**	**58.1%**	**63.4%**	**57.8%**	**49.1%**	**43.8%**	**43.6%**	**51.5%**



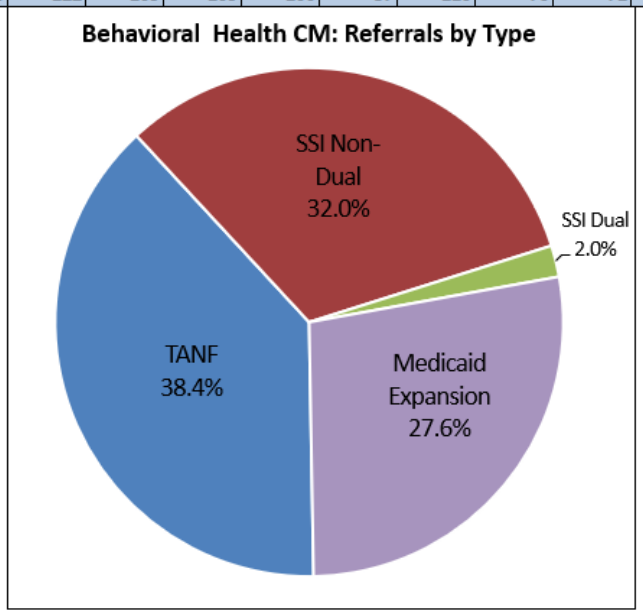
Behavioral Health

- Referrals by Type:
  - Total number of referrals 1,102.
  - 34% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 27.6% of the members referred were Medi-Cal Expansion.
  - 38.4% of the members referred were TANF.

Table D. Behavioral Health CM Referrals by Type

CAL VIVA Behavioral Health Care Management Referrals By Type: 1/1/2022 - 12/31/2022

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	28	37	54	39	47	34	34	38	31	30	34	17	**423**
SSI Non-Dual	28	29	35	35	27	29	31	30	30	26	24	29	**353**
SSI Dual	3	2	1	2	3	2	1	3	0	1	1	3	**22**
Medicaid Expansion	16	32	32	33	32	35	21	42	12	14	13	22	**304**
TOTAL REFERRALS	**75**	**100**	**122**	**109**	**109**	**100**	**87**	**113**	**73**	**71**	**72**	**71**	**1,102**

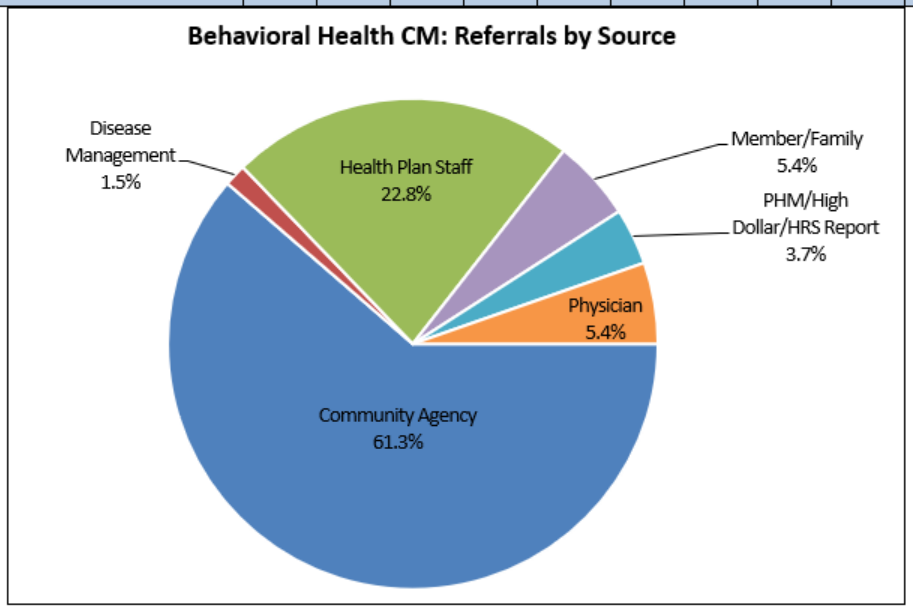


- Referral sources:
  - 22.8% of referrals came from within the Health Plan.
  - 61.3% Community agency.
  - 3.7% Reports/Impact Pro/HRS.
  - 5.4% Member and Family.
  - 5.4% Physician.
  - 1.5% Disease Management.

Table E. Behavioral Health CM Referrals by Source

CAL VIVA Behavioral Health Care Management Referrals By Source: 1/1/2021 - 12/31/2021

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	32	41	46	63	64	60	64	81	52	49	63	61	**676**
Disease Management	2	2	4	2	3	2	1	0	0	0	0	0	**16**
Health Plan Staff	29	45	44	24	19	20	11	19	13	12	8	7	**251**
Member/Family	4	3	13	6	7	4	6	7	2	4	1	2	**59**
PHM/High Dollar/HRS Report	8	7	9	4	2	8	2	0	0	1	0	0	**41**
Physician	0	2	6	10	14	6	3	6	6	5	0	1	**59**
TOTAL REFERRALS	**75**	**100**	**122**	**109**	**109**	**100**	**87**	**113**	**73**	**71**	**72**	**71**	**1,102**

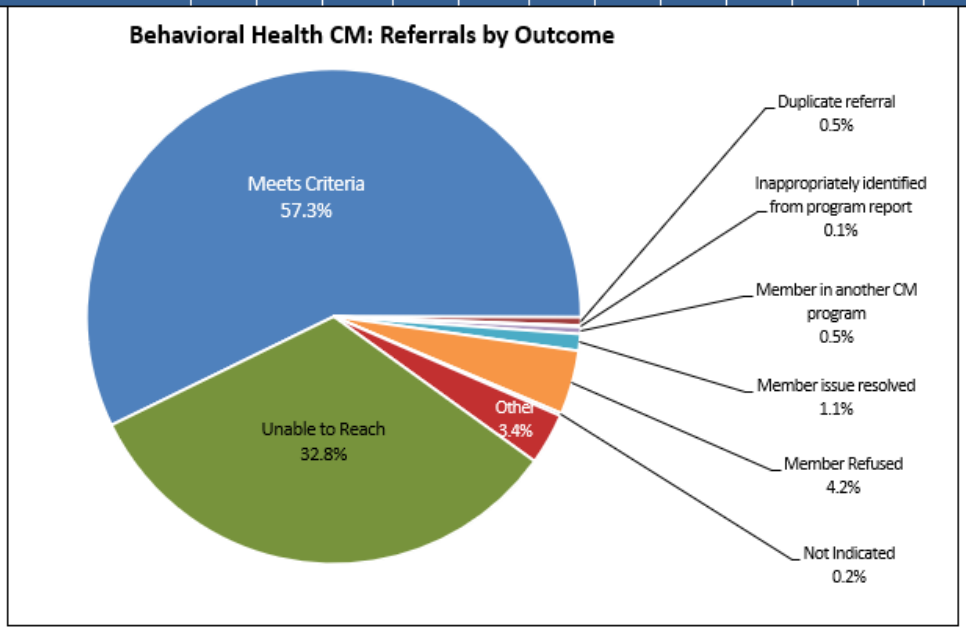


- Referral Outcome:
  - 57.3% meet criteria and agreed to CM.
  - 32.8% of the members were unable to be reached.
  - 4.2% of the members/representatives refused CM.
  - 5.7% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, coverage termination, duplicate referrals, expired, member issue resolved.
  - 98% of members who met criteria and initially agreed to CM resulted in an open case.

Table F. Behavioral Health CM Referral Outcome

CAL VIVA Behavioral Health Care Management Referrals By Outcome: 1/1/2022 - 12/31/2022

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	42	51	67	62	63	50	47	67	47	43	44	48	**631**
Duplicate referral	0	0	2	0	2	1	1	0	0	0	0	0	**6**
Inappropriately identified from program	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Member in another CM program	0	1	1	1	1	0	0	1	0	0	0	0	**5**
Member issue resolved	2	0	2	1	1	2	1	1	0	1	0	1	**12**
Member Refused	1	5	8	2	3	4	5	6	2	5	4	1	**46**
Not Indicated	0	0	0	1	1	0	0	0	0	0	0	0	**2**
Other	0	1	3	4	3	4	1	9	2	6	3	1	**37**
Unable to Reach	30	41	39	38	35	39	32	29	22	16	21	20	**362**
TOTAL REFERRALS	**75**	**100**	**122**	**109**	**109**	**100**	**87**	**113**	**73**	**71**	**72**	**71**	**1,102**
%Meets Criteria	**56.0%**	**51.0%**	**54.9%**	**56.9%**	**57.8%**	**50.0%**	**54.0%**	**59.3%**	**64.4%**	**60.6%**	**61.1%**	**67.6%**	**57.3%**



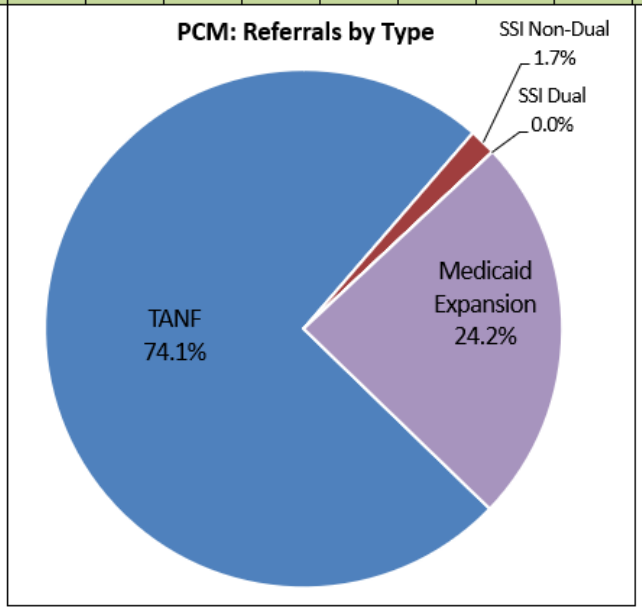
Perinatal Care Management

- Referrals by Type:
  - 1,906 referrals in 2022.
  - 1.7 % for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 24.2% of the members referred were Medi-Cal Expansion members.
  - 74.1% of the members referred were TANF members.

Table G. Perinatal CM Referrals by Type

CAL VIVA Perinatal Care Management Referrals By Type: 1/1/2022 - 12/31/2022

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	109	120	118	149	138	178	86	119	133	106	79	78	**1,413**
SSI Non-Dual	0	3	2	3	3	8	0	7	2	0	0	4	**32**
SSI Dual	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicaid Expansion	36	30	51	40	54	21	50	63	25	34	38	19	**461**
TOTAL REFERRALS	**145**	**153**	**171**	**192**	**195**	**207**	**136**	**189**	**160**	**140**	**117**	**101**	**1,906**

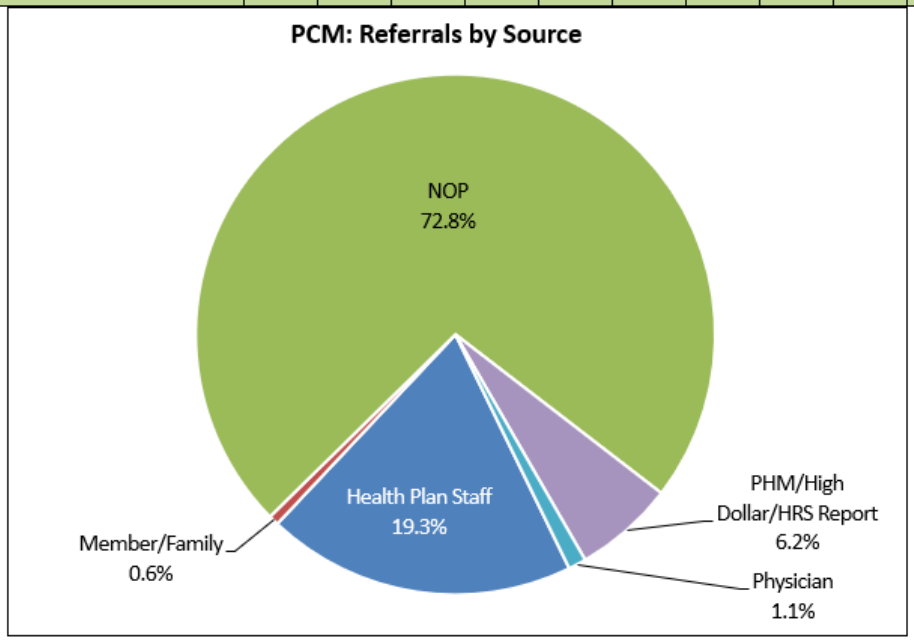


- Referral sources:
  - 72.8% of all referrals to this program were from the NOP form.
  - 19.3% of referrals came from within the Health Plan.
  - 6.2% Reports/Impact Pro/HRS.
  - 1.7% of the remaining referrals to Perinatal CM were from self-referrals by members/family, and physicians.

Table H. Perinatal CM Referrals by Source

CAL VIVA Perinatal Care Management Referrals By Source: 1/1/2021 - 12/31/2021

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Health Plan Staff	19	23	39	32	32	35	35	48	32	29	16	27	**367**
Member/Family	2	0	1	0	3	1	2	0	3	0	0	0	**12**
NOP	107	124	121	138	136	143	95	128	116	108	98	73	**1,387**
PHM/High Dollar/HRS Report	13	6	10	22	24	23	4	10	4	2	1	0	**119**
Physician	4	0	0	0	0	5	0	3	5	1	2	1	**21**
TOTAL REFERRALS	**145**	**153**	**171**	**192**	**195**	**207**	**136**	**189**	**160**	**140**	**117**	**101**	**1,906**

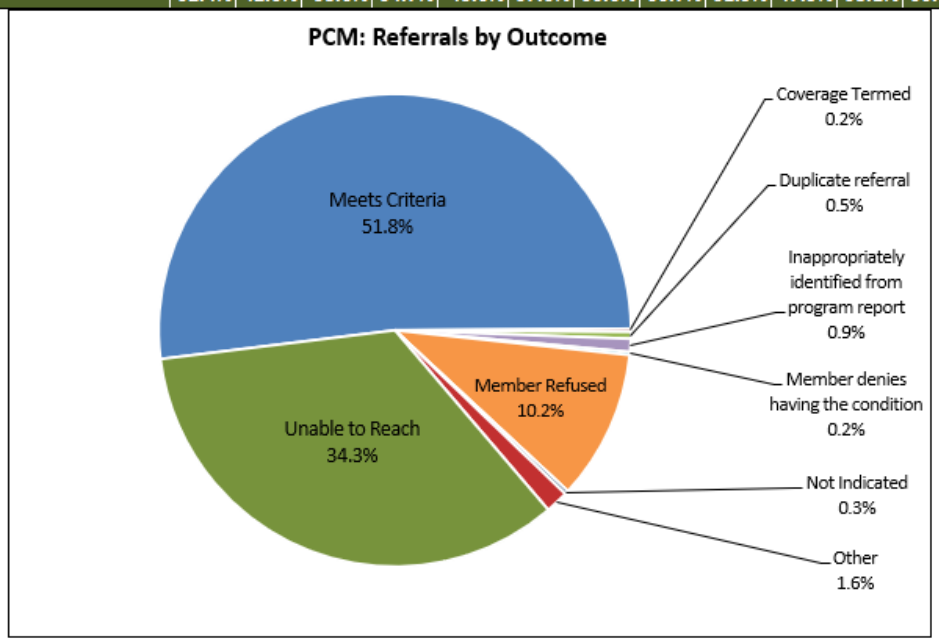


- Referral Outcome:
  - 34.3% of the members were unable to be reached.
  - 51.8% meet criteria and agreed to CM outreach.
  - 10.2% of the members refused CM.
  - 3.7% Comprised of other, duplicate request, coverage termed, out of service area, not indicated (member reported not pregnant) and enrolled in another CM program.
  - 99% of members who met criteria and initially agreed to CM resulted in an open case.

