Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
November 21st, 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**, 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 10:05 am. A quorum was present. Dr. Marabella introduced Dr. Hodge, RHA Commission Chair and QIUM Committee alternate to the CalViva staff and members of the QIUM Committee.	
#2 **Approve Consent Agenda** Committee Minutes: October 17,	The October 17th, 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
2024 - Standing Referrals Report (Q3 2024) - California Children's Services Report (Q3 2024) - Concurrent Review IRR Report (Q3 2024) - Evolent (NIA) (Q3 2024) - A&G Inter-Rater Reliability Report (Q3 2024) - Quarterly A&G Member Letter Monitoring Report (Q3 2024) - A&G Validation Audit Summary (Q2 2024) - Customer Contact Center DMHC Expedited Grievance Report (Q3 2024) - Potential Quality Issues (PH & BH) (Q3 2024) - Provider Preventable Conditions (Q3 2024) - Lead Screening Quarterly Report (Q2 2024) - Initial Health Appointment Quarterly Audit (Q2 2024) - County Relations Quarterly Report (Q3 2024) - Pharmacy Provider Updates (Q2 2024) - Compliance Regulatory Report (Attachments A-P)	for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Hodge) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair		
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (September 2024) - A&G Executive Summary (Q3 2024) - A&G Quarterly Member Report (Q3 2024) (Attachments Q-S) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through September 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 reporting period (monthly) with a narrative description of the grievance and including the resolution. A total of 1,620 grievances were received during the current quarter (YTD Q3 2024), and the total received for Q3 2023 was 1,887. For Q3 2024, 484 grievances were categorized as Quality of Service (QOS) especially around prior authorizations and network access, with 1,368 related to service quality issues. • Administrative issues have increased, largely due to changes in PPG contracting and network access issues. • Balanced Billing has shown some improvement this quarter, however, we will continue to monitor for sustained improvement. • Interpersonal grievances have decreased slightly but remain a concern, with efforts to improve customer service. • Transportation Access, like no-shows, has been halved compared to last year, but some grievances still exist due to concerns about quality of service. There were 210 YTD 2024 Quality of Care (QOC) grievances. A projected increase compared to 361 for 2023. • PCP Care/Delay QOC grievances remain a concern but have improved. Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes for this category increased to 626 in Q3 2024. • Behavioral health grievances have increased, reflecting changes in how grievances are captured since the MHN transition. • The Attitude/Service Provider category has increased from 43 in 2023 to 146 YTD in 2024 through Q3.	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (September 2024) - A&G Executive Summary (Q3 2024) - A&G Quarterly Member Report (Q3 2024) (Cardona/Hodge) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• ID cards and balance billing issues still cause grievances, though improvements are being made in addressing these. • Issues with out-of-network consultations, DME (Durable Medical Equipment), and advanced imaging have seen an increase, especially related to pediatric care and the need for specialized equipment. • Cardiology imaging has also risen, partly due to new providers' unfamiliarity with submission rules. The **Appeals & Grievances Executive Summary Q3 2024 and Appeals & Grievances Quarterly Member Report Q3 2024** were presented. Trends were noted as above with the following additional issues identified: • Comparing Q3 2023 to Q3 2024: Total Appeals have increased from 86 to 136 compared to last year, and Total Grievances have risen from 535 to 557. The number of exempt grievances is also up, from 430 to 607. Specific areas of increase include issues with PCP assignment, health plan materials, attitude and service, and member billing. Transportation grievances have decreased with 23 formal and 28 exempt grievances for Q3 2024. • Top Access to Care Grievances include prior authorization delays, PCP referrals, appointment availability, and missed appointments. There were 23 formal transportation grievances in Q3 2024, and issues related to access and other administrative concerns, like balance billing, were common. There were no Continuity of Care cases in Q3 2024. o Challenges were noted in accessing specialists in fields such as neurology, rheumatology, orthopedics, OBGYNs, Cardiology, and otolaryngology (ENT), particularly in Fresno County. • Top Appeal categories include MRIs, CAT scans, and medically administered self-injectables, with several overturned decisions. Fresno County has the highest number of grievances, primarily about balance billing and prior authorization delays. • The top Quality of Care Grievances are Delays in referrals by PCPs and Prior Authorizations. • Top Quality of Service Grievances continue to be Balanced Billing and Access to Care-Prior Authorization Delays. A trend for PCP referral was identified and addressed with different locations of UPN/UHC sites. • Nine behavioral health grievances were recorded, mostly related to difficulty finding providers.	

