Fresno-Kings-Madera
Regional Health Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEXT MEETING: September 19th, 2024

Submitted this Day: September 19th, 2024

Submitted by: Amy Schneider RN

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

X

Patrick Marabella, MD Committee Chair