Table I. Perinatal CM Referral Outcome

CAL VIVA Perinatal Care Management Referrals By Outcome: 1/1/2022 - 12/31/2022

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	76	65	66	105	85	119	77	126	83	67	68	51	**988**
Coverage Termed	0	0	0	0	0	0	0	4	0	0	0	0	**4**
Duplicate referral	2	0	0	0	0	0	0	0	4	0	0	3	**9**
Inappropriately identified from program	0	2	2	7	0	0	0	0	0	0	3	3	**17**
Member denies having the condition	2	0	2	0	0	0	0	0	0	0	0	0	**4**
Member Refused	9	22	27	16	29	19	16	19	15	11	5	7	**195**
Not Indicated	2	0	0	0	0	0	0	0	0	0	3	0	**5**
Other	2	13	10	3	0	0	2	0	0	0	0	0	**30**
Unable to Reach	52	51	64	61	81	69	41	40	58	62	38	37	**654**
TOTAL REFERRALS	**145**	**153**	**171**	**192**	**195**	**207**	**136**	**189**	**160**	**140**	**117**	**101**	**1,906**
%Meets Criteria	**52.4%**	**42.5%**	**38.6%**	**54.7%**	**43.6%**	**57.5%**	**56.6%**	**66.7%**	**51.9%**	**47.9%**	**58.1%**	**50.5%**	**51.8%**



- Referral outcome comparison across programs:
  - Outcome category of other for Physical Health, Behavioral Health CM, and Perinatal CM were appropriate and represented referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, member delivered prior to referral, etc.
  - Number of program referrals was higher for Physical Health CM followed by Perinatal CM and Behavioral Health CM respectively.
  - Percentage of members unable to be reached was lower for Physical Health CM followed by Behavioral Health CM and Perinatal CM correspondingly.
  - Percentage of members who met criteria and agreed to CM outreach was higher in Perinatal CM than the other programs.
  - Actions taken included:

- Continuing to address variation of success rates among CMs through individual coaching and staff development.
- Re-educated staff on existing alternate sources of member contact information such as OMNI, pharmacy data, HIE.
- Collaborated with MHN on strategy to continue to increase referrals to BH CM and implemented a plan to have all county referrals for members not meeting county criteria come directly from MHN to BH CM team to manage.

Managed Population

In 2022, CM focused on processes related to the number of members managed in CM as well as the number of high-risk members managed in the high-risk OB program. The measures were:

- 1% high risk population in PHM level 1
- 50% of high-risk moms in CM

Physical and Behavioral Health high-risk members are identified proactively through the Population Health Management (PHM) Level I report. The PHM report combines data from multiple sources to use in its population and program eligibility process including Impact Pro. Members are stratified into 1 of 10 Population Health Categories ranging from healthy to end of life. Members stratified into levels 08b High Priority Homeless/SUD, 07b High Priority PH CM, 07a high Priority BH CM, 05d Chronic Highly Complex, 05c Chronic High Risk - With Care Gap and meeting the additional criteria outlined below are evaluated for CM.
Members stratified in above levels AND have other designated parameters such as:

- CM engagement score ≥ 80
- Priority Flag = Yes
- Annual ER designated cost

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Screening HRA shall be referred to Care Management.

Moderate and high-risk pregnancies are proactively identified through the Notification of Pregnancy; members with a score of 34 or greater are referred to High Risk OB CM; a component of the Perinatal CM Program.

High Risk Populations Managed

The volume of high-risk members managed in the CM programs *across the combined Medi-Cal membership* was 7,826, meeting the goal of >7,800 in 2022. High risk was defined as those members stratified into PHM Pyramid Level 1 (Tier 1 and 2).

Table J. High-Risk Population Managed

Case Management Metrics Key Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Definition
High Priority Managed														
High Priority Unique Member Managed	472	540	826	718	585	817	699	745	663	690	568	503	7,826	Members in PHM Pyramid Level 1 Teir 1 &2

High Risk OB Population Managed

The volume of high-risk members managed in the Perinatal CM Program increased from 33.62% in 2021 to 37.22% in 2022. This report includes all high-risk members regardless of when the NOP was conducted during the reporting year.

Table K. Percentage of High-Risk Members Enrolled in Perinatal CM by Month of Referral

CY 2022 CalViva Percent of High Risk NOP in Perinatal CM

CA412 Report Date	Denominator High Risk	Numorator Case Managed	Percentage
January 31, 2022	206	54	26.21%
February 27, 2022	381	100	26.25%
March 31, 2022	338	105	31.07%
April 30, 2022	356	116	32.58%
May 31, 2022	413	146	35.35%
June 30, 2022	426	158	37.09%
July 31, 2022	361	145	40.17%
August 31, 2022	332	133	40.06%
September 30, 2022	329	136	41.34%
October 31, 2022	333	154	46.25%
November 30, 2022	297	140	47.14%
December 31, 2022	271	118	43.54%
CY 2022 Average	**337**	**125**	**37.22%**

Overall Population Managed

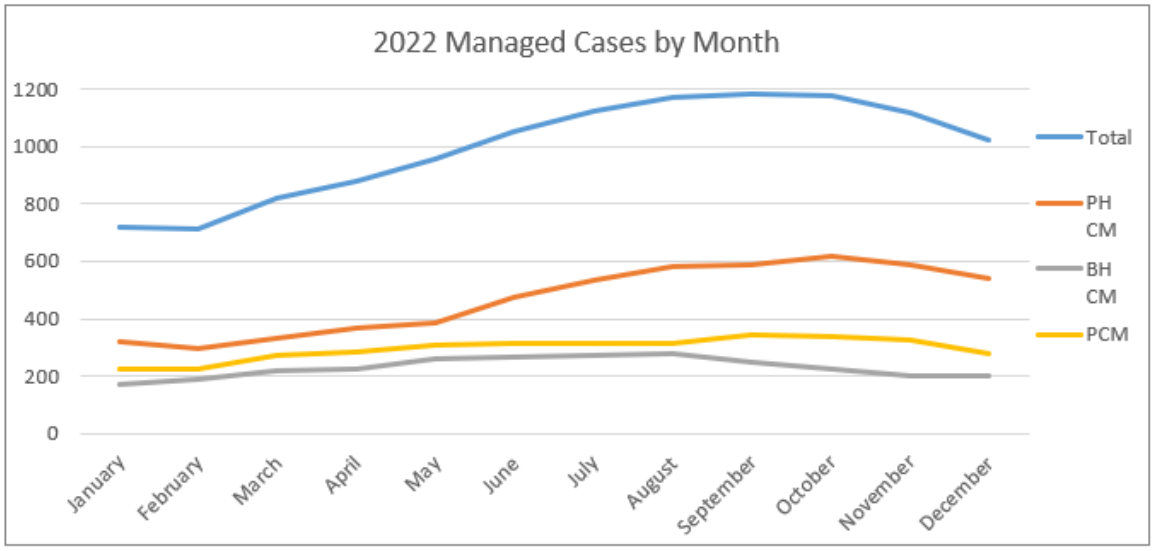
The data for cases managed is divided into three categories: Physical Health (PH CM), Behavioral Health (BH CM), and Perinatal (PCM). The table below reflects the number of cases managed each month per program. The number of cases managed each month includes cases active at any point during the month.

The average volume of cases managed by program per month in 2022 was:

- PH CM: 469
- BH CM: 229
- PCM: 295
- Total average per month: 993, an increase over 2021 avg of 838

Table L. CM Managed Case Volume by Month and Program

Program	January	February	March	April	May	June	July	August	September	October	November	December
PH CM	322	296	334	366	386	475	535	581	590	616	588	540
BH CM	172	187	216	227	261	267	273	276	248	222	202	199
PCM	225	227	270	283	309	311	313	314	344	337	327	280
Total	719	710	820	876	956	1053	1121	1171	1182	1175	1117	1019



Similarly, the total volume of CM cases managed per program are broken down by category and case type, complex versus noncomplex.

- PH CM
  - 4.4% Cases Complex
  - 95.6% Noncomplex
  - 35.6% members managed were SPD (dual and non-dual) members, followed by 41.1% Medi-Cal Expansion and 23.3% TANF

- BH CM
  - 3.7% Cases Complex
  - 96.3% Noncomplex
  - 15.4% members managed were SPD (dual and non-dual), followed by 37.8% Medi-Cal Expansion and 46.8% TANF
- PCM
  - 5.4% Cases Complex
  - 94.6% Noncomplex
  - 87.3% members managed were TANF members, followed by 10.9% Medi-Cal Expansion and 1.8% SPD (dual and non-dual)

The goal of 10% complex cases for PH and BH was not met in 2022. The goal of 7% complex for Perinatal CM was also not met. The decline in complex cases was attributed to staff working to increase overall caseloads, new staff not yet taking complex cases. and some CMs not following the CM process. Actions taken included:

- Reviewing both the CM process for management of complex cases and expectations with the staff
- Performance management

Table M. CM Managed Population by Program and Category

CalViva CM Managed Population by Program and Category in 2022

Program												
	Medicaid Expansion	SPD	TANF	TOTAL Managed	Medicaid Expansion	SPD	TANF	TOTAL Managed	Medicaid Expansion	SPD	TANF	TOTAL Managed
PH CM	51	46	21	**118**	1,054	910	606	**2,570**	1,105	956	627	**2,688**
BH CM	11	9	10	**30**	295	115	369	**779**	306	124	379	**809**
PCM	3	4	41	**48**	93	12	729	**834**	96	16	770	**882**
Total	**65**	**59**	**72**	**196**	**1,442**	**1,037**	**1,704**	**4,183**	**1,507**	**1,096**	**1,776**	**4,379**

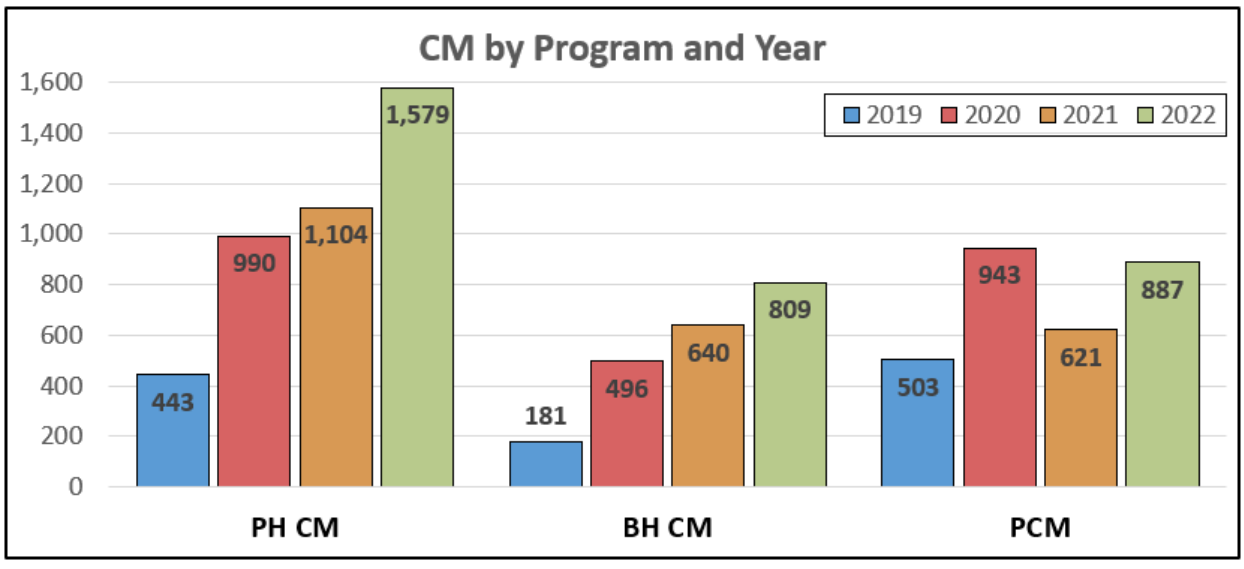
Source: CM Dossier and 412 NOP Reports

The volume of cases managed by program increased compared to prior years. Comparing 2022 specifically to 2021:

- PH CM demonstrated a 43% increase
- BH CM demonstrated a 26.4% increase
- Perinatal CM demonstrated a 42.8% decrease

Table N. CM Cases Managed Year to Year by Program

CalViva Medi-Cal



Care Management Program Evaluation - 2022

Overall, 1.04% of the total population was managed in 2022 amongst physical health and behavioral health CM and the perinatal CM program. The average population of members in 2021 was 419,272. The overall percentage of population managed in Physical Health CM was 0.64%. Behavioral Health demonstrated 0.19%. The population managed in Perinatal CM was 0.21%.

Table O. Percentage of Total Population Managed

Percentage of Total Population Managed by Program and Type in 2022

Program								
	Medicaid Expansion	SPD	TANF	TOTAL	Medicaid Expansion	SPD	TANF	TOTAL
PH CM	116,045	36,459	266,768	**419,272**	0.95%	2.62%	0.24%	**0.64%**
BH CM	116,045	36,459	266,768	**419,272**	0.26%	0.34%	0.14%	**0.19%**
PCM	116,045	36,459	266,768	**419,272**	0.08%	0.04%	0.29%	**0.21%**
Total	**116,045**	**36,459**	**266,768**	**419,272**	**1.30%**	**3.01%**	**0.67%**	**1.04%**

Care Management (CM) Quality Audit Scores

Complex and Non-Complex Care Management

Health Net CM processes include specific instructions for documentation of CM activity specific to individual members who require complex or integrated care management with (BH) Behavioral Health. Required documentation focuses on the standards of CM practice, NCQA standards, and contractual obligations. All documentation is in the Plan's medical management system, TruCare.

Each month, audits of care management documentation are performed by the designated CM leads and or managers. In 2022, 33 audit elements were measured each quarter. Audit results for 2022 are comprised of 4 completed quarters. Typically, at least 2 unique cases that were open and actively managed for at least 60 days per care manager per month were audited. However, associates who maintained a 90% or above on each of their two monthly audits for 3 consecutive months, were audited on a quarterly basis (at the beginning of each quarter). If an employee on quarterly audits fell below the 90% threshold monthly audits were resumed.