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	• The turnaround times for Acknowledgement letters across all categories met the standard at 100%, except for Grievance Acknowledgment Letters at 99.6%. Resolution Letters met all timeliness standards at 100%. • The A&G Inter-rater Reliability audit results for Q3 2024 increased slightly to 98%. *Discussion:* *Dr. Cardona asked if there were specific specialties that had access to care issues.* *Dr. Marabella stated that the Plan tracks all grievances, and access issues and reports these findings in the Specialty Referral Report included in today's packet. Member access is routinely discussed at our monthly Management Oversight Meetings (MOM). Some specialty providers do not take Medi-Cal patients which restricts access to care.* *Dr. Cardona asked if there were other reasons besides money that providers do not take MediCal.* *Dr. Marabella said the primary reason was financial, but sometimes it is medically based as it is harder to treat the indigent population. Some providers allow a small volume of their assigned patients to have Medi-Cal coverage.*	

#3 **QI Business**
- A&G Classification Audit Report (Q3 2024)
 	
(Attachment T)
 	
Action
Patrick Marabella, M.D Chair
	The **Appeals & Grievances Classification Audit Report Q3 2024** is a review of a random sample of grievance logs and grievance classification while the case is still open to ensure appropriate disposition of grievances.
	• Out of 298 cases reviewed by A&G Clinical staff this quarter, 278 cases were classified correctly, yielding a 93% accuracy rate.
	• Out of 20 misclassified cases:
	  • Fourteen (14) were classified as QOS instead of QOC.
	  • Three (3) cases were duplicate complaints.
	  • Two (2) members did not want to file a formal complaint for QOS.
	  • One (1) was identified as a carveout benefit (Medi-Cal RX) for QOS.
	Audits were completed on approximately 53% of the Q3 grievance universe. All case classifications were corrected prior to case closure.
		Motion: *Approve*
		- A&G Classification Audit Report (Q3 2024)
		
		(Cardona/Hodge)
		4-0-0-4

#3 **QI Business** - Call Center Inquiry Audit Report (Q3 2024)	The **Call Center Inquiry Audit Report Q3 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	**Motion**: *Approve* - Call Center Inquiry Audit Report (Q3

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(Attachment U) **Action** Patrick Marabella, M.D Chair	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 Q3 2024, a total of 33 cases were audited with three cases deemed not auditable due to the absence of recordings. Overall, the remaining cases were found to be 100% compliant.	2024) (Cardona/Hodge) 4-0-0-4
#3 **QI Business** - Preventive Health Guidelines (2024) (Attachment V) **Action** Patrick Marabella, M.D Chair	**CalViva Health's Preventive Screening Guidelines 2024*** were presented and reviewed. • The screening guidelines list the schedule of immunizations for children aged 0 through 18 years and adults aged 19-65+ • The screening guidelines listed the schedule of recommended screenings for the following categories of members: o Children aged 0 to 18 o Adults aged 19 to 65+ o Women aged 19 to 65+ o Men aged 19 to 65+ *Based on National Guidelines *Discussion:* *Dr. Cardona asked if there were any changes to the Guidelines.* *Dr. Marabella indicated there was a change to the recommended age to begin mammography screenings to 35 years.*	**Motion**: *Approve* - Preventive Health Guidelines (2024) (Cardona/Waugh) 4-0-0-4
#4 **Key Presentations** - Quarterly CAHPS Root Cause Analysis Report (Q3 2024) **Action** Patrick Marabella, M.D Chair	The **Quarterly CAHPS Root Cause Analysis Report Q3 2024** was presented and reviewed. NCQA requires Health Plans: Evaluate member satisfaction for physical health at least annually. (Quantitative and qualitative analysis of CAHPS Survey.) Evaluate member satisfaction for behavioral health at least annually. (Experience of Care and Health Outcomes ECHO® Survey) Aggregate all complaints* and appeals** into the following required categories: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, and Quality of Practitioner Office Site. Annually opportunities for improvement should be identified, priorities set, and decisions made regarding which opportunities to pursue based upon analysis of the following information: • Member complaint and appeal data (Separately PH & BH) (At least one opportunity for each PH/BH from this data). • CAHPS/ECHO survey results (Separately PH & BH) (At least one opportunity for each PH/BH from this data).	**Motion**: *Approve* - Quarterly CAHPS Root Cause Analysis Report (Q3 2024) (Cardona/Waugh) 4-0-0-4

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	Implement actions to improve member satisfaction and address issues based on these identified opportunities. Assess the effectiveness of the actions and modify the plan. *As defined by NCQA, a * "Grievance" is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of one's health plan, or its providers, regardless of whether remedial action is requested.* ***An "Appeal" is a request for your health plan to review a decision that denies a benefit or payment.* The current process for CAHPS Improvement includes: • The CAHPS Team conducts root cause analysis (RCA) to highlight member pain points. • RCA is based on resolved cases. • Conducted quarterly. • Better understanding of CAHPS results, rate movement, and areas for improvement. Year Over Year Comparison - Q3 Appeals & Grievances Volume by County: There was an increase in the appeals volume for Fresno (45.6%), Kings (100%), and Madera (200%) counties, which resulted in a higher PTMPY rate compared to 2023 Q3. There was a slight increase in the volume of grievances of 12.2% in Fresno County. Kings and Madera counties showed a decrease of 28.3% and 36.9% respectively compared to Q3 2023. 