Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
February 20th, 2025

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**, Medical Management Senior 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 10:03 am. A quorum was present. Dr. Marabella mentioned that he will be polling Committee Members regarding the structure and frequency of future QIUM Committee meetings.	
#2 **Approve Consent Agenda** Committee Minutes: November	The November 21st, 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	**Motion**: *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
21, 2024 - Member Incentive Programs Semi-Annual Report (Q3 & Q4 2024) - California Children's Services Report (Q4 2024) - Concurrent Review IRR Report (Q4 2024) - A&G Inter-Rater Reliability Report (Q4 2024) - Provider Preventable Conditions (Q4 2024) - Provider Office Wait Time Report (Q4 2024) - County Relations Quarterly Report (Q4 2024) - Customer Contact Center DMHC Expedited Grievance Report (Q4 2024) - SPD HRA Outreach (Q3 2024) - Enhanced Care Management and Community Supports Performance Report (Q3 2024) - TurningPoint Musculoskeletal Utilization Review (Q3 2024) - MedZed Integrated Care Management Report (Q3 2024) - Access Work Group Minutes from 12/03/2024 - Access Work Group Quarterly Report (Q4 2024)	for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Ramirez/Cardona) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments A-O) **Action** Patrick Marabella, M.D Chair		
#3 **QI Business** - A&G Dashboard (December 2024) - A&G Executive Summary (Q4 2024) - A&G Quarterly Member Report (Q4 2024) (Attachments P-R) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard through December 2024, Appeals & Grievances Executive Summary Q4 2024, and Appeals & Grievances Quarterly Member Report Q4 2024** were presented. Dr. Marabella explained the process in which members and providers submit grievances via phone, fax, email, or online, and how each of these grievances are categorized and reported on the dashboard, with supportive narratives in the separate quarterly reports. Monthly Excel files include the logs identifying each member who submitted a grievance during the monthly reporting period with a narrative description of the grievance and resolution (as applicable). A total of 2,118 grievances were received for YTD 2024, and the total received for 2023 was 1,887. For YTD 2024, 1,841 grievances were categorized as Quality of Service (QOS), main categories include: prior authorizations, network access, and balanced billing. • Administrative issues have increased (430 YTD 2024), largely due to changes in PPG contracting and network access issues. • Balanced Billing cases started being tracked in 2024. The YTD total is 279. As the number of cases continues to rise; monitoring continues for sustained improvement. • Monitoring Other category corresponds to CalAIM benefits, specifically medically tailored meals (144 YTD 2024). • Transportation Access, like no-shows, has decreased compared to last year. There were 293 YTD 2024 Quality of Care (QOC) grievances; a decrease from 2023 (361). • PCP Care QOC grievances remain a concern and were only slightly higher than the 2023 rate. Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one (1) business day. • The Attitude/Service Provider category increased from 43 in 2023 to 173 YTD 2024. • ID cards remain an issue, though improvements are being made to address these grievances. • No-shows in the Transportation exempt category have decreased but have increased in the QOS category. • Balance Billing grievances remain fairly consistent.	**Motion**: *Approve* - A&G Dashboard (December 2024) - A&G Executive Summary (Q4 2024) - A&G Quarterly Member Report (Q4 2024) (Ramirez/Cardona) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Total Appeals Received have increased (484 YTD 2024) compared to last year (365 YTD 2023). • Requests for various DMEs have increased, including equipment for children's cranial issues, CPAP oxygen, scooters, and wheelchairs. The cause of the increase is unclear. • Advanced imaging requests are stable, with improvements noted in cardiology. MRI requests have been significant, especially in non-cardiac cases. • Meal appeal requests have spiked, particularly for extended meal plans (two (2) meals/day for 26 weeks). Strict criteria exist, but some requests do not meet the guidelines (e.g., elderly people are unable to cook). • The uphold/overturn ratio for appeals remains unbalanced, primarily due to non-cardiac advanced imaging cases. The appeal outcomes for January improved (from 40% overturned to 40% upheld).	

#3 **QI Business**
- A&G Classification Audit Report (Q4 2024)
- A&G Member Letter Monitoring Report (Q4 2024)
 	
(Attachment S, T)
 	
Action
Patrick Marabella, M.D Chair
	The **Appeals & Grievances Classification Audit Report Q4 2024** is a review of a random sample of grievance logs and grievance classifications while the case is still open to ensure appropriate disposition of grievances.
	• Out of 261 cases reviewed by A&G Clinical staff this quarter, 247 cases were classified correctly, yielding a 95% accuracy rate.
	• Out of 14 misclassified cases:
	  • Eight (8) were classified as QOS instead of QOC.
	  • Four (4) were misclassified as QOS; three (3) remained QOS, and one (1) was reclassified as an appeal.
	  • One (1) identified as Invalid which was closed/opened in error.
	  • One (1) misclassified as QOS; closed as a duplicate.
	Audits were completed on approximately 55% of the Q4 grievance universe. All case classifications were corrected prior to case closure.
	