Table P Complex and Non-Complex Care Management Audit Results show the results of the average per quarter for each program. The graph also shows individual elements shared in monthly meetings with CalViva. Trends are assessed to monitor compliance with the care management process including demonstrating member and provider collaboration. The goal for audit scores is no less than 90%. The overall average score across programs for 2022 was 95%, meeting overall goal of $\geq$90%. The overall average score per program was: Physical Health 95%, Behavioral Health 93%, and Maternity 97%.

Table P. Complex and Non-Complex Care Management Audit Results

2022 audit results	Physical Health				Behavioral Health				Maternity			
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Overall Score	92%	94%	96%	94%	94%	98%	98%	97%	97%	100%	97%	97%
Welcome letter sent to member and PCP	93%	95%	95%	100%	92%	100%	100%	100%	100%	100%	100%	100%
Calling PCP to discuss and request plan of care from PCP	80%	90%	93%	91%	100%	100%	100%	100%	100%	100%	100%	100%
Sending PCP a copy of the care plan	93%	100%	91%	91%	100%	100%	100%	100%	100%	100%	100%	100%
Documentation of case closure discussed with the member & PCP/involved provider	90%	95%	95%	92%	100%	100%	100%	100%	100%	100%	98%	98%

Barriers impacting audit scores:

- Staff not following the CM process.

Actions taken to mitigate the barriers:

- Reviewed audit findings with staff and held review sessions as needed.
- Escalated performance management for applicable associates.

Care Management Outcomes

Outcomes of the Care Management Program are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Health Plan specific state requirements/expectations.

Utilization and Clinical Outcome Measures

Measures of effectiveness for care management are evaluated no less than annually using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM. Measures of effectiveness include the following indicators:

- Readmission rates
- ED utilization
- Overall health care costs

These parameters were measured 90 days prior to the member's enrollment in physical and behavioral health care management and 90 days after enrollment.

The members included in the outcome measures met the following criteria:

- Had an active or closed case on or between 1/1/2022 and 12/31/2022 with claims paid through 5/1/2022
- Remained eligible 90 days after Case Open Date

One thousand five hundred twenty-eight (1,528) members met the outcome criteria for the Physical and Behavioral Health CM programs. All cause admissions and readmissions were compared using claims data 90 days pre and post member enrollment into care management. Claims data demonstrated a reduction in readmissions for the care managed members, 3.8% decrease (pre 42.5% vs post 38.7%) in readmission rate based on claims. There was also a reduction in ED utilization for this population by 204 ED visits and a reduction of 534 ED visits per 1,000 members per year.

Table Q. CM Readmission Outcomes

CALVIVA CARE MANAGEMENT OUTCOMES REPORT

Members Care Managed Between 1/1/2022 and 12/31/2022, claims paid through 5/1/2023

Measure for Care Management	Members	90 days prior to CM enrollment			90 days following CM enrollment			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	1,528	985	419	42.5%	679	263	38.7%	-3.80%

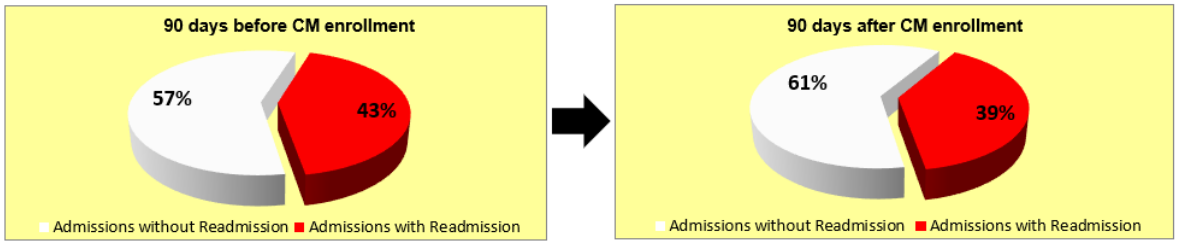
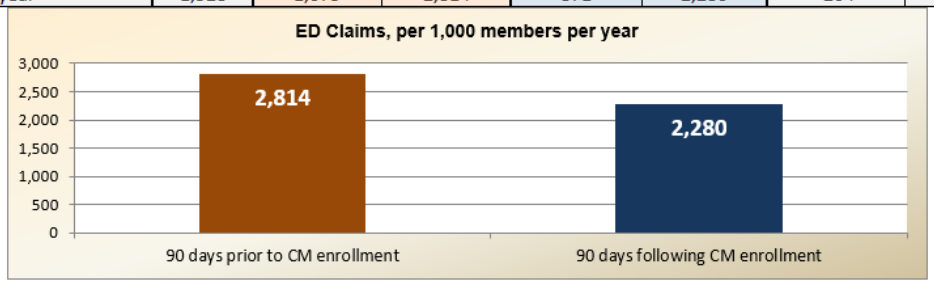


Table R. CM ED Utilization Outcomes

Measure for Care Management	Members	90 days prior to CM enrollment		90 days following CM enrollment		Difference	
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.
Emergency Department (ED) Claims, per 1,000 members per year	1,528	1,075	2,814	871	2,280	-204	-534

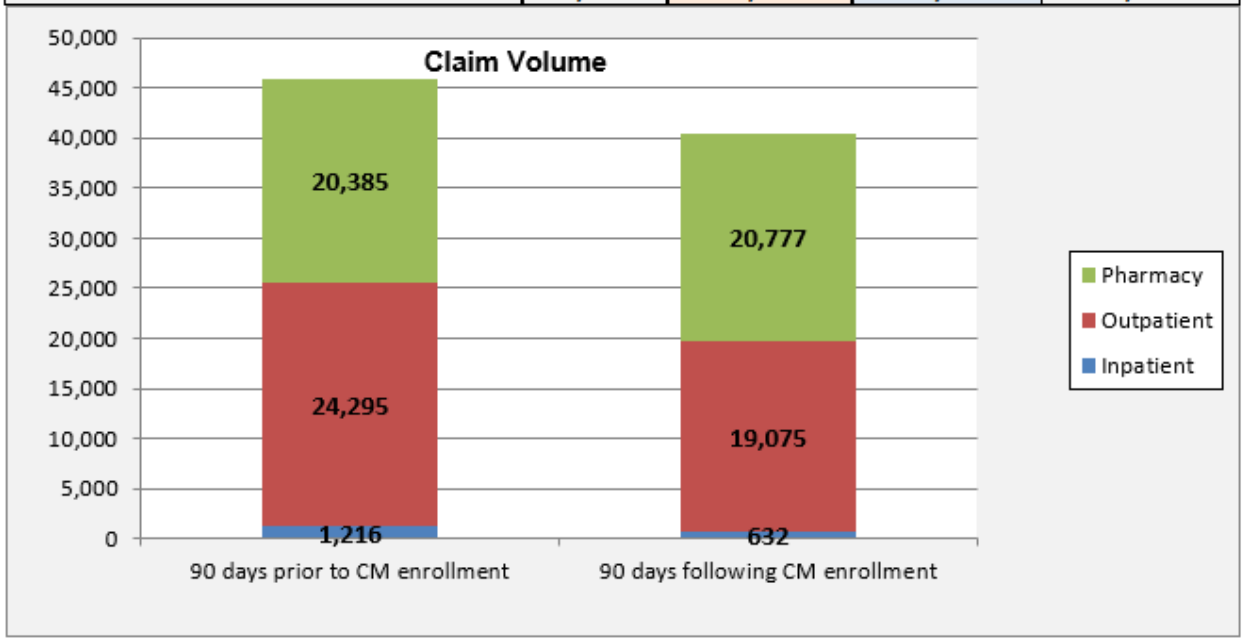


Care Management Program Evaluation - 2022

Comparing health care costs 90 days pre and post care management enrollment managed members demonstrated a reduction in inpatient claims of 584, a decrease of 5,220 for outpatient services, and a 392 increase for pharmacy.

Table S. Physical and Behavioral Health CM Utilization Outcomes

Measure for Care Management	Members	90 days prior to CM	90 days following CM	Difference
		# Claims	# Claims	# Claims
Inpatient Paid Claims	1,528	1,216	632	-584
Outpatient/Other Paid	1,528	24,295	19,075	-5,220
Pharmacy Paid Claims	1,528	20,385	20,777	392
TOTAL PAID CLAIMS	**1,528**	**45,896**	**40,484**	**-5,412**



The effectiveness of the Perinatal CM program was evaluated based on the member's compliance with completing their first prenatal visit within the first trimester and their post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery of high-risk members managed to high-risk members not managed was compared. Preterm is defined as delivery prior to 36 weeks.

The members in the Perinatal CM program evaluated for compliance with the pre and post-partum visits were limited to those who met the following criteria:

- Continuous enrollment
- For the prenatal metric were enrolled during their first trimester
- For the post-partum metric delivered prior to 12/31/2022.

Two hundred ninety-one members met the criteria for both the prenatal and the post-partum visit metrics and one hundred eight members met the criteria for the pre-term delivery metric.

Table T. Clinical Outcomes for High-Risk OB Members

Measure for Maternity Program	Members not enrolled in Maternity Program		Members enrolled in Maternity Program		Difference
	Members	Rate	Members	Rate	Rate
First prenatal visit within the first trimester	4,809	83.7%	291	87.6%	3.9%
Pre-term deliveries by high risk members	545	8.6%	108	6.5%	-2.1%
Postpartum visit between 7 and 84 days after delivery	4,809	72.3%	291	81.8%	9.5%

Members in the Perinatal CM program demonstrated a 3.9% percentage increase in compliance with completing the first prenatal visit in their first trimester and a 9.5% percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program. There were 2.1% fewer pre-term deliveries for high-risk members managed than high-risk members not managed.

Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. Member satisfaction is evaluated quarterly using a member satisfaction survey and monitoring complaints/grievances related to CM. The goal for member satisfaction is > than 90% and the goal for member complaints/grievances is < 1/10,000 members.

Care Management Satisfaction Survey

A Member Satisfaction Survey is conducted near and or upon case closure. The survey is offered to members who have been in care management for a minimum of 45 days and are near case closure or subsequently closed for one of the following reasons: completion of all goals, successful closure, member requesting discontinuation of CM services or no longer eligible with the Plan. Members may be invited to complete the survey by email, text, and/or phone.

The survey consists of two parts with nine questions related to satisfaction with the care team and five questions related to improvement in the member's quality of life. The survey results are loaded into TruCare, the medical management system.

Care Management Program Evaluation - 2022

Care Team Satisfaction:

1. How satisfied are you with the help you received from your Care Manager?
2. How satisfied are you that the goals worked on by you and your Care Manager have improved your health and understanding of your health?
3. If you required additional services, (or services from the community), how satisfied are/were you with those that your Care Manager offered?
4. How satisfied are you with any learning and/or resource health information materials you received from your Care Manager?
5. Were you able to understand the information about your health condition(s) given to you by your Care Manager?
6. Have you been able to follow any of your Care Manager's healthcare suggestions to improve your health?
7. Did your Care Manager help you get the healthcare services that you needed?
8. Did your Care Manager consider and include your personal beliefs and preferences during your discussions?
9. Was your Care Manager available to speak with you at times that were convenient for you?

Table U. Care Team Satisfaction

CM & TCM SATISFACTION SURVEY REPORT — CalViva — 1/1/2022 - 12/31/2022

Section	Question	Responses	Satisfied	Satisfied	Dissatisfied	Dissatisfied	N/A	Satisfied or
Satisfaction	How satisfied are you with the help you are receiving or have received from your Care Manager?	140	92	48	0	0	0	100.0%
Satisfaction	How satisfied are you that the goals worked on by you and your Care Manager have improved your health and understanding of your health?	126	96	30	0	0	0	100.0%
Satisfaction	If you required additional services, (or services from the community), how satisfied are/were you with those that your Care Manager offered?	129	98	31	0	0	0	100.0%
Satisfaction	How satisfied are you with any learning and/or resource health information materials you received from your Care Manager?	129	64	65	0	0	0	100.0%

Section	Question	Responses	Very Much	Very Well	Somewhat	Not Really	Not at all	% Yes
Satisfaction	Were you able to understand the information about your health condition(s) given to you by your Care Manager?	129	0	91	38	0	0	100.0%
Satisfaction	Have you been able to follow any of your Care Manager's healthcare suggestions to improve your health?	129	0	110	19	0	0	100.0%
Satisfaction	Did your Care Manager help you get the healthcare services that you needed?	149	98	0	51	0	0	100.0%
Satisfaction	Did your Care Manager consider and include your personal beliefs and preferences during your discussions?	124	83	41	0	0	0	100.0%

Section	Question	Respon	Always	Sometim	Not	%
Satisfaction	Was your Care Manager available to speak with you at times that were convenient for you?	128	117	11	0	91.4%

Quality of Life (QOL):

1. Before working with your Care Manager, how would you have rated your overall health?
2. After working with your Care Manager, how would you rate your overall health?
3. Before working with your Care Manager, how would you have rated your ability to care for yourself and/or your family (includes cooking, housekeeping, shopping, bathing, dressing, etc.)?

4. After working with your Care Manager, how would you rate your ability to care for yourself and/or your family (includes cooking, housekeeping, shopping, bathing, dressing, etc.)?
5. Did we exceed your expectations?

Table V. Quality of Life

Section	Question	Respon	Good	Fair	Poor	% Good
Quality of Life	Before working with your Care Manager, how would you have rated your overall health?	111	110	1	0	99.1%
Quality of Life	After working with your Care Manager, how would you rate your overall health?	129	129	0	0	100.0%

Section	Question	Respon ses	Not limited	at limited	Very limited	% Not Limited
Quality of Life	Before working with your Care Manager, how would you have rated your ability to care for yourself and/or your family (includes cooking, housekeeping, shopping, bathing, dressing, etc.)?	125	123	2	0	98.4%
Quality of Life	After working with your Care Manager, how would you rate your ability to care for yourself and/or your family (includes cooking, housekeeping, shopping, bathing, dressing, etc.)?	129	129	0	0	100.0%

Section	Question	ses	Yes	No	% Yes
Quality of Life	Did we exceed your expectations?	123	123	0	100.0%

Results are reported for each response option per question. The response options include Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied, Yes-Very Much, Yes-Very Well, Yes-Somewhat, No-Not really, No-Not at all, Always, Sometimes, Not often, Never, Good, Fair, Poor, Not Limited, Somewhat Limited, Very Limited, Yes, No.

The positive responses were used to calculate the end result: Very Satisfied, Satisfied, Yes-Very Much, Yes-Very Well, Yes-Somewhat, Always, Good, Not Limited, Yes. The CM satisfaction goal for is 90%.

Tables V Care Team Satisfaction and Table W Quality of Life demonstrate 149 members were surveyed in 2022. Responses were not captured for all questions. The discrepancy in the number of members responding to the individual questions is attributed to members not answering all the questions or the response was not captured during data entry.

- 124-149 members responded to questions in the Care Team Satisfaction section
    - 100% (140/140) of respondents were satisfied with the help they received from CM.
    - 100% (126/126) reported the goals they worked on improved understanding of their health.
    - 100% (129/129 reported when additional services or services from the community were needed, they were satisfied with resources CM offered.
    - 100% (129/129) reported they were satisfied with resource/health information materials provided by CM.
    - 100% (129/129) reported ability to understand the information about their health condition given to them by CM.