2024 Q1-Q3 Trends - Appeals & Grievances Volume Comparison by County: Appeals showed an increase in volume of 29.2% in Fresno County, 20% in Kings County, and a decrease of 21% in Madera County compared to Q2 2024. Overall, grievances volume for Q3 2024 showed a slight decrease compared to Q2 2024 in Fresno (1.64%) and Madera (28%) counties. Kings County stayed the same as Q2 2024. Year-Over-Year Comparison - Q3 Top Appeals & Grievances Trend by Classification Codes: In 2024 Q3, there was a 60.2% increase in appeals for the Not Medically Necessary classification code compared to 2023 Q3. For grievances, there was a decrease in three of the top five grievances: 5.4% in Access to Care, 30.1% in Balanced Billing, and 22% in Quality of Care – PCP compared to Q3 2023. Administrative Issues and transportation grievances had an increase of 85% and 17.2% respectively compared to last year, in the same quarter. Quarter over Quarter - Top Appeals & Grievances Trends by Classification Codes: In 2024 Q3, there was a 19.8% increase in appeals for the Not Medically Necessary classification code compared to 2024 Q2. For grievances, an increase was noted in three of the top five grievances in volume,	

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	11.4% in Access to Care, 2.7% in Administrative Issues, 36% in Transportation compared to 2024 Q1. There was a decrease of 34.8% in Balance Billing and 6.1% in Quality of Care - PCP grievances in Q3 2024 compared to Q2 2024. Trending Appeals (volume) by Category: In 2024 Q3, appeals appear steady compared to last year, at the same time, in two out of the four categories. Diagnostic –CAT Scan had an increase of 166.6% compared to Q3 2023. As for 2024 Q2 & Q3 appeals, there was an increase of 42.1% in the category of Diagnostic – MRI. Other – Self-Injectable Medication and Outpatient – Procedure appeals returned after skipping Q2 2024 with an increase of 180% and 175% compared to 2024. *Discussion:* *Dr. Cardona asked why the PCP Referral for Services grievances had increased.* *Dr. Marabella indicated that the grievances for PCP Referral were primarily due to members not being able to see a specialist.* 2023 & 2024 Q3 Trending Grievances (volume) by Category: Most of the trending grievances had a decrease in Q3 2024 compared to Q3 2023. Prior Authorization Delay (13.7%), Transportation Missed Appointment (70.2%), and Inappropriate Payment Demand (par) (30.6%) had a decrease in volume compared to Q3 2023. The trending grievances that had a noted increase are PCP Referral for Services of 200% and Health Plan of 420% compared to Q3 2023. 2024 Q1 - Q3 Trending Grievances (volume) by Category: Similar trend where most of the grievances had a decrease in Q3 2024 compared to Q1 and Q2 2024. Prior Authorization Delay and Inappropriate Payment Demand (in-network providers) volume showed an improvement of 15.3%, Referral Process of 57.1%, and Inappropriate Payment Demand (in-network providers) of 27.1% in Q3 2024 compared to Q2 2024. There was an increase in grievance volume in PCP Referral for Services of 114.2% and a Delay in Referral by PCP of 116.6% from the previous quarter. Actions & Next Steps: • Live and Recorded Provider Training Webinars • Started in July 2024 with topics on how to be compliant related to Prior Authorizations and use of e-consults. • Best Practices Tip Sheets were released in September 2024. Guidelines developed for Prior Authorizations on how to avoid processing delays and improve member satisfaction. • Corrective Action Plans (CAPs) Improvement plans were required from PPGs with low scores in the Access and Availability	

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	results (PAAS and PAHAS surveys). • Isolated Appeals Cases Plan leadership to discuss issues and opportunities to improve members' experience with PPG leaders. • Future Activities CalViva A & G Work Group will work with A & G Team and Data Analysts to analyze CAHPS results and A & G Quarterly Data to identify priority opportunities and establish interventions to address identified issues and improve member satisfaction. *Discussion:* *Dr. Marabella framed the opportunity for discussion using prompting questions related to oversight responsibilities.* *Dr. Cardona mentioned that HN should call out providers who do not meet requirements.* *Dr. Marabella mentioned that HN could enforce compliance with Letters of Agreement. Dr. Marabella added that there is a shortage of Specialty providers, and they don't always take Medi-Cal patients. It is an issue that is not easily solved. One action would be to set up a satellite office where specialties could rotate in to see patients on a specific day of the week.* *Dr. Cardona mentioned another issue is dual payment models. More revenue is generated through surgeries than seeing patients in the clinic.* *Dr. Marabella stated that since Madera doesn't currently have a hospital in the county Camarena is trying to set up its own specialty group.*	