	The **Quarterly A & G Member Letter Monitoring Report Q4 2024** provides a summary of the daily audits of acknowledgment and resolution letters to ensure:
	• Required bolding of DMHC and Plan Phone numbers.
	• The branding is consistently CalViva Health.
	• Communication to members regarding decision documentation in Appeal Resolution Letters must be clear and concise.
		Motion: *Approve*
		- A&G Classification Audit Report (Q4 2024)
		- A&G Member Letter Monitoring Report (Q4 2024)
		
		(Ramirez/Cardona)
		5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Decision criteria and rationale are fully referenced. o This metric shows improvement, with a few minor issues that are being corrected. All errors identified by the A & G team in Table 1 were corrected prior to mailing. The clinical team will continue to monitor and track acknowledgment and resolution letters.	
#3 **QI Business** - Call Center Inquiry Audit Report (Q4 2024) (Attachment U) **Action** Patrick Marabella, M.D Chair	The **Call Center Inquiry Audit Report Q4 2024** report is conducted to ensure all member expressions of dissatisfaction are properly identified and processed as grievances and ensures the proper handling and/or routing of grievances to the Appeals and Grievances department where the Oversight team will implement a quarterly internal audit. A monthly audit of a randomized sample of ten (10) inquiry call audio files are evaluated against established criteria. If an individual audio file is not auditable or is otherwise unavailable, a replacement file is selected for the audit. Both English and Spanish calls are evaluated. • During Q4 2024, a total of 30 cases were audited and were found to be 100% compliant.	**Motion**: *Approve* - Call Center Inquiry Audit Report (Q4 2024) (Ramirez/Cardona) 5-0-0-3
#3 **QI Business** - Behavioral Health Performance Indicator Report (Q3) - Potential Quality Issues Report (Q4) (Attachment V, W) **Action** Patrick Marabella, M.D Chair	The **Behavioral Health Performance Indicator Report Q3 2024** provides a summary to evaluate specific elements of the behavioral health services provided to CalViva members. The behavioral health potential quality issues, provider disputes, network availability, and adequacy metrics were previously included in this report. However, due to organizational changes, this information has been integrated into other existing reports. Five metrics remain. In Q3 2024, all five (5) metrics met or exceeded set targets. The non-ABA review timeliness metric met the 100% target. Therefore, a barrier analysis and an improvement plan were not required. • CalViva overall membership for Q3 2024 was 438,944. • The Q3 2024 behavioral health utilization rate (of unique members with at least one (1) behavioral health claim) was 3%. (This metric has a 1-quarter lag.) • Appointment availability met the target at 100%, and there were zero (0) Urgent cases. • Authorization timeliness is reported at 100%, with a breakdown of 35 non-ABAs and 1,293 ABAs for Q3 2024. The **Potential Quality Issues (PQI) Report Q4 2024** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or Peer Review activity. 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. The PQI report also includes behavioral health under SB 850 (parity regulations). Data for Q4 2024 was reviewed for all case types including the follow-up actions	**Motion**: *Approve* - Behavioral Health Performance Indicator Report (Q3) - Potential Quality Issues Report (Q4) (Waugh/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	taken when indicated. • There were two (2) non-member-generated PQIs in Q4, both scoring a level 0 indicating minimal issues. • Member-generated PQIs decreased based on previous quarters with a total of 82 Physical Health cases and one (1) Behavioral Health case. PCP-related cases were reported at 54, Specialist-related cases were reported at 17, and Hospital/ER cases were reported at seven (7). The remaining four (4) cases were categorized as Cultural, Vendor, and Home Health related cases. Outcome scores were reported as 49 at level zero, 21 at level I, 12 cases scored at level II, and one (1) at level III which automatically is referred to Peer Review. • There were fifteen (15) Peer Review generated cases (none were Behavioral Health). Nine (9) cases are closed, and six (6) cases are open. • There were 34 Peer Review generated cases that required further action (none were Behavioral Health).	

#4 **QI/UM/CM Business**
- QI/HE Work Plan End of Year Evaluation & Executive Summary 2024
 	
(Attachment X)
 	
Action
Patrick Marabella, M.D Chair
	2024 Quality Improvement Work Plan End of Year Evaluation and Executive Summary were presented and reviewed. The 2024 Quality Improvement and Health Education (QIHEd) End of Year Program Evaluation includes:
	• Summary of Overall Effectiveness of QI Program
	• Goals and Quality Indicators
	• Overall Effectiveness of QI & HEd Work Plan Initiatives
	• QI & HEd Reporting
	• Summary of Key Accomplishments
	• Annual QI & HEd Program Changes
	The QIHEd Oversight Structure was reviewed noting the roles and frequency of each committee's meetings.
	Goals and Quality Indicators: The QIHEd 2024 Work Plan includes the following categories:
	• Behavioral Health: 0/6 MY2023 Objectives Met: 0% Rate
	  ○ Focus on improving follow-up after E.D. visits for substance use or mental health disorders measured by the HEDIS® metrics FUA-7/30 and FUM-7/30.
	  ○ Overall, CVH did not meet the 50th Percentile Quality Compass performance goal. Kings County did meet the MPL for both measures in MY2022, so Kings was excluded from activities in 2024.
		Motion: *Approve*
		- QI/HE Work Plan End of Year Evaluation & Executive Summary 2024
		