  - 100% (129/129) reported ability to follow CM healthcare suggestions to improve health.
  - 100% (149/149) reported CM helped them get the healthcare services they needed.
  - 100% (124/124) reported CM considered personal beliefs and preferences during discussions.
  - 91.4% (117/128) reported the CM was always available to speak with the member at times convenient for the member
  - All elements in the Care Team Satisfaction section met goal of >90% met goal.
- 175 members responded to questions in the Quality-of-Life section
  - 1% increase in overall rating of health as good post CM (100%) vs pre-CM (99%)
  - 2% increase in ability to care for self/family post CM (100%) vs pre-CM (98%)
  - 100% (123/123) of respondents reported CM exceeded their expectations.

Care Management Complaints/Grievances

There were no grievances related to care management in 2022. The goal for member complaints/grievances < 1/10,000 members was met.

Table W. CM Grievances/Complaints

	Quarter 1 2022		Quarter 2 2022		Quarter 3 2022		Quarter 4 2022	
CM Complaints	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.
	0	0	0	0	0	0	0	0

*Based on average CalViva membership from https://cnet.centene.com/sites/CAMedi-calDataAnalytics: 2022: Q1 400,938; Q2 406,549; Q3 412,982; Q4 417,634

Special Programs

Perinatal CM

Pregnant members are managed in the Perinatal CM program. Perinatal CM incorporates the concepts of CM, care coordination, and condition management in an effort to teach at risk pregnant members how to have healthier babies. Perinatal CM is a complete program that promotes education and communication between pregnant members, care managers, and physicians to ensure a healthy pregnancy and first year of life for babies.

Our multi-faceted approach to prenatal and postpartum care includes extensive member outreach, wellness materials, provider incentives, and intensive care management, which reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

Care Management Program Evaluation - 2022

The Perinatal CM program is comprised of multiple components which allow us to identify more pregnant members, interact with them earlier in pregnancy, reduce the rate of prematurity, shorten neonatal hospital stays, increase birth weights, and lessen the chance of repeat premature deliveries.

The Notification of Pregnancy (NOP) is generally the earliest notice to the Plan of a member's pregnancy. It can be completed by the physician, telephonically, via the Provider Portal, by the member on-line on the Plan's web site, or by completing and mailing a written form. Once the NOP is entered into the system, the pregnant member automatically receives a mailing from our Perinatal CM Program.

All members who completed an NOP and pregnant members who were referred by the Quality Department received outreach by the CM staff. If the NOP reflects the mother to be low to no risk, she was normally provided information about the Perinatal CM program and received regular periodic educational mailings that encouraged a healthy lifestyle for pregnancy, fetal development, and post-partum care. However, if the mother felt that she needed additional support she was offered the Perinatal CM program.

The mailings also encourage appropriate physician visits during the pregnancy and provide suggestions related to pediatrician selection. For those members identified as being medium or high risk for pregnancy complications the CM staff attempted to complete the full OB Assessment and offer the Maternity CM program. In addition to the benefits of the Perinatal CM program, members in the program were assigned to an experienced OB RN, or social worker, for one-on-one regular phone contact. It is at this point that a highly individualized plan of care was developed with the members consent and participation to achieve goals aimed at improving the overall health of both the pregnant member and fetus.

After consent for program participation and program enrollment was completed, ongoing telephonic contact was established with frequency varying depending on member need and acuity. Ongoing reassessment of need and progress was reviewed at least monthly with updates and adjustments to plan of care occurring as needed.

Providers were notified of their patient's participation in care management programs and are encouraged to provide feedback and input to the care manager regarding the patient plan of care.

Metrics associated with the Perinatal CM program managed
Analytics provided data related to NOP Completion and Percentage of Deliveries with NOP.

NOP Completion – The number of NOPs completed. NOPs can be submitted by members and providers and may also be completed during CM telephonic outreach to members identified as pregnant on the **413 No NOP** report. In 2022 2,642 NOPs were completed.

Table X. NOP Completion per Month

2022 Perinatal CM HBR: Members with a Completed NOP Assessment

Source: 412 NOP report

By Month of Frist NOP Assessment date

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Health Net CalViva	211	211	256	249	261	241	182	237	247	231	163	153	2,642

Percentage of Deliveries with an NOP - The percentage of births with an NOP completed within eight months prior to delivery. The goal set for the Plan by Centene varied by month and was not exclusive to CalViva in 2022. There was variation in performance from a low of 43.0% in March to a high of 51.4% in June. The total at year-end average was 47.2%; a small decrease from 48.2% in 2021.

Table Y. Percentage of Deliveries with NOP

2022 Perinatal CM HBR: % of Deliveries with NOP

Sources: 412 NOP report and IP Validation Report

By Month of Delivery Date

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Health Net CalViva	48.8%	46.3%	43.0%	45.1%	48.4%	51.4%	47.7%	43.4%	47.7%	47.5%	47.7%	48.8%	47.2%
NUMERATOR	204	167	181	176	187	226	225	232	244	226	229	244	2,541
DENOMINATOR	418	361	421	390	386	440	472	534	511	476	480	500	5,389

The percent of timely NOP outreach to High-Risk Members - The percentage high risk members with a call/note within 7 days of NOP entry.

NOP CM Success (30-days) - Percentage of members indicated as high risk on an NOP who are put into active care management within 30 days of the NOP.

Neonatal Rate - Percentage of NICU admits per delivery.

17P Utilization Rate – 17P/Makena is a hormone to reduce the risk of preterm labor. This metric is the percentage of our high-risk members that have documentation in the 17P Journal. The Perinatal CM team manages a 17P journal for members whether or not the member is in the Perinatal CM Program. The goal is to ensure the member is regularly receiving the medication. For members who decline CM the care manager coordinates with the provider regarding member compliance.

Enrollment in this program in 2022 was 887. We continued to make outreach to all risk categories including low risk. We found this to be of great importance and superior customer service as it allowed us to reach members that may need assistance who were not identified through the NOP. Overall, there were 12,847 pregnancy related materials mailed in 2022. Members may sign up for mailings outside of care management which explains more material being sent than members managed. Mailings are based on completion of an NOP for the

Pregnancy mailing and presence of a completed Birth Event in TruCare for the Post-delivery Packet.

Table Z. Perinatal CM Outreach

Educational Packet	*Number of Packets Sent in 2021*
NOP mailings	10,104
Pregnancy mailings	1,664
Post-delivery packets	1,079
Total	12,847

Transition Care Management Program

The purpose of the Transition Care Management Program (TCM) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The program includes:

- Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, use of a personal health record.
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.
- Preparation for discussions with other health care professionals.
- Supporting the patient's self-management role.
- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge.

During the post discharge period, staff evaluates the member to provide the best support to the member in managing their continued needs.

In 2022 1,288 members were referred to the Transition Care Management Program and 1,010 (78.4%) participated. The number of members participating in the program decreased from 1,214 in 2021.

Palliative Care Program

A Palliative Care Program is offered to eligible members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care can provide nurses, medical directors, and social workers in a home setting to members at no additional cost. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle.

The Palliative Care Program may be appropriate if there is a chronic or serious illness that is significantly affecting the quality of life or daily activities of the member. Palliative Care is available to members meeting these criteria regardless of the age of member. The Palliative Care team works in accordance with the member's current primary physician and specialists to provide pain management, symptom management and disease management to enhance the member's quality of life. Palliative Care services are in addition to other current benefits, and existing curative medical treatment and social services may continue as before. Services include:

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Individualized Plan of Care including Pain and Symptom Management
- Care Coordination
- Mental Health and Medical Social Services
- Chaplain Services
- 24/7 Telephonic Palliative Care Support
- Additional medically necessary or reasonable services as provisioned within regulatory requirements

Palliative Care Services may be provided in inpatient, outpatient, home-based, community-based, and other settings based on what is medically necessary for the member's needs.

In 2022, 97 members were referred to the Palliative Care Program and 70 (72.2%) participated.

Care Coordination Activities

In addition to providing care management to members, the CM department supports care coordination with other entities within the community.

California Children Services

The plan works with CCS counties to support members turning 21 who will be aging out of the CCS program. Outreach to members begins six months prior to the 21st birthday to educate on plan benefits and determine if the member needs assistance in transitioning to in network specialty and/or ancillary providers as well as ongoing authorizations for durable medical equipment.

Private Duty Nursing (PDN) Care Management for Eligible Members Under 21

In 2020 the Department of Health Care Services published All Plan Letter (APL) 20-012 date 05/15/20, mandating all Managed Care Plans care manage members under the age of 21 receiving PDN services to make sure that authorized PDN services were being monitored to ensure medically necessary services were being delivered even if those services were carved out to California Children Services. Care Management developed a process to manage these referrals to promote continuity of services for members receiving PDN. The CM team in conjunction with Public Programs and Delegation Oversight obtained monthly reports from CCS and the delegated PPGs of members approved for PDN. The CM team collaborated with the parents and/or members, CCS, and home care agencies regarding ongoing care and assisted with transition to Home and Community-Based Services one year prior to 21st birthday.

Regional Centers

Care management also worked collaboratively with the Regional Centers that are associated with the CalViva Health counties for members active in care management and have a need as described below. These needs include members:

- Under the age of 18 who are at risk or have a developmental disability that may require supportive services not otherwise provided such as early intervention for infants and families (Early Start)
- Requiring lifelong individual planning, and service coordination, placement, and monitoring for 24-hour out of home care, and advocacy for legal, civil, and service rights.

Targeted Case Management

Support continued for collaboration in counties that continue to offer targeted case management. Programs offered through targeted case management vary by county. There continued to be very limited participation on behalf of the counties in 2022. The CalViva counties offering targeted case management include Madera. The Service Coordination liaison continued efforts to re-engage related activities with these counties with limited success. Support for collaborative activities will continue in 2023.

CalAIM

A program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the plan's most vulnerable members. It provides non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Supports, formally in Lieu of Services (ILOS), were the first two programs to launch

- Enhanced Care Management (ECM) is a plan benefit that provides a whole-person approach to care coordination that addresses the clinical and non-clinical circumstances

of high-need members, building on the current Whole-Person Care pilots and Health Homes Programs

- Community Supports (formally ILOS) are designed to be used to provide health related services as an alternative to covered Medi-Cal benefits. It integrates care management for members at high levels of risk and is intended to address SDoH. Support services that are available include housing transition and navigation services, housing tenancy and sustaining services, recuperative care otherwise known as medical respite, sobering centers, meals, including medically tailored, and asthma remediation.

The program began on January 01, 2022, in the CalViva county of Kings which had an WPC pilot prior to the CalAIM implementation with plans by DHCS to include San Joaquin County along with the CalViva counties of Fresno and Madera on July 01, 2022. DHCS initial populations of focus for both implementation dates are members that are:

- Experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless, with complex health and/or behavioral health conditions
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
- Adults with high utilization and/or with severe mental illness (SMI) or substance abuse disorders (SUD).

Members inquiring about or who are active in the plan's current care management program are able to self-refer to (ECM) and assigned CM staff make outreach to determine if they met the population of focus criteria and then forwarded an authorization to the assigned (ECM) provider to make outreach to determine eligibility for their program. Per DHCS policy members accepted into (ECM) cannot be in the plan's complex care management program due to duplication of services but can still be referred to Community Support services, Condition Specific CM/ DM Programs, Palliative Care and Transitional Care Management.

COVID-19 Response

In March 2020 care management associates working in an office were transitioned to work from home. In some instances, this required distribution of equipment and software to support remote work. Throughout 2022 Care Management worked closely with other departments to coordinate outreach efforts to support members. Care Management initially outreached to members in our CM Program to provide information about COVD-19 including signs and symptoms, testing, options to receive health care services, and prevention. Member support expanded to include follow-up calls to members who contacted our Nurse Advice Line with COVID-19 related questions and or signs and symptoms and to those members who tested positive for COVID-19 and had co-morbidities. Members were informed of available resources and access to care options as well as being invited to participate in our CM program.

Population Health Management

We are committed to evolving to a collaborative community-wide approach to Population Health Management. We recognize that to achieve that goal requires knowledge of the community, appropriate information management tools and the application of evidence-based interventions

derived from industry standards.[1] During 2022, we continued to support relationships within the public and provider communities however our focus shifted on collaborating on a COVD-19 response. We also expanded our reporting capabilities to include COVID-19 related encounters and analyze health data specific of our members within the communities served by CalViva. We believe that ongoing health needs assessments, increase the probability of effective implementation of well-targeted initiatives that improve the health of our membership. The Institute of Medicine (IOM) has defined three principal domains that effect successful health population management: [2]

1. The social, economic and environmental conditions that often act as the primary determinants of individual and population health.
2. Health care services for individuals.
3. Public health activities that target populations and address individual health behaviors, such as smoking and excessive alcohol consumption.

A population assessment is completed which provides the interdisciplinary team with a vehicle by which to analyze and prioritize health needs. Review of this information facilitates the identification of new initiatives, the ability to establish goals, evaluating and measuring progress, while improving quality, transparency and community engagement. The population health needs assessment is completed annually by the Plan's Population Health Management Team and is reported to the QIUM Committee.

Population Assessment and CM Criteria

In 2022, we continued to utilize a comprehensive Population Health Management report to support an integrated care model; care management being one component. This data is used to identify members for various programs. Impact pro data is included in the algorithm for this report.

[1] Institute of Medicine, *Primary Care and Public Health* (Washington D.C., 2012) [pre-publication copy], p. S-1

[2] IBID.

Impact Pro is a predictive modeling and care management analytic tool with a built-in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. Members are stratified into one of ten Population Health Categories: Level 01: Healthy, 02: Acute Episodic, 03: Healthy, At Risk Level and 04A: Chronic Big 5 Stable, 04B: Chronic Other Condition Stable, 04C: BH Primary Stable, Level 05A: Health Coaching, Level 05B: Physical Health CM, Level 05C Behavioral Health CM, Level 06: Rare High Cost Condition, Level 07A: Catastrophic: Dialysis, Level 07B: Catastrophic: Active Cancer, Level 07C: Catastrophic: Transplant Level 08A: Dementia, Level 08B: Institutional (custodial care) Level 09A: LTSS and MMP - Service Coordination, Level 09B: LTSS and MMP - High Needs Care Management or Level 10: End of Life. Members stratified into levels 05B and 5C are identified as higher risk and impactable and are referred to care management as described below.

Members identified on the PHM report who are stratified into Level 5B: Physical Health CM and Level 05C Behavioral Health CM AND have other designated parameters such as:

- CM engagement score ≥ 80
- ORCA (opioid risk classification) score of medium or high
- Priority Flag = Yes
- Annual ER designated cost

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Screening HRA and/or who requested an individualized care plan or individualized care team may be referred to Care Management.

III. Summary and Priorities

In 2022, the key accomplishments for the CM were:

- Continued COVID-19 outreach activities.
- Successful coordination for CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Successful transition of Rx carve out to the State and use of Magellan's Rx system.
- Filled open CM positions.

The primary goals for 2023 are to complete activities related to:

- Increase caseload per CM to align with goals.
- Support CalAIM activities, prepared for additional Populations of Focus.
- Support CalAIM Community Supports programs and increased offerings.
- Manage more members across CM programs.