#4 **Key Presentations** - SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan **Action** Patrick Marabella, M.D Chair	The **SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan** was presented and reviewed. SB 1019 and APL 24-012 require Managed Care Plans to: Develop and implement an Annual Outreach and Education Plan for Members and PCPs regarding covered Non-Specialty Mental Health Services (NSMHS) by January 1, 2025. Managed Care Plans (MCPs) are required to provide the following NSMHS for Members of any age with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders; five or with potential mental health disorders not yet diagnosed: • Mental health evaluation and treatment, including individual, group, and family psychotherapy. • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental	**Motion**: *Approve* - SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	health condition. • Outpatient services for purposes of monitoring drug therapy. • Psychiatric consultation. • Outpatient laboratory, drugs, supplies, and supplements. **Objectives:** 1. To address the historic underutilization of Non-Specialty Mental Health Services (NSMHS) by ensuring Members and PCPs are aware of all covered NSMHS. 2. To address gaps in utilization by focusing on culturally and linguistically appropriate outreach and education materials. **The Outreach and Education Plans will be reviewed to ensure:** • Alignment with culturally and linguistically appropriate standards (CLAS). • Use of best practices in stigma reduction. • Provide multiple points of contact for Members to access Mental Health benefits. No Wrong Door Policy. **Factors We Will Consider:** • Population Needs Assessment (DHCS) or Population Health Assessment (NCQA) • NSMHS Utilization Assessment (Current rates) • County Mental Health Plan to coordinate with. • The Public Policy Committee (PPC) and Quality Improvement Committee (QI/UM) must be consulted to provide recommendations for the Outreach and Education Plan. • Consider other organizations such as tribal liaisons, CBOs, navigators, CHWs, promotores, etc. • Member Experience Assessment of NSMHS (CAHPS & ECHO results). **We are seeking your suggestions and recommendations to inform our communication strategies:** • Preferred method of outreach or availability of education materials for both Members and Providers • What should the Plan avoid? • What are the barriers the plan should be aware of when accessing NSMHS? • Keywords to include or exclude in the messaging to Members and Providers? • Suggestions to reduce stigma in outreach and education or materials the Plan provides? *Discussion:* *Dr. Marabella framed the opportunity for discussion using prompting questions on suggestions for*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	outreach to our members. *Mary Lourdes Leone suggested a texting campaign.* *Dr. Cardona asked whether we have a closed-loop system that tracks prescribed medication linked to mental health such as antidepressants which triggers a follow-up with a mental health professional for counseling support or other strategies to encourage medication adherence, etc.* *Dr. Marabella stated that our system does track the use of antidepressants relating to HEDIS® scores. Additionally, we're doing a HEDIS® project on follow-up out of the ED for FUM/FUA.* *Dr. Waugh suggested increased BH integration with primary care, not only educating members with materials provided by their primary care physicians but also having them facilitate a warm handoff to onsite BH specialists from their trusted provider. Having onsite BH specialists discuss what therapy options look like can help reduce negative stigmas and on a general level might make it seem a little less threatening.*	
#4 **Key Presentations** - CalViva Operations Guide Annual Review (Attachment W) **Action** Patrick Marabella, M.D Chair	The **CalViva Operations Guide Annual Review** was presented and reviewed. In 2024 all Medi-Cal Managed Care Plans signed a new contract with the Department of Health Care Services (DHCS). Article A, Section III,3.2.4 Requires that a Provider Manual is issued to network providers, subcontractors, and downstream subcontractors regarding covered services and responsibilities. <u>DHCS Contract</u> The Provider Manual must be updated at least annually and include information on: Basic Population Health Management Care Coordination for Non-Covered Services Policies and Procedures Quality Improvement & Monitoring UM & Prior Authorization clinical protocols Timeliness Standards & Telephone Access Credentialing Appeals and Grievances & State Fair Hearings* Other regulations and reporting requirements *The contract includes specific requirements regarding A & G-related information to be addressed. <u>New in 2024</u> Must solicit feedback from the Community Advisory Committee (CalViva's Public Policy Committee) and Quality Improvement Committee.	**Motion**: *Approve* - CalViva Operations Guide Annual Review (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Purpose of this activity is to: Obtain information regarding the development of future Provider Manuals. Clarify New and Revised Policies and Procedures. Most Recent Redline Changes were reviewed as examples of the topics covered and the kinds of edits generally made to include: Pg 59 Minor's consent (16 yrs) for MAT/ MH Pg 78 Subacute Care Facilities Pg 90 Palliative Care as a Benefit Pg 98 Revised Education Programs Pg 107 Peer to Peer Review Requests Discussion & Recommendations Review of Chapters Who to Contact Enrollment & Disenrollment Access to Care Medical Standards Sensitive and Referral Services Public Health Carve-out Services Public Health Waiver Programs Health Care Management Claim Billing and Encounter Information Grievance and Appeal Procedures *Committee members had no specific recommendations for improvement at this time. Dr. Cardona indicated that now they are aware of this requirement they will observe for future opportunities and notify the Plan.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (September 2024) - UM Concurrent Review Report (Q3 2024) - Specialty Referrals Report – HN	The **Key Indicator Report & Turnaround Time Report** through September 2024 were presented. • Utilization for Acute Admissions, Bed Days, Acute Length of Stay, and Readmissions (all adjusted PTMPY), for TANF, MCE, and SPDs show a steady decline in recent months. o The decline could be attributed to an increase in the 30-day Transition of Care services to all members with an emphasis on connecting them to community services or telehealth post-discharge. • Behavioral Health Care Management referrals and engagement rate have improved for Q3	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (September 2024) - UM Concurrent Review Report (Q3