		(Cardona/Ramirez)
		5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Non-clinical PIP to focus on Fresno and Madera Counties with education for CHWs/SUNs & social workers on: • #1 Coding education and • #2 Hispanic Cultural Competency. ▪ The project is ongoing until 2026. • Chronic Conditions/Chronic Disease: 6/6 Objectives Met: 100% Rate (excluding asthma) o Implement strategies to improve performance in Asthma Medication Ratio (AMR), Blood Pressure Control (CBP), and Diabetes (CDC >9): ▪ Connected via phone calls with members to close care gaps in diabetes management and blood pressure control. ▪ Partnered with Asthma Remediation and Education Services to educate members on how they may reduce at-home asthma triggers. • Hospital Quality/Patient Safety: 9/11 Objectives Met: 81.82% Rate o CVH has 5 facilities in total all working to ensure hospitals provide appropriate, safe care to patients that avoid preventable harm, and guide members about informed choice when selecting a site. ▪ All CVH hospitals submitted sufficient data to develop a scorecard. ▪ Improvement is still needed in hospital-acquired infections (CLABSI & SSI Colon did not improve). All hospitals continued good performance towards the goal rates of: Clostridioides difficile (C.Diff), MRSA, and CAUTI. ▪ C-section performance improved in 3/5 hospitals, meeting the target rate of 23.5% compared to improvement in just one last year. • Member Engagement & Experience: 0/1 Objectives Met: 0% Rate o CAHPS Survey: 3/8 measures met the Outcome Quality Compass (QC) 25th percentile goal. ▪ For MY2023 73.50% of members felt that they are getting needed care. ▪ For MY2023 81.38% of members rated their Personal Doctor favorably. ▪ For MY2023 81.98% of members rated the Health Plan favorably. • Pediatric/Children's Health: 15/30 Objectives Met (Pediatric/Perinatal/Dental): 50% Rate o Clinical PIP Project: Increase rates of Well-Child Visits for Black/African American members in the first 30 months of life (W30-6+). o Target Population: Black/African American members in Fresno County.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ First Intervention focuses on birthing parents & infants up to three (3) months are referred to Black Infant Health for education and encouragement to attend well-child visits. ○ PIP Submission: Steps 1-8 and intervention worksheet submitted in September 2024 with updates in December, validation results expected in Q1 2025. ○ Intervention #2 Focuses on the promotion and utilization of the CDC Milestone Tracker app by parents/caregivers and providers. Additional supportive activities include a Provider Webinar and member incentives to encourage BIH class attendance. • Perinatal Health/ Reproductive Health ○ All CVH Counties are exceeding the 50th percentile for timely prenatal care, postpartum care and Chlamydia screening. ○ Kings County exceeded the 90th percentile for PPC-post. Fresno and Madera Counties exceeded the 75th percentile for PPC-pre. ○ Disparity exists for Black/African American members and CVH will refer all pregnant women to Black Infant Health (BIH). • Pharmacy: 1/3 Objectives Met: 33.33% Rate (Asthma Medication Ratio) • Preventative Health/ Cancer Prevention: 12/12 Objectives Met (Preventative Health): 100% Rate ○ Cancer Screening: Breast Cancer, Cervical Cancer & Chlamydia Screening ▪ 16 Alinea (vendor) mobile mammography events that were completed for CalViva in 2024. ▪ Member outreach to schedule appointments was also completed. ▪ Opportunity in 2025 to form a direct partnership with radiology facilities and collaborate with CBOs to deliver equitable and culturally sensitive care. • Provider Engagement: 5/9 Objectives Met: 55.56% Rate ○ Quality Evaluating Data to Generate Excellence (EDGE): ▪ Special focus to align with DHCSs' goal to achieve the 50th percentile for all pediatric MCAS measures in 2025. ▪ Full implementation of a standardized data reconciliation process to address challenges with data workflow, provider use of codes, and other systems issues that impact the receipt of evidence of member care will take place in 2025.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Continuity/Coordination of Care (Non-BH/BH) o CVH utilizes NCQA as a roadmap for improvement on how an organization can deliver high-quality care. o Non-Medical: During 2024 CVH monitored several aspects of COC such as Timeliness of Perinatal Care- Postpartum Care (PPC) and Eye Exams for Patients with Diabetes. o Behavioral: Throughout 2024 the focus was on E.D. visits for behavioral health and substance use coordination of care and follow-up. • Access, Availability, and Service and Satisfaction o Provider Access, Availability, and Satisfaction Survey Measures met the following goals: ▪ 50.82% of PAAS measures for Providers. ▪ 100% of PAAS (DMHC) - Access to Ancillary measures. ▪ 66.67% of Provider After-Hours Survey measures. ▪ 64% of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures. ▪ 100% of Behavioral Health PAAS by Risk Rating measures. • Health Education o Health Education programs were aimed at increasing participation in: ▪ Well Care Visit ▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Childhood Immunizations and Well Child Visits. o Providers and members have the ability to order health education materials on many topics. o In 2024 the most ordered topics included: lead poisoning, diabetes, nutrition, and weight management/exercise. o Health Education Information Phone line was active in 2024 and received a total of ten (10) calls. **FINAL HEDIS® Results RY2024** **Quality of Care – MCAS (HEDIS®):** Overall, CalViva achieved 59% of MCAS measures above the MPL for MY 2023.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#4 **QI/UM/CM Business** - UM/CM Work Plan End of Year Evaluation & Executive Summary 2024 (Attachment Y) **Action** Patrick Marabella, M.D Chair	**2024 Utilization Management/Care Management Work Plan End of Year Evaluation and Executive Summary** were presented and reviewed. 1. <u>All Accreditation & Regulatory Requirements</u>: Objectives Met Except for: 1.3 Separation of Medical Decisions from Fiscal Considerations (Affirmative Statements) and 1.4 Periodic Audits for Compliance with Regulatory Standards (Post Stabilization). Actions taken: 1.3 Separation of Medical Decisions: • Job aid was updated to address the Affirmative Statement training yearly assignment. Effective July 2024 Clinical Managers will assign the training in January and July. • New finding in Q1 2025 (Audit of 2024) Attestation completion below goal. The Root Cause Analysis will be re-evaluated and corrective actions implemented. 1.4 Oversight Audits • Evaluation was completed regarding Post Stabilization CAP to ensure all points of APL 23- 009 are accurately followed. P&Ps were updated, and retraining was provided to staff as of December 2024. Provider notification was distributed in December 2024 to ensure compliance with the APL. 2. <u>Monitoring the UM Process:</u> • **TAT was met with a 95%** or better threshold in all areas and all quarters. 3. <u>Monitoring Utilization Metrics:</u> Objectives Met Except 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance and 3.3 PPG Profile. Actions taken: Inpatient Performance: • Opportunities were identified to improve tight management of inpatient stays with successful handoffs to Transitional Care Services (TCS) and CM which were implemented in August 2024. Changes implemented increased collaboration with TCS and CM at discharge. PPG Performance: • Continued monitoring and engagement to address PPG CAPs. 4. <u>Monitoring Coordination with Other Programs and Vendor Oversight:</u> • All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end-of-year evaluation.	**Motion**: *Approve* - UM/CM Work Plan End of Year Evaluation & Executive Summary 2024 (Ramirez/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	5. Monitoring Activities for Special Populations: All monitoring activities for this section **met goals.** • CCS Tracking ongoing • SPD Tracking ongoing • CBAS Tracking ongoing • Mental Health Tracking ongoing 6. Adequacy of UMCM Program Resources: • Utilization metrics met the goal of a 2% decrease or greater in bed days, acute admissions, and length of stay. Readmissions 8-30 did not meet the goal (-1.4%) but the source of issues was process-based, not resource. • Satisfaction data reports noted consistent results with previous years with some improvements and some opportunities for MY2023. MY2024 results are pending. Will be reported in Q1 2025. • Improvement in the timeliness of referrals was identified as an opportunity and BH referrals increased with data from ADT reports. An increase in perinatal referrals was noted compared to the prior year. 7. Program Scope, Processes, and Information Sources: • Annual DHCS survey (2024) which had only two (2) deficiencies identified. • Ongoing outreach and monitoring. • Criteria used for decision-making updated and approved by the QIUM Committee in November 2024. 8. Practitioner Participation and Leadership Involvement in the UM Program: • Contracted network providers participated in the QI/UM Committee and Credentialing and Peer Review Sub-Committees. • Weekly Multi-disciplinary Care Rounds. • Leadership and staff provided reports, participated in improvement activities, and attended monthly meetings. *Dr. Cardona left the meeting at 10:42 AM and returned at 10:43 AM.*	
#4 **QI/UM/CM Business** - UM Program Description and Change Summary 2025	**2025 Utilization Management Program Description & Change Summary** were presented and changes for this year include: • Page 5. Distinguished medical and behavioral health. • Page 6. Updated goals and objectives to include "mental health parity".	**Motion**: *Approve* - UM Program Description and Change Summary