- Enhance Transitional Care Management program in preparation for the DHCS PHM Roadmap.
- Regionalize Care Management program and staff to better support member needs.

Item #10

Attachment 10.A

Financials as of May 31, 2023

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of May 31, 2023

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	198,709,926.41
5	Total Bank Accounts	$ 198,709,926.41
6	Accounts Receivable	
7	Accounts Receivable	124,487,649.65
8	Total Accounts Receivable	$ 124,487,649.65
9	Other Current Assets	
10	Interest Receivable	406,824.18
11	Investments - CDs	0.00
12	Prepaid Expenses	235,416.70
13	Security Deposit	23,662.50
14	Total Other Current Assets	$ 665,903.38
15	Total Current Assets	$ 323,863,479.44
16	Fixed Assets	
17	Buildings	6,010,364.56
18	Computers & Software	56,000.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	102,799.60
21	Total Fixed Assets	$ 9,330,583.26
22	Other Assets	
23	Investment -Restricted	301,621.96
24	Lease Receivable	3,267,359.32
25	Total Other Assets	$ 3,568,981.28
26	TOTAL ASSETS	$ 336,763,043.98
27	LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	86,941.96
32	Accrued Admin Service Fee	4,872,978.00
33	Capitation Payable	123,738,285.87
34	Claims Payable	57,284.98
35	Directed Payment Payable	2,165,916.26
36	Total Accounts Payable	$ 130,921,407.07
37	Other Current Liabilities	
38	Accrued Expenses	2,076,974.85
39	Accrued Payroll	144,259.24
40	Accrued Vacation Pay	322,252.09
41	Amt Due to DHCS	55,238,731.48
42	IBNR	88,735.63
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	6,050,878.61
46	Premium Tax Payable to DHCS	0.00
47	Total Other Current Liabilities	$ 63,921,831.90
48	Total Current Liabilities	$ 194,843,238.97
49	Long-Term Liabilities	
50	Renters' Security Deposit	25,906.79
51	Subordinated Loan Payable	0.00
52	Total Long-Term Liabilities	$ 25,906.79
53	Total Liabilities	$ 194,869,145.76
54	Deferred Inflow of Resources	$ 2,861,324.55
55	Equity	
56	Retained Earnings	127,950,997.92
57	Net Income	11,081,575.75
58	Total Equity	$ 139,032,573.67
59	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 336,763,043.98

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2022 - May 2023

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	**Interest Income**	4,763,148.60	311,663.00	4,451,485.60
3	**Premium/Capitation Income**	1,199,635,364.54	1,066,031,951.00	133,603,413.54
4	**Total Income**	**1,204,398,513.14**	**1,066,343,614.00**	**138,054,899.14**
5	**Cost of Medical Care**			
6	**Capitation - Medical Costs**	1,039,019,730.34	911,638,760.00	127,380,970.34
7	**Medical Claim Costs**	1,247,695.94	990,000.00	257,695.94
8	**Total Cost of Medical Care**	**1,040,267,426.28**	**912,628,760.00**	**127,638,666.28**
9	**Gross Margin**	**164,131,086.86**	**153,714,854.00**	**10,416,232.86**
10	**Expenses**			
11	**Admin Service Agreement Fees**	51,273,453.00	47,107,500.00	4,165,953.00
12	**Bank Charges**	0.00	6,600.00	(6,600.00)
13	**Computer/IT Services**	172,699.59	214,016.00	(41,316.41)
14	**Consulting Fees**	39,935.00	275,000.00	(235,065.00)
15	**Depreciation Expense**	271,814.45	297,275.00	(25,460.55)
16	**Dues & Subscriptions**	241,835.50	188,100.00	53,735.50
17	**Grants**	4,296,818.19	4,296,818.20	(0.01)
18	**Insurance**	178,424.34	179,883.00	(1,458.66)
19	**Labor**	3,032,331.84	3,255,303.00	(222,971.16)
20	**Legal & Professional Fees**	79,911.01	174,900.00	(94,988.99)
21	**License Expense**	1,077,042.43	1,076,130.00	912.43
22	**Marketing**	1,251,431.03	1,420,000.00	(168,568.97)
23	**Meals and Entertainment**	19,328.22	23,650.00	(4,321.78)
24	**Office Expenses**	73,706.06	81,000.00	(7,293.94)
25	**Parking**	184.39	1,430.00	(1,245.61)
26	**Postage & Delivery**	3,053.01	3,740.00	(686.99)
27	**Printing & Reproduction**	1,724.82	4,400.00	(2,675.18)
28	**Recruitment Expense**	38,645.73	34,000.00	4,645.73
29	**Rent**	0.00	11,000.00	(11,000.00)
30	**Seminars and Training**	8,022.99	23,800.00	(15,777.01)
31	**Supplies**	8,768.12	10,450.00	(1,681.88)
32	**Taxes**	91,436,708.20	91,437,500.00	(791.80)
33	**Telephone**	28,306.26	36,575.00	(8,268.74)
34	**Travel**	14,065.58	22,500.00	(8,434.42)
35	**Total Expenses**	**153,548,209.76**	**150,181,570.20**	**3,366,639.56**
36	**Net Operating Income/ (Loss)**	**10,582,877.10**	**3,533,283.80**	**7,049,593.30**
37	**Other Income**			
38	**Other Income**	498,698.65	605,000.00	(106,301.35)
39	**Total Other Income**	**498,698.65**	**605,000.00**	**(106,301.35)**
40	**Net Other Income**	**498,698.65**	**605,000.00**	**(106,301.35)**
41	**Net Income/ (Loss)**	**11,081,575.75**	**4,138,283.80**	**6,943,291.95**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2023 vs FY 2022

		Total	
		July 2022 - May 2023 (FY 2023)	July 2021 - May 2022 (FY 2022)
1	Income		
2	Interest Income	4,763,148.60	388,065.89
3	Premium/Capitation Income	1,199,635,364.54	1,239,303,270.63
4	Total Income	$ 1,204,398,513.14	$ 1,239,691,336.52
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,039,019,730.34	1,015,156,915.75
7	Medical Claim Costs	1,247,695.94	973,148.17
8	Total Cost of Medical Care	$ 1,040,267,426.28	$ 1,016,130,063.92
9	Gross Margin	$ 164,131,086.86	$ 223,561,272.60
10	Expenses		
11	Admin Service Agreement Fees	51,273,453.00	47,795,616.00
12	Bank Charges	0.00	8.22
13	Computer/IT Services	172,699.59	139,490.57
14	Consulting Fees	39,935.00	0.00
15	Depreciation Expense	271,814.45	262,621.32
16	Dues & Subscriptions	241,835.50	154,338.45
17	Grants	4,296,818.19	3,413,636.37
18	Insurance	178,424.34	168,118.67
19	Labor	3,032,331.84	3,323,749.69
20	Legal & Professional Fees	79,911.01	72,374.32
21	License Expense	1,077,042.43	730,652.23
22	Marketing	1,251,431.03	1,301,307.48
23	Meals and Entertainment	19,328.22	18,394.54
24	Office Expenses	73,706.06	54,467.72
25	Parking	184.39	279.62
26	Postage & Delivery	3,053.01	3,229.49
27	Printing & Reproduction	1,724.82	4,113.27
28	Recruitment Expense	38,645.73	20,049.97
29	Rent	0.00	0.00
30	Seminars and Training	8,022.99	10,036.34
31	Supplies	8,768.12	8,965.09
32	Taxes	91,436,708.20	152,394,839.62
33	Telephone	28,306.26	29,587.35
34	Travel	14,065.58	11,053.16
35	Total Expenses	$ 153,548,209.76	$ 209,916,929.49
36	Net Operating Income/ (Loss)	$ 10,582,877.10	$ 13,644,343.11
37	Other Income		
38	Other Income	498,698.65	331,182.24
39	Total Other Income	$ 498,698.65	$ 331,182.24
40	Net Other Income	$ 498,698.65	$ 331,182.24
41	Net Income/ (Loss)	$ 11,081,575.75	$ 13,975,525.35

Item #10

Attachment 10.B

Compliance Report

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of DHCS Filings													
Administrative /Operational	22	20	28	18	25	23	7						143
Member Materials Filed for Approval;	2	3	4	3	3	3	1						19
Provider Materials Reviewed & Distributed	15	12	23	13	10	14	1						88
# of DMHC Filings	11	8	12	10	8	5	2						56

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	0	4	3	1	3	2	0						13
High-Risk	0	0	0	0	0	0	0						

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of New MC609 Cases Submitted to DHCS	0	0	2	0	1	0	1						4
# of Cases Open for Investigation (Active Number)	10	12	12	10	9	11	11						

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 5/18/23 Compliance Regulatory Report to the Commission, there have been two new MC609 cases filed. One case involved a participating Applied Behavior Analysis (ABA) provider, after a referral was received from DHCS. The provider billed all services under one credentialed Board Certified Behavior Analyst (BCBA), but the services were rendered by two non-credentialed BCBAs. No additional information was provided. The other case involved a non-participating provider specializing in hospice services for suspected services not rendered or non-appropriate billing.

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: Fraud Waste & Abuse; Pharmacy, Appeals & Grievances; Emergency Room, and Privacy & Security The following audits have been completed since the last Commission report: Member Call Center (CAP)

Regulatory Reviews/Audits and CAPS:	Status
2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit	The Plan is still awaiting the DMHC's final determination on our 2021 CAP response.
Department of Managed Health Care ("DMHC") 2022 Medical Audit	The Plan is awaiting DMHC's Preliminary Report.
Department of Health Care Services ("DHCS") 2022 Medical Audit	The Plan is awaiting DHCS' CAP closure.
Department of Health Care Services ("DHCS") 2023 Medical Audit	The Plan is awaiting the DHCS' Preliminary Final Report which is to be sent in advance of the formal "Exit Conference".

New Regulations / Contractual Requirements/DHCS Initiatives:	Status
California Advancing and Innovating Medi-Cal (CalAIM)	For the Populations of Focus (POFs) that went live 7/1/23, specifically those pertaining to Children and Youth, CalViva received approval of its Community Supports Model of Care (MOC) and its Enhanced Care Management (ECM) MOC on 6/1/23 and 6/30/23, respectively. The next ECM MOC submission scheduled for 9/1/23 submission will focus on the Justice Involved POF that will go live 1/1/24.
Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP	Starting January 1, 2024, DHCS will expand the availability of Medi-Medi Plans (EAE D-SNPs) for dual eligible Medicare and Medi-Cal members to five additional central valley counties, including Fresno, Kings, and Madera. CalViva Health continues to work with Health Net as it stands up its EAE D-SNP product, "Wellcare by Health Net". Health Net and DHCS have recently executed the State Medicaid Agency Contract (SMAC) which is a care coordination and benefit coordination agreement. CalViva is waiting to obtain from Health Net the integrated Medicare Advantage/Medi-Cal member materials (i.e., EOC and Member ID card, member notices) for CalViva's submission to DMHC. CalViva must obtain DMHC approval to co-brand with Wellcare/Health Net.
Member Handbook/Evidence of Coverage	On 6/29/23, DHCS released the 2024 Model EOC. Plans must review and customize the EOC by 9/1/23.
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 2023 as of July 2023.

Plan Administration:	Status
DHCS 2024 Operational Readiness Work Plan & Contract	The Plan has completed the monthly filings to DHCS of the various policies and other required documents through June 2023, and has received approvals on most but is still responding to additional DHCS information requests for some of the items. The Plan is on schedule to continue the required monthly filings through September 2023.

DHCS 2024 Operational Readiness Work Plan & Contract

As part of the 2024 Operational Readiness Work Plan, on 7/3/23 the DHCS has issued new draft MOU agreement templates that plans will have to use when entering Third Party Entity relationships such as those with local public and behavioral health departments, and educational and governmental agencies such as those listed below:

Department	Program
County Behavioral Health Departments	Specialty Mental Health Services
County Behavioral Health Departments	Substance Use Disorder Services
Local Health Departments	Including, without limitation, California Children's Services (CCS),[1] Maternal, Child, and Adolescent Health (MCAH), TB Direct Observed Therapy
Local Health Departments	Women, Infant, & Children (WIC)
Regional Centers	Behavioral Health Treatment; Intermediate Care Facility – Developmentally Disabled Services
Local Government Agencies	In-Home Services and Supports (IHSS)
Local Government Agencies/County Social Services Departments	County Social Services programs and Child Welfare
Local Government Agency	Targeted Case Management

Committee Report:	
Public Policy Committee (PPC)	The PPC meeting was held on June 7, 2023 at 11:30 in the CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. The following programs and reports were presented: 2022 Health Education (HE) Work Plan Summary, 2023 HE Program Description and 2023 HE Work Plan; 2022 Health Equity Work Plan Evaluation, 2022 Language Assistance Program Evaluation, 2023 Health Equity Program Description, and 2023 Health Equity Work Plan; and the Appeals and Grievances Report. Additionally, a discussion of the Appeals and Grievances report with the PPC members was led by Dr. Marabella which covered how the A&G data is derived, trended, compiled, and reported in the A&G Dashboard (which is also reviewed by the QIUM Committee and the Commission).