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(Q3 2024) - PA Member Letter Monitoring Report (Q3 2024) (Attachments X - AA) **Action** Patrick Marabella, M.D Chair	2024. • Perinatal Care Management referrals have fluctuated but have rebounded with a 70% engagement rate. • Physical Health Care Management referrals follow a similar pattern to Perinatal. • Transitional Care Services' (TCS) engagement rate is back up to 65%. Referral numbers have steadily increased from the beginning of the year to 1,746 for Q3 2024. TCS receives all the Care Management cases initially and then refers to the different programs accordingly. • First Year of Life engagement rate remains high for Q3 2024. • One Deferral letter failed the Turnaround Time for September. The **Utilization Management Concurrent Review (CCR) Report** presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness during Q3 2024. • Sepsis, Pneumonia, and UTI were identified as diagnoses over-utilized in Q3 2024. Clinical Concurrent Review (CCR) has implemented a mandatory Medical Director Review for those diagnoses as of 8/1/24. • The CM department, Saint Agnes Medical Center and Transitional Care Clinical and Outreach teams is now communicating with inpatient members with status updates, discharges, and care coordination. • The CCR team will continue validating the correct diagnoses utilized by hospitals and review cases completed by nurses in admissions with mandatory diagnosis, identifying trends to provide appropriate coaching to the staff. The **Specialty Referral Report Q3 2024** provides a quarterly summary of CalViva member referrals requiring prior authorization, with a breakdown of SPD and Non-SPD member Specialty Referral Requests in the three-county area (Fresno, Kings, and Madera) with a specific focus on in-network and out-of-network cases. • Referral statistics include: o Overall, 119 cases with a 10% denial rate. o Denial rates for out-of-network cases are higher than for in-network cases. o The most common specialty referrals are neurology, surgery, and dermatology.	2024) - Specialty Referrals Report – HN (Q3 2024) - PA Member Letter Monitoring Report (Q3 2024) (Hodge/Waugh) 4-0-0-4

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	○ Nephrology is now the leading specialty for out-of-network referrals, surpassing otolaryngology. Further investigation into nephrology and neurology referrals is planned, especially regarding why nephrology is increasingly out of network. ○ A notable concern is providers switching from contracted in-network status to out-of-network, contributing to denials. ○ Specific surgical referrals include treatments for cancer, organ transplants, and pain management. The **PA Member Letter Monitoring Report Q3 2024** monitors Notice of Action (NOA) letters including Prior Authorizations, Concurrent, and Post Service denials. Findings are discussed with the entire UM Management Directors monthly. All metrics are expected to meet the standard of 100% compliance. The Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. • There was a total of 47- decision letters and six unique deferral letters impacted by letter opportunities. • Of the 40 letters that were not deemed clear and concise (LTR Code 48), 27 were CalAim services that included unexplained abbreviations and 13 lacked clarity. • Denial and Deferral LTR Codes 48, 49, & 60 will continue to be monitored. In follow-up, Medical Management implemented staff/physician coaching focused on the use of clear and concise language and no medical jargon.	
#5 **UM/CM Business** - Care Management & CCM Report (Q3 2024) (Attachment BB) **Action** Patrick Marabella, M.D Chair	The **Care Management and CCM Report Q3 2024** 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 volume, member engagement, and an evaluation of Program effectiveness. • PCP visits within thirty (30) days of referral decreased 3% from Q2 to Q3 2024. • When a member is in care management, readmission rates, ED visits, and costs decrease while positive outcomes increase. ED claims per 1,000 members per year decreased by 480 (22%) for Q2 2024). There was a 4.3% decrease in readmission rate 90 days following CM enrollment from BH and PH. • Perinatal Outcomes demonstrated increases in compliance rates for prenatal and postpartum visits and decreased pre-term deliveries for high-risk members.	Motion: *Approve* - Care Management & CCM Report (Q3 2024) (Cardona/Hodge) 4-0-0-4

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	• Forty-five members completed a Member Satisfaction Survey, with 93% being satisfied with the Care Management program. • There was one member complaint regarding CM in Q3 2024. • Next steps to improve CM include: o Managers will attend JOMs with Providers and PPGs to provide CM overview, build partnerships, and encourage referrals into CM teams. o Continue to look for and evaluate additional phone options for CM staff (to increase member engagement). o Support of CalAIM activities.	