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment Z) **Action** Patrick Marabella, M.D Chair	• Pages 8, 9, and 10. Moved auth exclusion references to Preauthorization/ Prior authorization. • Page 11-12. Removed clinical onsite staff, LCD, and NCD references from Inpatient Facility Concurrent Review. • Page 16. Added non-specialty mental health services and APL references and removed LCD/NCD from behavioral health care services. • Page 17-18. Added description of Pharmacy advisory committee role. • Page 19-21. Updated Health Promotion Programs (weight management, pregnancy, diabetes prevention, health promotion incentive, community health) removed Health Hearths. • Page 22. Updated types of methods for over and under-utilization. • Page 23. Added SB855 to utilization decision criteria. • Page 25. Revised consistency of application of Utilization decision criteria. • Page 36. Removed reference to separate behavioral health committees. • Page 39-40. Revised Delegation section to better describe activities. *Dr. Ramirez left the meeting at 10:47 AM and returned at 10:50 AM.*	2025 (Quezada/Cardona) 5-0-0-3
#4 **QI/UM/CM Business** - CM Program Description and Change Summary 2025 (Attachments AA) **Action** Patrick Marabella, M.D Chair	**2025 Care Management Program Description & Change Summary** were presented and changes for this year include: • Pages 7-10. Added in CVH QIUM info and organization, updated health net job titles (removed VP PHCO and added CM Director, VPMM changed to CMO), removed Member Connections and changed to TCS. • Page 11. Update to team staffing, changed average active caseload to up to 75 for PH/BH, and 150 for SSFB CM • Page 24. Updated Transitions of Care program section to reflect requirements for 2025. • Page 25. Added CVH Pregnancy Program to Special Program section.	Motion: *Approve* - CM Program Description and Change Summary 2025 (Ramirez/Quezada) 5-0-0-3
#4 **QI/UM/CM Business** - UM/CM Work Plan 2025 (Attachments BB) **Action** Patrick Marabella, M.D Chair	**2025 Utilization Management/Care Management Work Plan** was presented, and areas of focus include: • Compliance with Regulatory & Accreditation Requirements • Monitoring the UM Process • Monitoring Utilization Metrics • Monitoring Coordination with Other Programs and Vendor Oversight • Monitoring Activities for Special Populations UMCM Work Plan Changes for 2025 include:	Motion: *Approve* - UM/CM Work Plan 2025 (Cardona/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Five (5) Sections remain the same for the 2025 Work Plan with minor edits and updates throughout. • Updates were focused on streamlining documentation to ensure ongoing and consistent evidence of compliance with NCQA accreditation standards. • Updating Section 3.2 Over/Under Utilization – to clarify and update metrics and reporting. • Section 4.4 Captures Chronic Condition Management required reporting.	