APPENDIX A

2023 DHCS All Plan Letters:

APL 23-001 Annual Network Certification (ANC) (Supersedes 21-006)
APL 23-003 CalAim Medical Incentive Payment Program (IPP)
APL 23-004 Skilled Nursing Facilities-LTC Benefit Standardization
APL 23-005 Requirements for Coverage of EPSDT
APL 23-006 Delegation and Subcontractor Network Certification
APL 23-007 Telehealth
APL 23-008 Prop 56 Directed Payments for Family Planning
APL 23-009 Authorization for Post-Stabilization Care Services
APL 23-010 Responsibilities for Behavioral Health Treatment for Mrbs Under 21
APL 23-011 Treatment of Recoveries of Overpayments to Providers
APL 23-012 ENFORCEMENT ACTIONS ADMINISTRATIVE AND MONETARY
APL 23-013 Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework
APL 23-014 PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS
APL 23-015 PROPOSITION 56 DIRECTED PAYMENTS FOR PRIVATE SERVICES
APL 23-016 DIRECTED PAYMENTS FOR DEVELOPMENTAL SCREENING SERVICES
APL 23-017 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES
APL 23-018 MANAGED CARE HEALTH PLAN TRANSITION POLICY GUIDE & 2024 MCP TRANSITION POLICY GUIDE

2023 DMHC All Plan Letters:

APL 23-001 - Large Group Renewal Notice Requirements (1.5.2023) - NA to CVH.pdf
APL 23-002 - SB 979 - Health Emergencies Guidance APL (OPL 1.12.23).pdf
APL 23-005 Network Service Area Confirmation Process (2.13.23).pdf
APL 23-006 - Independent Medical Review Application Form (2.24.23).pdf
APL 23-007 - Provider Directory Annual Filing Requirements (3_23_23).pdf
APL 23-008 - Health Plan Requirements to Timely Pay Claims (3.24.2023).pdf
APL 23-009 - Health Plan Coverage of Preventive Services (3.30.2023).pdf
APL 23-010 - Coverage of Misoprostol-Only Abortion Care (4.10.2023).pdf
APL 23-012 - 2023 Health Plan Annual Assessments.pdf
APL 23-014 - Mandatory Signatories to the CalHHS Data Exchange Framework - REVISED (5.19.23).pdf
APL 23-014 - Mandatory Signatories to the CalHHS Data Exchange Framework (04.24.23).pdf
APL 23-015 - Supplemental Provider Directory Policy Filing (5.16.23).pdf
APL 23-016 - Implementation of SB 1338 (2022) - Community Assistance, Recovery, and Empowerment (CARE) (6.29.2023).pdf

Item #10

Attachment 10.C

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2023

Current as of End of the Month: May
Revised Date: 6/19/2023

CalViva - 2023

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022
Expedited Grievances Received	8	13	13	34	16	12	0	28	0	0	0	0	0	0	0	0	62	74
Standard Grievances Received	93	108	131	332	136	179	0	315	0	0	0	0	0	0	0	0	647	1109
Total Grievances Received	**101**	**121**	**144**	**366**	**152**	**191**	**0**	**343**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**709**	**1183**
Grievance Ack Letters Sent Noncompliant	0	1	0	1	1	1	0	2	0	0	0	0	0	0	0	0	3	5
Grievance Ack Letter Compliance Rate	**100.0%**	**99.1%**	**100.0%**	**99.7%**	**99.3%**	**99.4%**	**0.0%**	**99.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.54%**	**99.5%**
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	7	12	13	32	17	13	0	30	0	0	0	0	0	0	0	0	62	74
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	93	79	116	288	118	157	0	275	0	0	0	0	0	0	0	0	563	1105
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.9%**
Total Grievances Resolved	**100**	**91**	**129**	**320**	**135**	**170**	**0**	**305**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**625**	**1180**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**65**	**68**	**100**	**233**	**102**	**134**	**0**	**236**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**469**	**826**
Access - Other - DMHC	13	12	19	44	26	29	0	55	0	0	0	0	0	0	0	0	99	176
Access - PCP - DHCS	5	7	2	14	14	7	0	21	0	0	0	0	0	0	0	0	35	85
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	6	3	6	15	9	10	0	19	0	0	0	0	0	0	0	0	34	57
Administrative	10	6	13	29	5	18	0	23	0	0	0	0	0	0	0	0	52	119
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	5	5	10	20	9	8	0	17	0	0	0	0	0	0	0	0	37	102
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	12	19	42	20	28	0	48	0	0	0	0	0	0	0	0	90	101
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Transportation - Access	9	14	13	36	12	10	0	22	0	0	0	0	0	0	0	0	58	81
Transportation - Behaviour	3	4	10	17	4	12	0	16	0	0	0	0	0	0	0	0	33	66
Transportation - Other	3	5	8	16	3	12	0	15	0	0	0	0	0	0	0	0	31	30
Quality Of Care Grievances	**35**	**23**	**29**	**87**	**33**	**36**	**0**	**69**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**156**	**354**
Access - Other - DMHC	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	1	0	2	0	0	0	0	0	0	0	0	2	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	2	6	15	3	2	0	5	0	0	0	0	0	0	0	0	20	43
PCP Care	8	9	6	23	8	13	0	21	0	0	0	0	0	0	0	0	44	93
PCP Delay	12	5	13	30	11	10	0	21	0	0	0	0	0	0	0	0	51	104
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	4	2	12	9	6	0	15	0	0	0	0	0	0	0	0	27	66
Specialist Delay	2	3	2	7	1	3	0	4	0	0	0	0	0	0	0	0	11	33
Exempt Grievances Received	144	208	218	**570**	163	199	0	**362**	0	0	0	**0**	0	0	0	**0**	**932**	2429
Access - Avail of Appt w/ PCP	1	3	5	**9**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**11**	53
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Wait Time - wait too long on telephone	0	0	1	**1**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**3**	25
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	10
Access - Panel Disruption	3	3	2	**8**	3	1	0	**4**	0	0	0	**0**	0	0	0	**0**	**12**	25
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Geographic/Distance Access PCP	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	5
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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	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	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	1	2	3	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**6**	6
Attitude/Service - Provider	1	2	3	**6**	4	9	0	**13**	0	0	0	**0**	0	0	0	**0**	**19**	198
Attitude/Service - Office Staff	0	4	0	**4**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**5**	0
Attitude/Service - Vendor	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	15
Attitude/Service - Health Plan	0	2	0	**2**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	5
Authorization - Authorization Related	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	14
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Eligibility Issue - Member not eligible per Provider	2	2	5	**9**	1	6	0	**7**	0	0	0	**0**	0	0	0	**0**	**16**	44
Health Plan Materials - ID Cards-Not Received	14	20	28	**62**	9	14	0	**23**	0	0	0	**0**	0	0	0	**0**	**85**	243
Health Plan Materials - ID Cards-Incorrect Information on Card	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	7
Health Plan Materials - Other	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	6
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Health Plan Assignment - Change Request	53	88	86	**227**	60	60	0	**120**	0	0	0	**0**	0	0	0	**0**	**347**	629
PCP Assignment/Transfer - HCO Assignment - Change Request	35	41	41	**117**	38	50	0	**88**	0	0	0	**0**	0	0	0	**0**	**205**	533
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
PCP Assignment/Transfer - PCP Transfer not Processed	0	1	2	**3**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**5**	20

PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
PCP Assignment/Transfer - Mileage Inconvenience	1	0	2	**3**	3	5	0	**8**	0	0	0	**0**	0	0	0	**0**	**11**	32
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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	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	8	4	3	**15**	3	5	0	**8**	0	0	0	**0**	0	0	0	**0**	**23**	133
Transportation - Access - Provider Late	2	4	5	**11**	5	4	0	**9**	0	0	0	**0**	0	0	0	**0**	**20**	77
Transportation - Behaviour	13	10	14	**37**	10	3	0	**13**	0	0	0	**0**	0	0	0	**0**	**50**	139
Transportation - Other	0	2	1	**3**	1	5	0	**6**	0	0	0	**0**	0	0	0	**0**	**9**	12
OTHER - Other	0	1	1	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	7
Claims Complaint - Balance Billing from Provider	8	15	13	**36**	20	30	0	**50**	0	0	0	**0**	0	0	0	**0**	**86**	173

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	1	1	2	7	0	0	7	0	0	0	0	0	0	0	0	9	42
Standard Appeals Received	29	43	22	94	19	46	0	65	0	0	0	0	0	0	0	0	159	396
Total Appeals Received	**29**	**44**	**23**	**96**	**26**	**46**	**0**	**72**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	168	**438**
Appeals Ack Letters Sent Noncompliant	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	2	3
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.5%**	**98.9%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.74%**	**99.2%**
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	1	2	**3**	7	0	0	**7**	0	0	0	**0**	0	0	0	0	10	42
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	21	29	40	90	19	21	0	40	0	0	0	0	0	0	0	0	130	414
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**21**	**30**	**42**	**93**	**26**	**21**	**0**	**47**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**140**	**457**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**21**	**30**	**39**	**90**	**25**	**21**	**0**	**46**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**136**	454
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	2	2	1	1	0	2	0	0	0	0	0	0	0	0	4	7
DME	2	5	4	11	3	0	0	3	0	0	0	0	0	0	0	0	14	49
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	2
Advanced Imaging	10	18	17	45	8	13	0	21	0	0	0	0	0	0	0	0	66	244
Other	2	0	2	4	2	1	0	4	0	0	0	0	0	0	0	0	8	33
Pharmacy/RX Medical Benefit	4	2	2	8	4	1	0	4	0	0	0	0	0	0	0	0	12	58
Surgery	3	5	12	20	7	5	0	12	0	0	0	0	0	0	0	0	32	61
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**3**	**3**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	3
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
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	2	2	1	0	0	1	0	0	0	0	0	0	0	0	3	2
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	6	10	15	**31**	15	9	0	24	0	0	0	0	0	0	0	0	55	196
Uphold Rate	**28.6%**	**33.3%**	**35.7%**	**33.3%**	**57.7%**	**42.9%**	**0.0%**	**51.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**39.3%**	**42.9%**
Overturns - Full	15	19	26	**60**	11	11	0	**22**	0	0	0	**0**	0	0	0	**0**	82	244
Overturn Rate - Full	**71.4%**	**63.3%**	**61.9%**	**64.5%**	**42.3%**	**52.4%**	**0.0%**	**46.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**58.6%**	**53.4%**
Overturns - Partials	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	9
Overturn Rate - Partial	**0.0%**	**0.0%**	**2.4%**	**1.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**0.7%**	**2.0%**
Withdrawal	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	0	**2**	8
Withdrawal Rate	**0.0%**	**3.3%**	**0.0%**	**1.1%**	**0.0%**	**4.8%**	**0.0%**	**2.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.4%**	**1.8%**
Membership	421,006	435,392	437,493		440,882	443,410	-		-	-	-		-	-	-			417,000
Appeals - PTMPM	0.05	0.07	0.10	0.07	0.06	0.05	-	0.05	-	-	-	-	-	-	-	-	0.06	0.09
Grievances - PTMPM	0.24	0.21	0.29	0.25	0.31	0.38	-	0.34	-	-	-	-	-	-	-	-	0.29	0.24

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 Grievance	Balance billing issue, claims delay in processing
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
Mental 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
Mental 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
Mental 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.

Item #10

Attachment 10.D

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 5/01/2023 to 5/31/2023

Report created 6/27/2023

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.com

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 5/01/2023 to 5/31/2023
Report created 6/27/2023

ER utilization based on Claims data	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
MEMBERSHIP																**Quarterly Averages**						**Annual Averages**		
Expansion Mbr Months	109,227	110,494	112,057	113,089	114,058	114,706	115,670	116,368		116,424	118,919	119,098	120,345	120,949		107,353	109,323	113,068	115,581	118,147		111,331	94,957	
Family/Adult/Other Mbr Mos	268,684	271,216	272,745	273,419	274,053	274,444	275,783	276,086		266,305	278,071	270,885	270,388	269,531		267,342	269,389	273,406	275,438	271,754		271,394	217,130	
SPD Mbr Months	36,021	36,388	36,528	36,696	36,867	37,064	37,288	37,496		39,224	50,115	50,616	51,132	51,364		35,754	36,067	36,697	37,283	46,652		36,450	38,217	
COUNTS																								
Admits - Count	2,242	2,160	2,282	2,313	2,387	2,284	2,319	2,188		2,267	2,573	2,395	2,298	2,371		2,142	2,171	2,327	2,264	2,412		2,226	2,381	
Expansion	707	673	720	682	708	682	644	579		630	619	705	723	772		625	670	703	635	651		658	690	
Family/Adult/Other	1,004	985	1,033	1,127	1,141	1,142	1,201	1,155		1,038	925	1,030	949	1,000		1,024	985	1,100	1,166	998		1,069	988	
SPD	531	499	525	502	528	458	469	452		594	1,026	656	620	595		489	514	518	460	759		495	698	
Admits Acute - Count	1,632	1,535	1,588	1,565	1,666	1,583	1,670	1,516		1,574	1,475	1,634	1,597	1,702		1,538	1,571	1,606	1,590	1,561		1,576	1,596	
Expansion	608	563	600	560	589	570	539	484		526	511	591	605	618		537	568	583	531	543		555	570	
Family/Adult/Other	532	503	497	535	590	585	687	604		560	502	561	512	581		545	525	541	625	541		559	543	
SPD	492	469	491	470	485	428	442	428		487	462	482	480	502		456	478	482	433	477		462	483	
Readmit 30 Day - Count	216	218	240	226	229	238	196	197		247	208	240	222	162		221	208	232	210	232		218	216	
Expansion	93	78	98	97	93	90	76	65		98	79	98	88	58		89	80	96	77	92		86	84	
Family/Adult/Other	49	38	38	36	45	53	48	31		44	41	60	39	38		43	40	40	44	48		42	44	
SPD	74	102	104	93	91	95	72	101		105	88	82	95	66		90	88	96	89	92		91	87	
**ER Visits - Count	16,738	15,182	14,408	14,239	14,232	14,632	15,404	14,339		12,664	12,804	14,233	13,759	8,482		13,173	15,244	14,293	14,792	13,234		14,375	12,388	
Expansion	4,190	4,070	4,166	4,011	3,684	3,685	3,633	3,525		3,421	3,333	3,596	3,538	2,245		3,512	3,944	3,954	3,614	3,450		3,756	3,227	
Family/Adult/Other	6,981	6,520	6,109	6,393	7,135	7,653	8,733	8,373		7,534	7,755	8,450	7,995	5,148		4,787	6,322	6,546	8,253	7,913		6,477	7,376	
SPD	1,466	1,401	1,462	1,456	1,446	1,576	1,655	1,506		1,494	1,499	1,621	1,575	806		1,046	1,374	1,455	1,579	1,538		1,363	1,399	
PER/K																								
Admits Acute - PTMPY	47.3	44.0	45.2	44.4	47.0	44.5	46.7	42.3		43.6	39.6	43.6	42.3	44.8		45.0	45.4	45.5	44.5	42.2		45.1	42.8	
Expansion	66.8	61.1	64.3	59.4	62.0	59.6	55.9	49.9		54.2	51.6	59.5	60.3	61.3		60.0	62.3	61.9	55.1	55.1		59.8	72.1	
Family/Adult/Other	23.8	22.3	21.9	23.5	25.8	25.6	29.9	26.3		25.2	21.7	24.9	22.7	25.9		24.4	23.4	23.7	27.2	23.9		24.7	30.0	
SPD	163.9	154.7	161.3	153.7	157.9	138.6	142.2	137.0		149.0	110.6	114.3	112.6	117.3		153.0	159.1	157.6	139.3	122.7		152.2	151.5	
Bed Days Acute - PTMPY	246.4	229.8	230.2	222.9	238.1	225.9	252.0	234.2		227.5	204.5	230.8	208.5	212.3		240.2	237.1	230.4	237.4	220.9		236.3	216.7	
Expansion	361.4	319.5	341.6	305.7	357.2	347.5	363.5	335.0		333.0	264.8	333.7	314.4	307.8		341.9	333.9	334.9	348.7	310.4		339.9	389.8	
Family/Adult/Other	99.3	91.5	78.4	78.9	93.2	88.5	118.0	100.0		87.5	82.0	100.8	82.3	97.1		94.6	93.7	83.5	102.2	90.0		93.5	112.2	
SPD	997.1	989.7	1,023.3	1,042.5	948.2	868.3	895.3	911.1		931.0	742.5	725.9	673.1	648.5		1,023.8	1,020.2	1,004.6	891.7	789.3		984.3	932.6	
ALOS Acute	5.2	5.2	5.1	5.0	5.1	5.1	5.4	5.5		5.2	5.2	5.3	4.9	4.7		5.3	5.2	5.1	5.3	5.2		5.2	5.1	
Expansion	5.4	5.2	5.3	5.1	5.8	5.8	6.5	6.7		6.1	5.1	5.6	5.2	5.0		5.7	5.4	5.4	6.3	5.6		5.7	5.4	
Family/Adult/Other	4.2	4.1	3.6	3.4	3.6	3.5	3.9	3.8		3.5	3.8	4.1	3.6	3.8		3.9	4.0	3.5	3.8	3.8		3.8	3.7	
SPD	6.1	6.4	6.3	6.8	6.0	6.3	6.3	6.7		6.2	6.7	6.4	6.0	5.5		6.7	6.4	6.4	6.4	6.4		6.5	6.2	
Readmit % 30 Day	9.6%	10.1%	10.5%	9.8%	9.6%	10.4%	8.5%	9.0%		10.9%	8.1%	10.0%	9.7%	6.8%		10.3%	9.6%	10.0%	9.3%	9.6%		9.8%	9.1%	
Expansion	13.2%	11.6%	13.6%	14.2%	13.1%	13.2%	11.8%	11.2%		15.6%	12.8%	13.9%	12.2%	7.5%		14.2%	12.0%	13.6%	12.1%	14.1%		13.0%	12.2%	
Family/Adult/Other	4.9%	3.9%	3.7%	3.2%	3.9%	4.6%	4.0%	2.7%		4.2%	4.4%	5.8%	4.1%	3.8%		4.2%	4.1%	3.6%	3.8%	4.8%		3.9%	4.5%	
SPD	13.9%	20.4%	19.8%	18.5%	17.2%	20.7%	15.4%	22.3%		17.7%	8.6%	12.5%	15.3%	11.1%		18.3%	17.1%	18.5%	19.4%	12.1%		18.3%	12.5%	
**ER Visits - PTMPY	484.9	435.5	410.1	403.5	401.6	411.7	430.9	400.0		350.7	343.5	379.8	364.3	223.3		385.0	440.1	405.1	414.2	358.1		411.2	331.9	
Expansion	460.3	442.0	446.1	425.6	387.6	385.5	376.9	363.5		352.6	336.3	362.3	352.8	222.7		392.6	432.9	419.6	375.3	350.4		404.8	407.8	
Family/Adult/Other	311.8	288.5	268.8	280.6	312.4	334.6	380.0	363.9		339.5	334.7	374.3	354.8	229.2		214.9	281.6	287.3	359.6	349.4		286.4	407.7	
SPD	488.4	462.0	480.3	476.1	470.7	510.3	532.6	482.0		457.1	358.9	384.3	369.6	188.3		351.0	457.0	475.7	508.2	395.6		448.8	439.3	
Services	TAT Compliance Goal: 100%									TAT Compliance Goal: 100%						TAT Compliance Goal: 100%						TAT Compliance Goal: 100%		
Preservice Routine	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%				
Preservice Urgent	98.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%		99.3%	99.1%	99.1%	100.0%	100.0%				
Postservice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	N/A	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	98.0%	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%	99.1%	100.0%	100.0%	100.0%				
Deferrals - Routine	88.9%	87.9%	95.5%	100.0%	100.0%	93.3%	96.0%	100.0%		100.0%	95.7%	96.0%	100.0%	100.0%		100.0%	91.5%	98.8%	96.0%	96.9%				
Deferrals - Urgent	N/A	100.0%	N/A	100.0%	100.0%	N/A	100.0%	N/A		N/A	100.0%	N/A	100.0%	N/A		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	NA	NA	NA	NA	NA	NA	NA	NA		null	null	null	null	null		null	null	null	null	null				
	CCS ID RATE									CCS ID RATE						CCS ID RATE						CCS ID RATE		
CCS %	8.85%	8.41%	8.36%	8.30%	8.27%	8.21%	8.57%	8.53%		8.50%	8.02%	7.98%	7.94%	7.90%		8.69%	8.72%	8.31%	8.44%	8.17%		8.54%	8.07%	
	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	14.3	14.8	16.3	17.8	16.8	16.0	14.8	16.3		14.2	12.1	13.2	12.7	12.8		14.3	14.0	17.0	15.7	13.2		15.2		
OB % Days	10.7%	11.0%	11.7%	12.9%	11.2%	11.5%	10.5%	11.8%		5.1%	1.4%	4.7%	5.7%	8.9%		10.1%	10.5%	11.9%	11.3%	3.7%		17.0%		
OB % Admits	22.0%	23.8%	25.2%	27.1%	25.0%	25.0%	22.9%	26.8%		22.7%	17.5%	20.6%	20.8%	20.5%		22.8%	22.3%	25.8%	24.9%	20.3%		30.0%		
	Perinatal Case Management									Perinatal Case Management						Perinatal Case Management						Perinatal Case Management		