#5 **UM/CM Business** - Medical Policies (October & September 2024) (Attachment CC) **Action** Patrick Marabella, M.D Chair	The **Medical Policies (September & October)** 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 September & October 2024 include but are not limited to: • CP.MP.108 – Allogeneic Hematopoietic Cell Transplant for Sickle Cell Disease • CP.MP.180 – Implantable Hypoglossal Nerve Stimulation • CP.MP.202 – Orthognathic Surgery • CP.MP.12 – Vagus Nerve Stimulation The following retired policies include but are not limited to: • CP.MP.53 - Ferriscan R2-MRI • HNCA.CP.MP.456 - Ultrafiltration for Heart Failure	Motion: *Approve* - Medical Policies (October & September 2024) (Waugh/Cardona) 4-0-0-4
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q3 2024) - Pharmacy Operations Metrics (Q3 2024) - Pharmacy Top 25 Prior Authorizations (Q3 2024) - Quality Assurance Reliability	The **Pharmacy Executive Summary Q3 2024** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q3 2024. o Overall, TAT for Q3 2024 was 97.8%.	Motion: *Approve* - Pharmacy Executive Summary (Q3 2024) - Pharmacy Operations Metrics (Q3 2024) - Pharmacy Top 25 Prior Authorizations

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Results (IRR) for Pharmacy (Q3 2024) (Attachments DD-GG) **Action** Patrick Marabella, M.D Chair	○ PA volume was slightly lower in Q3 2024 compared to Q2 2024 and there were some drug-specific differences. PA approval rate was slightly lower in August compared to July and September of 2024. The **Pharmacy Operations Metrics Q3 2024** provides key indicators measuring the performance of the PA Department in service to CalViva Health members. The turnaround time (TAT) expectation is 100% with a threshold for action of 95%. • The average Turnaround time met the standard with 97.8%. The **Pharmacy Top 25 Prior Authorizations Q3 2024** identifies the most requested medications to the PA Department for CVH members and assesses potential barriers to accessing medications through the PA process. The top ten denials of the quarter by percentage and total number are consistent with recent quarters except for a few placement variations. Non-preferred IV Iron requests were higher than expected in Q3 2024, however the total number is lower than seen in Q1 and Q2 2024. Testosterone authorizations continue to drive PA volume despite a high approval rate and limited requirements for PA. The **Quality Assurance Reliability Results (IRR) for Pharmacy Q3 2024** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten prior authorizations (four approvals and six denials) from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold for action of 90%. • The 90% threshold was met. The 95% goal was not met. The overall score was 93.33%.	(Q3 2024) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q3 2024) (Cardona/ Hodge) 4-0-0-4
#7 **Policy & Procedure Business** - UMCM Annual Policy & Procedure Review (Attachments HH) Action Patrick Marabella, M.D Chair	The **UMCM Annual Policy & Procedure Review** was presented to the committee. The following policies were presented for annual review with **no changes made:** UM-001 Post-Stabilization Inpatient Care Requested by Contracted/Non-Contracted Hospitals UM-002 Pre-Certification and Prior Authorization UM-003 Standing Referral to Specialty Care UM-010 Second Opinion UM-030 Potential Over and Under Utilization UM-050 Communications and Accessibility to UM	Motion: *Approve* - UMCM Annual Policy & Procedure Review (Hodge/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	UM-065 Skilled Nursing Facilities UM-100 Emergency Care and Services UM-111 Identification and Referral of CCS Members UM-118 Separation of Medical Management from Administrative and Financial Management UM-119 Concurrent Review UM-120 Hospice Care Services UM-121 Dental Services and IV Sedation and General Anesthesia UM-208 Appropriate Professionals and Use of Board-certified Physicians in UM decision making UM-210 Referrals to Non-Participating Practitioners/Providers CMP-040 HIV/AIDS Coordination with HCBS Waiver Program CMP-050 Developmental Disability and Community Resources Linkage CMP-051 Coordination of Care for Children in Foster Care CMP-102 WIC Coordination CMP-107 Care Coordination/Case Management Services CMP-108 Referrals to Specialty Mental Health, Alcohol and Substance Abuse Treatment Services CMP-109 Transitional Care Management CMP-110 Targeted Case Management CMP-112 Medi-Cal Disease Management Programs CMP-125 Case Management and Members Under 21 Receiving Private Duty Nursing Services CMP-401 Advance Directives CMP-500 Enhanced Care Management Program Overview and Requirements CMP-501 Administration of CalAIM Community Supports **The following policies were presented for annual review and were approved with minor edits:** UM-012 Discharge Planning UM-013 Provision of Enteral Nutritional Supplements/Replacements CMP-123 Case Management Program Effectiveness CMP-400 Palliative Care Program UM-060 UM Decisions and Timely Access to Care **The following policies were presented for annual review and were approved with updated definitions section:** UM-004 Delegation Evaluation and Determination of UM UM-005 Specialty Referral System	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	UM-007 Major Organ Transplant UM-103 Continuity of Care UM-113 Criteria for Utilization Management Care Management Decisions *(full policy included in meeting materials)*. This policy provides for clearly written, reasonable, and approved criteria that are based on evidence-based medical literature to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying, or denying requests for UM/Care Management Determinations. It was pointed out that state policy and national medical necessity criteria are used to determine benefit coverage and medical necessity. Where national or state guidelines do not exist, CalViva allows Health Net to develop medical guidelines, using physician experts, medical literature, and usual standards of practice. Such medical policies developed through Health Net's Medical Advisory Council (MAC Policies) will be presented to the CalViva CMO (Chief Medical Officer) and CalViva's QI/UM committee for review and adoption. It was also pointed out that the Plan also uses Inter-Qual® Care Planning Criteria along with other company-wide evidence-based medical policies which are approved and updated