#4 **QI/UM/CM Business**
- NCQA Non-Behavioral Health Member Experience Report MY 2023
 	
(Attachments CC)
 	
Action
Patrick Marabella, M.D Chair
	NCQA Non-Behavioral Health Member Experience Report MY 2023 was presented and reviewed.
	CVH oversees and monitors member experience and identifies areas of opportunity by conducting required activities to meet the standards and guidelines of accreditation (NCQA ME.7):
	• Annual satisfaction surveys (CAHPS (Non-Behavioral Health) and ECHO (Behavioral Health))
	• Ongoing analysis of grievances and appeals. All appeals and grievances, no sampling.
	NCQA requires Health Plans:
	• Evaluate member satisfaction for physical health at least annually.
	  o Quantitative and qualitative analysis of CAHPS Survey results. Compared to the Medicaid CAHPS National Averages.
	• Evaluate member satisfaction for behavioral health at least annually.
	  o Experience of Care and Health Outcomes ECHO® Survey results.
	CVH HSAG CAHPS Member Survey:
	• Rating of Health Plan rate fell in the 75th Accreditation percentile and met the QC National Average goal.
	• Rating of All Health Care rate fell in the 50th Accreditation percentile and met the QC National Average goal.
	• Rating of Personal Doctor fell in the 25th Accreditation percentile and did not meet the QC National Average goal.
	Discussion:
	Dr. Ramirez asked about how culture and language concordance affected results.
	Dr. Marabella indicated that the survey conducted by the State included a small sample size. The Plan will conduct its own survey next year and we will ensure adequate sample size for full analysis including those measures associated with language and culture.
	
	COMPOSITE MEASURES: The CVH composite measures saw a decrease in all measures compared
		Motion: *Approve*
		- NCQA Non-Behavioral Health Member Experience Report MY 2023
		