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 5/01/2023 to 5/31/2023
Report created 6/27/2023

ER utilization based on Claims data	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Total Number Of Referrals	199	209	130	184	162	148	126	112		145	133	161	151	148		472	598	476	386	439		1,932	741	
Pending	1	0	0	0	1	0	0	21		5	1	12	28	31		0	2	1	21	18		24	69	
Ineligible	15	10	2	5	3	6	7	6		6	1	9	8	5		18	32	10	19	16		79	30	
Total Outreached	183	199	128	179	158	142	119	85		134	131	140	115	112		454	564	465	346	405		1,829	642	
Engaged	73	76	37	62	84	63	46	28		63	57	53	52	50		157	224	183	137	173		701	276	
Engagement Rate	40%	38%	29%	35%	53%	44%	39%	33%		47%	44%	38%	45%	45%		35%	40%	39%	40%	43%		38%	43%	
New Cases Opened	73	76	37	62	84	63	46	28		63	57	53	52	50		157	224	183	137	173		701	276	
Total Cases Managed	309	311	313	314	344	337	327	280		291	309	320	314	317		344	432	496	410	401		887	504	
Total Cases Closed	73	35	61	52	69	56	73	51		39	41	57	47	47		136	154	182	180	137		652	231	
Cases Remained Open	231	263	247	256	263	278	249	224		242	258	261	258	267		199	263	263	224	261		224	267	
	Integrated Case Management									Integrated Case Management						Integrated Case Management						Integrated Case Management		
Total Number Of Referrals	135	231	190	223	209	221	158	150		220	212	370	344	247		288	503	622	529	802		1,942	1,393	
Pending	1	0	0	0	0	3	1	19		2	6	76	47	25		1	1	0	23	84		25	41	
Ineligible	10	12	11	17	14	14	8	10		48	76	69	51	55		16	26	42	32	193		116	301	
Total Outreached	124	219	179	206	195	204	149	121		170	130	238	246	167		271	476	580	474	538		1,801	1,051	
Engaged	85	172	153	150	142	133	97	98		92	96	145	165	109		185	341	445	328	333		1,299	636	
Engagement Rate	69%	79%	85%	73%	73%	65%	65%	81%		54%	74%	61%	67%	65%		68%	72%	77%	69%	62%		72%	61%	
Total Screened and Refused/Decline	17	15	13	18	23	28	17	15		49	24	71	48	37		19	46	54	60	144		179	262	
Unable to Reach	22	32	13	38	30	43	35	8		29	10	22	33	21		67	89	81	86	61		323	153	
New Cases Opened	85	172	153	150	142	133	97	98		92	96	145	165	109		185	341	445	328	333		1,299	636	
Total Cases Closed	82	92	101	128	104	129	143	123		110	114	102	109	186		181	238	333	395	326		1,147	617	
Cases Remained Open	287	368	414	437	471	469	429	411		382	371	399	464	406		267	368	471	411	399		411	406	
Total Cases Managed	386	475	535	581	590	616	588	540		505	491	522	602	611		458	622	900	818	746		1579	1045	
Critical-Complex Acuity	38	43	42	53	59	61	60	52		43	42	49	62	79		44	60	73	70	61		120	102	
High/Moderate/Low Acuity	348	432	493	528	535	555	528	488		462	449	473	540	532		414	562	827	748	685		1459	943	
	Transitional Case Management									Transitional Case Management						Transitional Case Management						Transitional Case Management		
Total Number Of Referrals	115	136	141	115	180	125	133	105		77	88	102	164	304		252	326	436	363	267		1,377	762	
Pending	0	0	0	0	0	0	0	5		0	0	1	0	10		0	0	0	5	1		5	10	
Ineligible	5	15	8	5	8	3	7	8		8	10	18	8	12		21	24	21	18	36		84	52	
Total Outreached	110	121	133	110	172	122	126	92		69	78	83	156	282		231	302	415	340	230		1,288	700	
Engaged	82	82	124	105	146	107	92	65		56	60	62	127	267		158	213	375	264	178		1,010	609	
Engagement Rate	75%	68%	93%	95%	85%	88%	73%	71%		81%	77%	75%	81%	95%		68%	71%	90%	78%	77%		78%	87%	
Total Screened and Refused/Decline	5	6	3	1	14	5	9	11		1	3	4	4	1		4	12	18	25	8		59	12	
Unable to Reach	23	33	6	4	12	10	25	16		12	15	17	25	14		69	77	22	51	44		219	79	
New Cases Opened	82	82	124	105	146	107	92	65		56	60	62	127	267		158	213	375	264	178		1,010	609	
Total Cases Closed	60	114	82	120	136	113	106	82		70	55	70	62	145		138	220	338	301	195		997	402	
Cases Remained Open	80	56	100	83	87	75	55	45		30	29	19	59	96		71	56	87	45	19		45	96	
Total Cases Managed	158	188	200	217	245	206	180	135		113	107	112	147	330		214	297	579	372	265		1127	660	
High/Moderate/Low Acuity	158	188	200	217	245	206	180	135		113	107	112	147	330		214	297	579	372	265		1127	660	
	Palliative Care									Palliative Care						Palliative Care						Palliative Care		
Total Number Of Referrals	10	13	9	21	21	17	7	15		11	10	12	16	15		24	32	51	39	33		146	63	
Pending	0	0	0	0	0	0	0	3		0	0	4	10	5		0	0	0	3	4		3	7	
Ineligible	1	4	1	8	8	5	0	6		6	3	2	1	1		11	7	17	11	11		46	16	
Total Outreached	9	9	8	13	13	12	7	6		5	7	6	5	9		13	25	34	25	18		97	40	
Engaged	5	8	5	11	7	7	6	6		5	5	5	3	6		9	19	23	19	15		70	30	
Engagement Rate	56%	89%	63%	85%	54%	58%	86%	100%		100%	71%	83%	60%	67%		69%	76%	68%	76%	83%		72%	75%	
Total Screened and Refused/Decline	1	1	1	0	4	4	0	0		0	2	1	2	3		2	2	5	4	3		13	8	
Unable to Reach	3	0	2	2	2	1	1	0		0	0	0	0	0		2	4	6	2	0		14	2	
New Cases Opened	5	8	5	11	7	7	6	6		5	5	5	3	6		9	19	23	19	15		70	30	
Total Cases Closed	1	5	4	7	4	7	9	3		7	4	8	4	4		23	12	15	19	19		69	27	
Cases Remained Open	77	82	83	86	92	87	86	92		88	91	88	89	95		73	82	92	92	88		92	95	
Total Cases Managed	83	90	89	96	97	99	96	95		99	97	98	94	100		99	97	114	111	109		167	123	
	Behavioral Health Case Management									Behavioral Health Case Management						Behavioral Health Case Management						ehavioral Health Case Managemer		
Total Number Of Referrals	107	101	90	111	69	70	65	79		70	76	89	47	61		295	318	270	214	235		1,097	342	
Pending	0	0	0	0	0	0	0	8		1	1	15	3	1		0	0	0	8	17		8	3	
Ineligible	4	10	4	8	1	0	2	4		2	5	9	3	4		25	18	13	6	16		62	27	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 5/01/2023 to 5/31/2023
Report created 6/27/2023

ER utilization based on Claims data	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Total Outreached	103	91	86	103	68	70	63	67		67	70	65	41	56		270	300	257	200	202		1,027	312	
Engaged	73	59	56	74	45	46	43	51		48	49	43	29	34		164	203	175	140	140		682	203	
Engagement Rate	71%	65%	65%	72%	66%	66%	68%	76%		72.0%	70.0%	66.0%	71.0%	61.0%		61%	68%	68%	70%	69%		66%	65%	
Total Screened and Refused/Decline	3	5	7	4	2	4	4	1		1	2	3	3	6		11	12	13	9	6		45	16	
Unable to Reach	27	27	23	25	21	20	16	15		18	19	19	9	16		95	85	69	51	56		300	93	
New Cases Opened	73	59	56	74	45	46	43	51		48	49	43	29	34		164	203	175	140	140		682	203	
Total Cases Closed	51	52	73	73	71	61	55	32		43	61	50	31	48		134	142	217	148	154		641	233	
Cases Remained Open	200	212	171	193	171	151	145	160		167	154	149	146	131		149	212	171	160	149		160	131	
Total Cases Managed	261	267	273	276	248	222	202	199		215	221	203	181	183		293	359	444	316	307		809	370	
Critical-Complex Acuity	12	12	12	7	9	9	11	7		7	9	11	18	15		18	15	17	12	13		30	18	
High/Moderate/Low Acuity	249	255	261	269	239	213	191	192		208	212	192	163	168		275	344	427	304	294		779	352	

Item #10

Attachment 10.E

Quarterly Summary Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick C. Marabella, MD
Amy R. Schneider, RN

COMMITTEE DATE: July 20th, 2023

SUBJECT: CalViva Health QI & UMCM Update of Activities Quarter 2 2023 (July 2023)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health QI & UMCM performance, program and regulatory activities in Quarter 2 of 2023.

I. Meetings

One QI/UM meeting was held in Quarter 2, on May 18th, 2023. Two new providers joined the CalViva Health QI/UM Committee to fill vacant positions during this reporting period and attended their first meeting in May. **Carolina Quezada, M.D.,** Family Health Care Network and **DeAnna Waugh, Psy.D.,** Adventist Health, Fresno County. The following guiding documents were approved at the May meeting:

1. 2022 Health Equity End of Year Evaluation
2. 2023 Health Equity Program Description
3. 2023 Health Equity Work Plan
4. 2022 Health Equity Language Assistance Program Report
5. 2022 Health Education End of Year Evaluation
6. 2023 Health Education Program Description
7. 2023 Health Education Work Plan

In addition, the following general document were adopted at the meeting:

1. Medical Policies
2. Pharmacy Provider Updates

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. The Committee received an orientation to the grievance process including how members and providers can submit grievances via various routes and each of these are categorized and reported on the dashboard and in other narrative reports. Standardized criteria are used to classify each case in order to include them in the appropriate area on the monthly dashboard. Each monthly Excel Report (dashboard) includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. The Outlier tab provides an analysis of the data trends.
   - **a.** The total number of grievances through March 2023 (Q1) was higher when compared to Q4 2022 but consistent with Q1 2022.
   - **b.** Quality of Care Grievances are consistent with prior year totals.
   - **c.** Exempt Grievances remain consistent or lower than prior year totals.

d. Appeals for Q1 2023 have remained consistent overall when compared to last year with some variation in the volumes of the various appeal types such as Advanced Imaging, surgery, and pharmacy quarter over quarter.

e. Transportation-related metrics remain consistent in overall volumes compared to 2022, with a moderate shift in volumes noted from Exempt to Quality-of-Service grievance type. This issue continues to be monitored closely to ensure improvement plans and CAPs are in place and actions are taken when indicated.

f. **The A & G Member Letter Monitoring Report** provides a summary of the daily audits of acknowledgement and resolution letters. Technical issues are identified and corrected before letters are mailed. Analysis of compliance with NCQA standards was still in progress when this report was presented in Q1 and will be followed with an updated report.