by the Plan's Medical Advisory Council. Committee members were in agreement with the policy as stated and voiced no questions or concerns. UM-211 Experimental and Investigational Services UM-212 Transgender Services UM-300 CBAS Authorization Process CMP-015 Seniors and Persons with Disabilities (SPDs) Health Risk Stratification and Assessment **The following policies were presented for annual review and were approved with the following changes:** UM-011 Long Term Care: Added reference to regulations guiding appropriate care level assessment. UM-014 Long-Term Care Transition to Managed Care: Updated to address APL-009/APL-010/APL-011 to include the Claims section. UM-015 Management of Enrollees in Subacute Long-Term Care: Updated to include appropriate clinical timeframes and access to dental services, specialty referral, behavioral health, standing referral, and arranging appointments with provider shortage. Updated to address APL-009/APL-010/APL-011 to include Claims section. UM-016 Intermediate Care Facilities for Members with Developmental Disabilities: Updated to include appropriate clinical timeframes and access to dental services, specialty referral, behavioral	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	health, standing referral, and arranging appointments with provider shortage. Updated to address APL-009/APL-010/APL-011 to include Claims section. UM-116 Clinical Criteria for Medical Management Decisions: Full policy attached for criteria review and approval. UM-117 Clinical Practice Guideline Development: Updated Regulation SB855 and removed reference to MHN. CMP-030 Tuberculosis Services and the Local Health Department (LHD) Direct Observed Therapy (DOT): Updated TBCB contact link. CMP-124 CalViva Pregnancy Program (CVPP) Case Management Services: Updated maternal health program goals. **The following is a new policy that was approved:** UM-040 System Controls Policy & Procedure: The full policy was included in the packet. The policy focuses on ensuring secure handling of data, control of member PHI and monitoring who has access to appeal decision data. The annual UM System Controls reports to monitor compliance with this policy are included on the QI/UM Committee reporting matrix and will be reported at a subsequent meeting in 2025. *Committee members were in agreement with the new policy as stated and voiced no questions or concerns.*	
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Q4 2024) (Attachments II) Action Patrick Marabella, M.D Chair	The **Credentialing Sub-Committee Quarterly Report Q4 2024** was presented. The Credentialing Sub-Committee met on October 17, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. The 2025 Credentialing Sub-Committee meeting dates were presented and approved. Reports covering Q2 2024 were reviewed for delegated entities and for Q3 2024 for Health Net (HN) and HN Behavioral Health (BH). A summary of Q2 2024 data was presented. • The **Credentialing Adverse Actions** report for Q3 2024 for CalViva from the HealthNet Credentialing Committee was presented. o There were two (2) cases presented for discussion for July, August, and September for CalViva Health. o One (1) case was placed on pending status awaiting the Medical Board of California's decision. o One (1) case was placed on annual monitoring for compliance with the Medical Board of California's orders.	Motion: *Approve* - Credentialing Subcommittee Report (Q4 2024) (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The **Adverse Events Q3 2024** report was presented. o One (1) case was identified in Q3 2024 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no (0) reconsiderations or fair hearings during Q3 2024. o There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of appointment availability. o There were no (0) cases identified outside of the ongoing monitoring process this quarter. (NCQA CR.5.A.4) • The **Access & Availability Substantial Harm Report Q3 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 by severity level. o After a thorough review of all Q3 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).	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q4 2024 (Attachment JJ) Action Patrick Marabella, M.D Chair	**Peer Review Sub-Committee Quarterly Report Q4 2024** was presented. The Peer Review Sub-Committee met on October 17, 2024. • The county-specific **Peer Review Sub-Committee Summary Reports for Q3 2024** were reviewed for approval. No significant cases to report. The 2025 Peer Review Sub-Committee meeting dates were presented and approved. • The **Q3 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 Six (6) cases involved a practitioner, and three (3) cases involved organizational providers (facilities). o Of the nine (9) cases, three were tabled, one (1) was deferred, one (1) was closed to track and trend with a letter of concern, and four (4) were closed to track and trend. o Five (5) cases involved seniors and persons with disabilities (SPDs). o Zero (0) cases involved behavioral health. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2024.	Motion: Approve - Peer Review Subcommittee Report Q4 2024 (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ No (0) cases met the Peer Review trended criteria for escalation. ○ No (0) cases were identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) ○ There were 34 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. • The **Access & Availability Substantial Harm Report for Q3 2024** was also presented. 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. ○ Eighteen (18) cases were submitted to the Peer Review Committee in Q3 2024. There was one (1) incident found involving appointment availability issues without significant harm to a member. Two (2) cases were determined to be related to significant harm to a member without appointment availability issues. No (0) cases were related to behavioral health issues. ○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2024. • The **Q3 2024 Peer Count Report** was presented and discussed with the committee. There was a total of 18 cases reviewed. Eleven (11) cases were closed and cleared. Three (3) cases were tabled for further information. Two (2) cases were pending closure for CAP compliance and one (1) case was deferred. No (0) cases were closed/terminated. One (1) case had a Corrective Action Plan (CAP) outstanding/continued monitoring.	