		(Cardona/Ramirez)
		5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	to the previous year. All the composite rates are below the 25th Accreditation Percentile.
	• Getting Needed Care measure is comprised of two individual composite measures:
	  o Getting Appointments with Specialists and
	  o Getting Needed Care, Tests, and Treatment.
	• The first composite measure is NR Non-reportable data due to the denominator been less than 100. The second composite measure had a slight decrease from the previous year and was below the QC Average for MY2023.
	• How Well Doctors Communicate is comprised of four composite measures:
	  o Explains Things in a Way You Could Understand
	  o Listens Carefully
	  o Showed respect for what you had to say.
	  o Spends Enough Time with You.
	• These measures decreased year over year and did not meet the QC Average.
	• Doctor communication should continue to be a focus area of improvement since communication has been shown to impact members' perceptions of ease of getting care.
	APPEALS & GRIEVANCES DATA MY2023 VS. MY2022:
	• **Formal Grievances:** can either be Quality of Care (QOC) or Quality of Service (QOS) in nature.
	  o Overall volume increased year over year in four (4) out of the five (5) grievance classifications.
	  ▪ MY2023 formal grievances increased above MY2022 volume and PTMPY rate.
	  ▪ Internal goals were not met.
	  o In MY2023:
	  ▪ Billing and Financial Issues saw an 180% increase in volume
	  ▪ Attitude and Service saw a 142.9% increase year over year.
	• **Exempt Grievances:** are grievances received by the Member Services Call Center that are not coverage disputes or regarding investigational treatment, and that are resolved by the close of the next business day.
	  o In MY2023 the Exempt Grievance volume decreased by 9.1%.
	  o Internal goals are met, except in the Billing and Financial Issues category.
	  o The Access Grievance category had a decrease in volume of 45.9% from the previous year.
	  o The largest Exempt category was Attitude & Service (78.3%).	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• **Appeals:** challenge the denial of a service or procedure not deemed medically necessary.
	  o Total number of appeals increased in volume, PTMPY rate, and Overturn (OT) rate in MY2023.
	  o internal goal was not met.
	  o The Billing and Financial Issues category continues to be the only appeal classification category in CVH with a 54.3% increase from the prior year.
	The following was presented as a table of planned actions to be implemented for the following categories:
	• Access/Covered Benefits
	  o Attend CVH A&G Workgroup meetings to share complaints with the transportation vendor and have the vendor leader address them with the vendor's staff.
	  o Implement New Member Wellness Platform, "Teladoc Mental Health (Digital Program)," a full spectrum digital program designed to help users become happier and healthier.
	  o Initiate Provider Network Access to Care Workgroup to encourage physician offices to move to open access scheduling.
	• Access to Care/Routine Appointment Availability
	  o Conduct quarterly root cause analysis that will drill down into the cause of these barriers. This will help identify any trends and points for improvement.
	  o Attend CVH A&G Workgroup meetings to discuss ways to improve services and decrease the volume of appeals and grievances.
	  o Routine training will be done with the Member Services staff on relevant member satisfaction issues particularly around how to address provider communication issues, access issues, and any referral and prior authorization delays.
	• Access/Routine Appointment Availability
	  o Utilize contract language to incentivize provider groups to improve member experience measures.
	• Billing and Financial/Claim Denials
	  o Routine customer service training for member-facing teams within the organization.
	• Attitude and Service Customer Service
	  o Continue to train provider groups, providers, and office staff on the importance of members' experiences with their staff and its impact on the CAHPS Survey results and	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	sharing best practice tools.	
#5 **UM/CM Business** - Key Indicator Report (December) - UM Concurrent Review Report (Q4) (Attachments DD, EE) **Action** Patrick Marabella, M.D Chair	The **Key Indicator Report December 2024 and the Utilization Management Concurrent Review (CCR) Report Q4 2024** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Admissions: o TANF and SPD populations are experiencing lower hospitalization rates and shorter stays, which may be driven by better preventive care, alternative treatment options, or system-wide efforts to reduce inpatient admissions. o The sharp decline in SPD bed days suggests significant changes in the management of high need patients, which could be due to policy adjustments or improvements in outpatient and community care. o These trends highlight a potential shift toward more efficient inpatient utilization and a growing emphasis on outpatient and community-based care models. • Average Length of Stay (ALOS): o MCE patients had shorter hospital stays in Q4 2024, with an ALOS of 4.8 days, a 19% reduction compared to the annual goal of 5.7 days. This trend again suggests improved discharge planning, more efficient inpatient care, or a shift toward outpatient and short-stay interventions. o TANF patients maintained an ALOS of 3.8 days, exactly in line with the annual goal. This stability suggests consistent hospital utilization patterns with no major changes in inpatient management for this group. o SPD patients had an ALOS of 5.4 days in Q4 2024, a 20% reduction from the 6.5-day annual goal. This sharp decrease may indicate enhanced efficiencies in hospital care, improved care transitions, or an increasing reliance on alternative care settings such as outpatient or home-based care. o The downward trend in ALOS for MCE and SPD populations suggests improved hospital efficiency, better discharge coordination, and potential shifts toward alternative treatment pathways. o The TANF population maintaining its ALOS at the goal level indicates a stable care approach with no significant shifts in inpatient care management. o Shorter hospital stays for MCE and SPD could result in cost savings and increased	Motion: *Approve* - Key Indicator Report (December) - UM Concurrent Review Report (Q4) (Quezada/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	hospital capacity. After further analysis of our data this does not lead to higher readmission rates. • Readmissions: o MCE 30-day readmission rates dropped to 11.1%, a 29% reduction from the 2023 average of 14.3%. This sharp decline suggests improved post-discharge care, better care coordination, or lower inpatient acuity levels leading to fewer complications after discharge. o TANF readmissions decreased to 4.1%, a 15% reduction from the 2023 average of 4.7%. This steady decline suggests enhanced outpatient follow-up, preventive care efforts, or improved patient management post-hospitalization. o SPD readmissions rose to 19.3%, a 3% increase compared to the 2023 average of 18.8%. This uptick in readmissions, despite a 25% reduction in acute bed days and a 20% drop in ALOS, raises concerns about potential gaps in post-discharge support or premature discharges. o MCE and TANF populations demonstrated improved readmission rates, suggesting effective discharge planning and post-hospitalization care. o SPD's increase in readmissions, despite shorter hospital stays, warrants closer monitoring to ensure that reductions in ALOS and inpatient utilization do not compromise care quality. • Targeted Review for High-Utilization Diagnoses: o Sepsis, pneumonia, and UTIs were identified as over-utilized diagnoses in Q4 2024, ranking among the top ten (10) diagnoses. o To improve care management and prevent unnecessary hospitalizations, Clinical Concurrent Review (CCR) implemented a mandatory Medical Director Review for these conditions as of August 1, 2024. • Enhanced Case Management and Discharge Planning: o CCR cases are now regularly reviewed during rounds, ensuring care teams can intervene early to optimize treatment and reduce unnecessary inpatient days. o Care Management (CM) and Enhanced Care Management (ECM) referrals are completed as needed, providing members with follow-up support post-discharge to prevent readmissions. • Improved Communication and Coordination:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ St. Agnes Care Management, Health Net Clinical TCS, and the TCS Outreach team have strengthened communication efforts with inpatient members. ○ These teams provide status updates, discharge planning assistance, and care coordination to ensure smooth transitions from hospital to home or outpatient care. • Expected Impact: ○ Early intervention and oversight for high-risk diagnoses should lead to better clinical outcomes and reduced inpatient stays. ○ Improved case management and follow-up care aim to reduce Readmissions, particularly for SPD patients. ○ Enhanced communication between care teams and members should ensure better discharge planning, minimizing gaps in post-hospitalization support. *Dr. Cardona left the meeting at 11:12 AM.*	
#5 **UM/CM Business** - Medical Policies (Q4 2024) (Attachment FF) **Action** Patrick Marabella, M.D Chair	The **Medical Policies (Q4 2024)** 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 Q4 2024 include but are not limited to: • CP.MP.97 - Testing for Select Genitourinary Conditions • CP.MP.145 – Electric Tumor Treatment Fields • CP.MP.248 – Facility Based Sleep Studies for Obstructive Sleep Apnea • CP.MP.22 – Stereotactic Body Radiation Therapy The following retired policies include but are not limited to: • CP.MP.151 - Transcatheter Closure of Patent Foramen Ovale	Motion: *Approve* - Medical Policies (Q4 2024) (Quezada/Ramirez) 5-0-0-3
#6 **Oversight Audit Business** - UM/CM - Continuity of Care - Emergency Services - Pharmacy	The **2024 UM/CM Oversight Audit** was presented and reviewed. A total of 135 standards were assessed with 131 in compliance**, a 97.0% overall compliance rating.** A total of 407 randomly selected case files were reviewed covering key case types to validate that the established policies and procedures, regulations, and laws were implemented and followed when providing care and services for CVH members. The following case types were reviewed with their associated results:	Motion: *Approve* - UM/CM - Continuity of Care - Emergency Services - Pharmacy