2. The **Potential Quality Issues (PQI) Report** provides a summary of 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. Data for Q1 was reviewed for all case types including the follow up actions taken when indicated. The number of cases reviewed in Quarter 1 was consistent with or slightly lower than recent months. Follow up occurs when indicated.
3. **Access Related Reports - Provider Office Wait Time Report** summarizes efforts to monitor how long members wait to be seen by a provider in the office or clinic. This is one of the ways we monitor timely access to care and services. In Q1 2023, all three counties were within the 30-minute office wait time threshold for both mean and median metrics. Sixty-four (64) providers submitted office wait time data in Quarter 1 for a total of 1431 patients monitored. This is higher than in recent quarters but did demonstrate a decline in Madera and Kings County reporting. Provider Engagement will be assisting with reminding and re-educating office staff with an emphasis on Kings and Madera counties.
4. **Additional Quality Improvement Reports** as scheduled for presentation at the QI/UM Committee during Q2.

III. UMCM Reports -

The following is a summary of the reports and topics reviewed:

1. **The Key Indicator Report (KIR) & UM Concurrent Review Report** provide data through March 31st, 2023. Quarterly comparisons are reviewed with the following results:
   a. Overall membership has leveled off but is expected to decline with the re-start of the member redetermination process. A comparison of Admissions, Bed Days, Average Length of Stay, and Readmissions was provided comparing Q1 '23 to Q4 '22.
   b. All Populations are better than the goal for bed days and admissions for Q1 2023.
   c. All Populations experienced a decrease in Q1 2023 for Average Length of Stay compared to Q4 2022.
   d. SPD utilization is noted to be down in March.
2. **TurningPoint Musculoskeletal Utilization Review** provides a summary of compliance with the prior authorization review process for ortho-neuro and pain procedures. Compliance was not achieved in Q1 for standard/non-urgent prior authorization turnaround times (TAT). A Corrective Action Plan (CAP) was issued in February 2023 to be completed by March 31, 2023. The Call Center established metrics were met. CAP closure will be monitored.
3. The **PA Member Letter Monitoring Report** monitors the Notice of Action (NOA) letters for compliance with regulatory standards including Prior Authorization, Concurrent, and Post-service denials. A total of seven (7) denial/deferral letters were found to have opportunities for improvement. Staff/physician coaching was provided focused on use of clear and concise language and to avoid medical jargon.

4. **Additional UMCM Reports** including Concurrent Review IRR Report, CCS Report, and others scheduled for presentation at the QI/UM Committee during Q2.

IV. HEDIS® Activity

In Q2, HEDIS® related activities were focused on finalizing and preparing **Measurement Year** (**MY)2022 full HEDIS® Data for submission** to HSAG & DHCS for the Managed Care Accountability Set (MCAS) measures. Final Attestations and IDSS submission were completed by the June 15th deadline. Medi-Cal Managed Care (MCMC) health plans currently have 15 quality measures (MCAS) on which we will be evaluated this year. The Minimum Performance Level (MPL) remains at the 50th percentile.
In 2023, MCPs are required to initiate two (2) new Performance Improvement Projects (PIPs) which will continue through the end of 2026. Each health plan is required to initiate one clinical PIP and one non-clinical PIP.
Medical Management's current improvement projects are:

1. *One clinical Disparity PIP* – ***Well-Child Visits in the African American population in Fresno County.*** In Q2 our proposal was submitted and approved. Sections 1-6 of the PIP Documentation Form are due to HSAG by 09/08/2023.
2. *One Non-clinical PIP* - ***Improve referrals to Community Support programs*** *(Sobering Centers, Day Habilitation programs)* ***within 7 days*** *of visiting emergency department (ED) for members with a* ***SUD/SMH diagnosis and seen in ED for the same diagnoses.*** In Q2 our proposal was submitted and approved. Sections 1-6 of the PIP Documentation Form are due to DHCS by 09/08/2023.
3. One SWOT Improvement Project **- Childhood Immunizations (CIS-10)** *Well-Child & Childhood Immunization* ***SWOT*** *in progress with three (3) strategies in the implementation phase. Our second Progress Report is due to DHCS on 07/17/2023.*

VI. Findings/Outcomes

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

Item #10

Attachment 10.F

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners
CalViva QI/UM Committee

FROM: Patrick C. Marabella, MD
Amy R. Schneider, RN

COMMITTEE DATE: July 20th, 2023

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 2 2023

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 2nd. Quarter 2023 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on May 18th, 2023. At the May meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the fourth quarter for 2022 were reviewed for delegated entities and first quarter 2023 for Health Net and MHN. A summary of the fourth quarter data is included in the table below.

III. Table 1. Fourth Quarter 2022 Credentialing/Recredentialing

	Sante	ChildNet	MHN	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	Totals
Initial credentialing	49	12	47	1	99	0	0	8	28	29	**273**
Recredentialing	50	28	27	11	31	2	3	11	45	9	**217**
Suspensions	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**99**	**40**	**74**	**12**	**130**	**2**	**3**	**19**	**73**	**38**	**490**

IV. Credentialing Adverse Actions for Q1 for CalViva from Health Net Credentialing Committee was presented. There were no cases for January or February 2023 and two cases presented in March. Both cases were pended awaiting the Medical Board's decision and actions.

V. The 2023 Adverse Events Report is a new report for the Credentialing Sub-Committee and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two cases identified for Q1 2023 with adverse outcomes associated with a contracted practitioner. Both cases remain open for review in the Peer Review Process.

VI. The 2023 Credentialing Sub-committee Charter was reviewed for annual approval. The following edits to the Charter were discussed: 1) Added NCQA to the list of credentialing and re-credentialing compliance activities. 2) The description of the composition of the physicians that make up the Credentialing Sub-Committee was revised to include, "external participating practitioners". The revised Charter was approved.

Item #10

Attachment 10.G

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	July 20th, 2023
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 2 2023

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the CalViva Health Peer Review Sub-Committee activities. All Peer Review information is confidential and protected by law under the Knox Keene Health Care Services Plan Act of 1975, Section 1370 which prohibits disclosure to any parties outside the peer review process.

I. The Peer Review Sub-Committee met on May 18th, 2023. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 1 2023 were reviewed for approval. There were no significant cases to report.

II. The 2023 Peer Review Sub-committee Charter was reviewed for annual approval. The following edits to the Charter were discussed: 1) Added NCQA to the list of criteria and compliance activities to comply with. 2) The description of the composition of the physicians that make up the Peer Review Sub-Committee was revised to include, "external participating practitioners". The revised Charter was approved.

III. The 2023 Adverse Events Report is a new report for the Peer Review Sub-Committee and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two cases identified for Q1 2023 with adverse outcomes associated with a contracted practitioner. Both cases remain open for review in the Peer Review Process.

IV. The Quarter 1, 2023 Peer Count Report was presented at the meeting with a total of twelve (12) cases reviewed. The outcomes for these cases are as follows:

- There were six (6) cases closed and cleared. There was one (1) case pending closure for Corrective Action Plan compliance. There were five (5) cases tabled for further information.

V. Follow up will be initiated to obtain additional information for the tabled case and ongoing monitoring and reporting will continue.

Item #10

Attachment 10.H

Executive Dashboard

	2022	2022	2022	2022	2022	2022	2022	2022	2023	2023	2023	2023	2023
Month	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**
CVH Members													
Fresno	326,706	328,315	330,629	331,857	333,152	334,058	335,572	336,359	338,835	349,660	351,313	353,806	355,821
Kings	34,780	34,935	35,216	35,453	35,619	35,804	36,051	36,208	36,388	38,617	38,772	39,184	39,372
Madera	43,528	43,819	44,285	44,542	44,805	44,997	45,377	45,484	45,783	47,115	47,408	47,892	48,217
Total	405,014	407,069	410,130	411,852	413,576	414,859	417,000	418,051	421,006	435,392	437,493	440,882	443,410
SPD	35,420	35,710	35,896	36,079	36,243	36,409	36,589	36,848	38,875	49,002	49,750	50,141	50,455
CVH Mrkt Share	68.61%	68.58%	68.41%	68.39%	68.38%	68.34%	68.29%	68.23%	68.10%	67.08%	67.14%	67.21%	67.26%
ABC Members													
Fresno	136,115	137,062	139,004	139,689	140,370	141,093	142,029	142,820	144,993	157,415	157,746	158,447	158,902
Kings	23,185	23,312	23,622	23,735	23,794	23,857	24,011	24,185	24,323	25,683	25,797	25,854	25,987
Madera	26,023	26,168	26,745	26,935	27,089	27,242	27,552	27,692	27,897	30,593	30,579	30,831	30,902
Total	185,323	186,542	189,371	190,359	191,253	192,192	193,592	194,697	197,213	213,691	214,122	215,132	215,791
Default													
Fresno	707	576	566	693	630								
Kings	186	138	133	159	144								
Madera	106	82	101	128	90								
County Share of Choice as %													
Fresno	62.40%	61.80%	65.10%	64.80%	62.60%								
Kings	57.10%	56.50%	47.90%	58.90%	55.40%								
Madera	64.00%	69.50%	61.60%	73.30%	72.40%								
Voluntary Disenrollment's													
Fresno	481	458	389	448	414								
Kings	60	35	48	46	63								
Madera	79	53	53	43	60								

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 Age of Workstations	**3 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**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**
		Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	(Main) Member Call Center	**# of Calls Received**	**26,972**	**31,993**	**26,858**	**26,747**	**24,875**	**35,660**
		# of Calls Answered	**26,570**	**31,509**	**26,465**	**26,495**	**24,707**	**35,418**
		Abandonment Level (Goal < 5%)	**1.50%**	**1.50%**	**1.50%**	**0.90%**	**0.70%**	**0.70%**
		Service Level (Goal 80%)	**92%**	**95%**	**94%**	**88%**	**96%**	**94%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,076**	**1,365**	**1,511**	**1,082**	**602**	**813**
		# of Calls Answered	**1,068**	**1,352**	**1,490**	**1,066**	**596**	**808**
		Abandonment Level (Goal < 5%)	**0.70%**	**1.00%**	**1.40%**	**1.50%**	**1.00%**	**0.60%**
		Service Level (Goal 80%)	**90%**	**89%**	**88%**	**86%**	**92%**	**91%**
	Transportation Call Center	**# of Calls Received**	**7,768**	**6,737**	**8,470**	**8,062**	**9,278**	**12,407**
		# of Calls Answered	**7,628**	**6,663**	**8,411**	**8,014**	**9,241**	**12,394**
		Abandonment Level (Goal < 5%)	**1.30%**	**0.80%**	**0.40%**	**0.50%**	**0.20%**	**0.10%**
		Service Level (Goal 80%)	**61%**	**75%**	**85%**	**85%**	**88%**	**94%**
	CalViva Health Website	**# of Users**	**22,000**	**28,000**	**25,000**	**32,000**	**27,000**	**54,000**
		Top Page	**Main Page**	**Provider Search**	**Provider Search**	**Provider Search**	**Do You Qualify?**	**Main Page**
		Top Device	**Mobile (62%)**	**Mobile (62%)**	**Mobile (59%)**	**Mobile (60%)**	**Mobile (57%)**	**Mobile (60%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 1 minute**	**~ 2 minutes**
Message from the CEO	Q1 2023 data were presented during the May 18, 2023 Commission Meeting. Q2 2023 data is not yet available.							

Provider Network & Engagement Activities	**Year**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Hospitals	**11**	**11**	**10**	**10**	**10**	**10**	**10**
	Clinics	**156**	**156**	**154**	**155**	**155**	**155**	**155**
	PCP	**391**	**386**	**378**	**382**	**383**	**385**	**387**
	PCP Extender	**284**	**284**	**284**	**305**	**310**	**314**	**318**
	Specialist	**1335**	**1284**	**1194**	**1277**	**1291**	**1346**	**1401**
	Ancillary	**242**	**240**	**240**	**239**	**240**	**238**	**236**
	Year	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Behavioral Health	**430**	**447**	**472**	**497**	**530**	**472**	**507**
	Vision	**45**	**43**	**39**	**39**	**25**	**30**	**37**
	Urgent Care	**13**	**13**	**14**	**10**	**11**	**11**	**12**
	Acupuncture	**6**	**5**	**5**	**6**	**4**	**4**	**4**
	Year	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	% of PCPs Accepting New Patients - Goal (85%)	**95%**	**95%**	**95%**	**95%**	**92%**	**97%**	**97%**
	% Of Specialists Accepting New Patients - Goal (85%)	**96%**	**96%**	**97%**	**98%**	**97%**	**97%**	**98%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**96%**	**97%**	**97%**	**97%**	**97%**	**96%**	**96%**
	Year	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Providers Touched by Provider Relations	**112**	**160**	**282**	**307**	**326**	**421**	**461**
	Provider Trainings by Provider Relations	**549**	**411**	**281**	**219**	**426**	**351**	**642**
	Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
	Total Providers Touched	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**	**1,797**
	Total Trainings Conducted	**762**	**808**	**1,353**	**257**	**3,376**	**5,754**	**1,919**
Message From the CEO	The increase in Specialists is attributed to a new provider group and the addition of those respective specialist providers to the network.							

Claims Processing	**Year**	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	95% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	99% / 99% N/A	96% / 99% N/A	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 95% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	99% / 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% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / NA NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	93% / 99% NO	97% / 99% YES	97% / 99% YES	99% / 100% YES	96% / 99% NO	99% / 100% NO	99% / 99% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	84% / 93% NO	88% / 95% NO	80% / 95% NO	78% / 87% YES	81% / 89% YES	90% / 94% YES	82% / 91% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 99% YES	63% / 99% YES	95% / 99% YES	79% / 95% YES	55% / 89% NO	95% / 100% YES	90% / 100% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% YES	98% / 99% YES	97% / 100% NO	88 / 100% YES	98% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% YES	99% / 100% YES	97% / 97% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	98% / 100% YES	84% / 89% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 100% NO	95% / 100% NO	91% / 96% NO	94% / 100% YES	99% / 99% NO	99%/100% NO	99%/100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	73% / 98% NO	89% / 96% NO	99% / 99% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q1 2023 data is available. Management is monitoring PPG 2 and PPG 3 as it pertains to Deficiency Disclosures and non-compliance metric(s). All other areas met goal.							

Provider Disputes	**Year**	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	99%	98%	97%	96%	98%
	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%)	100%	100%	100%	100%	100%	N/A	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	96%	94%	97%	100%	100%	100%	100%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	84%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	96%	99%	97%	97%	45%	85%	71%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	100%	100%	100%	100%	100%	99%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	97%	97%	86%	98%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	N/A	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	79%	39%	91%	43%	96%	98%	N/A
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	100%	100%	100%	100%	100%
Message from the CEO	Q1 2023 numbers are available. All areas met goal with the exception of PPG 3 & PPG4. Management is working with PPG 3 & PPG 4 on improving performance.							