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments GG-JJ) **Action** Patrick Marabella, M.D Chair	Standard 5A TAT Requirements for Members (Prior Authorization Denial Case Files) The audit of Prior Authorization Denial case files demonstrated **100% compliance overall,** with a total of 96 cases reviewed. Each element of the review was assigned one (1) point to establish the compliance rate, with the goal of achieving 100% compliance. No issues were identified, and no corrective action plan is required for this category. Cases were reviewed for the following PPGs: a. Health Net (8/8) b. Meritage (8/8) c. MHN (8/8) d. NIA/Magellan (8/8) e. LaSalle (8/8) f. Adventist (8/8) g. Sante (8/8) h. CVMP (8/8) i. IMG (8/8) j. United (8/8) k. Turning Point (8/8) l. ASH (8/8) 7B Overturned Denials: The audit of Overturned Denied case files demonstrated **30/30** cases to be compliant. Each element of the review was assigned one (1) point to establish the compliance rate, with the goal of achieving **100% compliance**. No issues were identified, and no corrective action plan is required for this category. 8B Continuity of Care: The audit of CCS Coordination Files demonstrated **100% compliance (8/8** cases reviewed). No issues were identified, and no corrective action plan is required for this category. 8D CCS Service Authorizations: The audit of CCS Coordination Files demonstrated **100% compliance (8/8** cases reviewed). No issues were identified, and no corrective action plan is required for this category. 8F Perinatal Case Management: The audit of Perinatal Case Management files demonstrated **100% compliance** for **11/11** cases. No issues were identified, and no corrective action plan is required for this category. 8J-2 Long-Term Care Skilled Nursing, Subacute Facilities, and Rehab Centers: The audit of Long-Term Care Skilled Nursing, Subacute Facilities, and Rehab Centers files demonstrated **100%**	(Quezada/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	compliance for **8/8** cases. No issues were identified, and no corrective action plan is required for this category. 8J-3 TCS: The audit of TCS files demonstrated **100% compliance** for **8/8** cases from Health Net. No issues were identified, and no corrective action plan is required for this category. 12B Sterilization Claim Files (PM330): The review of Sterilization Claim Files from Health Net and PPGs (PM330) including both paid and denied claims, demonstrated 107 of the 128 cases (**83.6% compliance**). Improvement is noted from the prior audit, but compliance was below the target threshold (90%), and a corrective action plan is required to address the identified gaps. Denial cases were appropriately denied (100%) when the PM330 consent was not present, but the mandatory form was missing in some instances when the claim was paid. Overall, HN plus the PPGs, for both paid and denied claims did not meet the 90% minimum performance. Two (2) of the six (6) organizations audited (LaSalle & Adventist) did not meet the 90% minimum performance goal for paid claims. Compliance with PM330 sterilization consent was a finding for the 2022 and 2023 UMCM Oversight Audits of HN as well. 14C Integrated Care Management Files: The audit of ICM files demonstrated **100% compliance** (8/8 cases reviewed). No issues were identified, and no corrective action plan is required for this category. Two (2) other areas for improvement requiring corrective action were identified. One (1) is related to staff completion of attestations in element 4A-2 regarding separation of financial concerns and medical decisions. In a sample of 29 physicians and staff, 22 individuals had evidence of attestation regarding separation of financial concerns and medical decisions. Three (3) of the individuals without attestation are no longer with the organization and four (4) did not complete the attestation for a 75.9% compliance rate. The second area identified relates to member access to UM staff who need to be available at least eight (8) hours per day for inbound calls regarding UM decisions. This is under elements 3A-1 & 2. Results of "secret shopper" calls revealed that Members were able to contact Customer Service Agents but were unable to obtain denial criteria or escalate requests to UM staff as required per regulation and UM Policy, "Communication and Accessibility to UM". Despite these gaps, the audit results demonstrate solid adherence to standards across most categories, with corrective actions set to ensure continued compliance. The **2024 Continuity of Care Oversight (COC) Audit** was presented and reviewed. HN provided	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	evidence demonstrating compliance with policies and procedures for 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% compliance noted with audit criteria. • COC 8/8 compliant (Sample of 30 cases requested with **100% compliance** in first eight (8) cases, 8/8 cases approved) • TOC 8/8 compliant (Sample of 30 cases requested with **100% compliance** in first eight (8) cases) The **2024 Emergency Access to Services Oversight Audit** was presented and reviewed. Emergency Services (ER) documents, reports, and files were reviewed and evaluated to ensure compliance with CVH policies and procedures, state and federal regulations. A policy and procedure review demonstrated good compliance with standards and regulations, however, the opportunity to clarify a number of issues does exist. The overall compliance rate for HNCS for the ER function **is 80%** based upon the number of compliant standards divided by those reviewed in the audit grid (16/20). • A total of nine (9) post-stabilization cases were available for the file review period selected from October 1, 2023, to March 31, 2024; all nine (9) cases were reviewed. Overall file review results demonstrated compliance with the management of claims, however, all lacked evidence of a post-stabilization response within 30 minutes. All cases were from contracted facilities. Further, a documentation discrepancy was noted in one (1) case, where the Notice of Action (NOA) letter indicated an InterQual level of care different from that documented in the MD decision under the review summary. This case warrants further review. Regarding standard **5A-2**, the health plan's accessibility and functionality standards for post-stabilization authorization, the audit revealed several key issues utilizing a "secret-shopper" style assessment to test the process. The post-stabilization phone/fax, while operational during business hours (Monday-Friday, 8 AM-5 PM PST), lacks consistent support during off-hours. During an initial test on 9/30/24, it was confirmed that the after-hours calls are routed to Member Services, but response times are inconsistent, and no direct access to Utilization Management staff is available. The subsequent audit call on 10/1/24 and a third test call on 10/6/24 reinforced these findings. Specifically, the hotline's responsiveness remains unreliable; the 10/6 call resulted in a touch-tone	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	system with no option to leave a message or reach a representative. These issues indicate that the current system does not fully meet the Plan's standards for 24/7 functional accessibility and timely response to authorization requests, particularly during off-hours. The regulation's requirement for Annual Notification to all acute care facilities in the state regarding post-stabilization procedures for the health plan did not meet standards. This failure was due to the fact that the notice provided applied only to non-contracted facilities, and it failed to address behavioral health. A corrective action plan is required to address the findings of this oversight audit: I. Retraining of Call Center Agents: A retraining session will be scheduled for all call center agents. II. Secret Shopper Calls: Conduct secret shopper calls to evaluate the effectiveness of the training and ensure agents are adhering to the correct procedures. III. Update CVH Provider Line Scripts and IVR: The Member Services IVR will be updated to ensure clarity in the CVH Provider Line scripts. This will include simplifying and clarifying language. The **2024 Pharmacy Services Oversight Audit** was presented and reviewed. CVH conducted an oversight audit of Health Net Pharmacy Services' (HNPS) pharmacy function. This audit period covered January through December 2023. • Ten (10) Prior Authorization Denial files were randomly selected that included non-formulary requests, urgent, and routine cases from all three (3) CalViva Health counties. The first ten (10) cases (eight (8) plus two (2) alternates) were **100% compliant** and therefore additional case review was not required. *Dr. Cardona returned to the meeting at 11:22 am.*	
#7 **Policy & Procedure Business** - UM-001 Post-Stabilization Care Requests (Attachments KK)	The **UMCM Policy & Procedure Review** included a review of one UM policy outside the standard annual review cycle in November. UM-001 Post-Stabilization Inpatient Care Requested by Contracted/Non-Contracted Hospitals: Update for mental health 988 crisis calls. Updated post-stabilization section. Revisions in alignment with DHCS, DMHC & other regulatory language. Minor updates to definitions.	Motion: *Approve* - UM-001 Post-Stabilization Care Requests (Ramirez/Waugh)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	*Committee members were in agreement with the changes to the policy as stated and voiced no questions or concerns.*	5-0-0-3
#8 **Compliance Update** - Compliance Regulatory Report (Attachments LL)	Mary Lourdes Leone presented the **Compliance Report**. **CVH Oversight Activities:** CVH'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 HN. CVH and HN also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. 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 Credentialing annual audit is in progress. The following annual audits have been completed since the last Commission report: UMCM (CAP Required), Access and Availability (No CAP), and Call Center (No CAP). **Fraud, Waste, and Abuse:** Since the 1/16/2025 Compliance Regulatory Report to the Commission, there has been one new MC609 filing. This is a provider specializing in internal medicine who allegedly billed for services for a deceased member whose date of death was 7/18/2022. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** As a reminder, on 9/6/24, the Plan received DHCS' Final Report findings and formal CAP request. There were nine (9) deficiencies in total (four (4) for behavioral health and five (5) for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 3/10/25. **Department of Health Care Services ("DHCS") 2024 Medical Audit:** The DHCS sent out the Final Audit Report and CAP request on 10/3/2024 with two (2) findings: • The Plan did not ensure the delegate, HN, met the contractual requirement that written PA extension notices specify the information HN requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten (10) working days. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 3/1/25. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit:** On 1/6/25, the Plan received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the	- Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. All requested documents were submitted on 2/5/25. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** On 2/10/2025, DHCS proposed a 6/2/2025-6/13/2025 time period for the virtual onsite 2025 audit and the Plan has accepted. The Entrance Conference will begin on 6/2/25 @ 10:00 am. **Memoranda of Understanding (MOUs):** Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the Madera County WIC MOU, which has been posted to CVH's website. **Annual Network Certifications:** 2024 Subnetwork Certification (SNC) Landscape Analysis – On 9/25/2024, the Plan received the 2024 SNC preliminary request for the Landscape Analysis and submitted a response on 10/25/2024. On 1/3/2025, the Plan submitted the 2024 SNC deliverable. DHCS has followed up requesting additional information. The Plan has submitted all additional documents and is awaiting approval. **Transgender, Gender Diverse, or Intersex (TGI):** Training DHCS APL 24-017 and DMHC APL 24-018 are requiring Plans to conduct TGI training for staff who are in direct contact with Members. By March 2025, Plans are required to submit evidence of training along with the curriculum. The Plan will also be working on deliverables associated with these APLs, such as updating its provider directory to show which providers are offering gender-affirming care, monitoring, and tracking grievances as they relate to gender-affirming care and updating the Plan's policies and procedures. **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 2025. **Public Policy Committee (PPC):** The next PPC meeting will be held on March 5, 32025, 11:30 am-1:30 pm, CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. Dr. Quezada left the meeting at 11:29 am and returned at 11:33 am.	
#9 **Old Business**	None.	
#10 **Announcements**	The next meeting is March 20th, 2025.	
#11 **Public Comment**	None.	
#12 **Adjourn**	The meeting adjourned at 11:37 p.m.	

NEXT MEETING: March 20th, 2025

Submitted this Day: March 20, 2025

Submitted by: Amy Schneider RN

Amy Schneider, RN, Senior Director Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, MD Committee Chair