#9 **Access Business** - Provider Office Wait Time Report (Q3 2024) (Attachment KK) **Action**	The **Provider Office Wait Time Report Q3 2024** was presented and reviewed. Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report provides a summary that focuses on Q3 2024 monitoring for Fresno, Kings, and Madera Counties. All counties are within the 30-minute office waiting time threshold for both mean and median metrics. • The combined number of providers per county who submitted data in Q3 2024 is Fresno (93), Kings (15), and Madera (6) for a total of 114 providers and 2,911 patients monitored.	Motion: *Approve* - Provider Office Wait Time Report (Q3 2024) (Hodge/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	• The average wait times by County for Q3 2024 are as follows: Fresno at 9 minutes, Kings at 12 minutes, and Madera at 17 minutes. • To encourage complete reporting data requirements, individual provider performance reports for Q3 2024 will be modified to visually demonstrate where data was missing if applicable. This change will graphically differentiate between a low average wait time and missing data. • Supplemental educational materials are in development to support providers in their office wait time improvement efforts. Materials will be distributed as soon as they become available. • Monitoring of wait times beyond two (2) hours and maintaining consistent contact with office staff via monthly reminders (emails and telephone calls) to sustain submission rates are ongoing.	
#9 **Access Business** - Access Workgroup Quarterly Report (November 2024) (Attachment LL) **Action** Patrick Marabella, M.D Chair	The **Access Work Group Quarterly Report November 2024** was presented and reviewed. This report is to provide the QI/UM Committee with an update on the CalViva Health Access Workgroup activities since the last report to the QI/UM Committee. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. On 9/24/24, the following Standing Reports were approved: Consent Items: • Appeals & Grievances Executive Report (Full & Executive Summary) – Q2 2024 • Provider Satisfaction Survey with Access Medical Providers and C&L - 2022 • Specialty Referrals Report (HN) – Q1 2024 • Telehealth Program and eConsult Report (September) • Provider Office Wait Times Report – Q2 2024 • 274 Monthly Provider Data Quality Check – July and August 2024 • Transportation Oversight Report – Q2 2024 Standing Reports: • MY 2023 Access & After-Hours CAP & Evaluation • Network Adequacy Report – Q2 2024 • Transportation Oversight Report – Q2 2024 • HNBH Services Triage and Screening Report – Q2 2024 • RY 2024 Practitioner Availability Report (incl. Behavioral Health) • Open Practice Report – Q2 2024 • Provider Over Capacity Grievance Report – Q2 2024	Motion: *Approve* - Access Workgroup Quarterly Report (November 2024) (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Triage and Screening Report – Q2 2024 • PPG Dashboard & Access Narrative (incl. Access & Network Adequacy) – Q2 2024 • BH Network Adequacy, Availability and Open Practice Report – Q1 2024 & Q2 2024 • Behavioral Health Performance Indicator -Q2 2024 • Long-Term Support Services (LTSS) – Q2 2024 • BH Triage and Screening Report – Q2 2024 The following are some of the key standing reports/matters approved and discussed: • **Network Adequacy Report (Q2 2024)** - This report is a quarterly analysis measuring compliance with geographic distribution standards for member distance and drive times to Primary Care Providers (PCPs) and Specialists within Fresno, Kings, and Madera Counties. DMHC PCP reviews are done to the standard of 10 miles **or** 30 minutes, and Specialist reviews are done to the standard of 45 miles **or** 75 minutes. DHCS PCP reviews are done to the standard of 10 miles **or** 30 minutes, and Specialist reviews are done to the standard of 45 miles **or** 75 minutes. **DMHC Analysis:** o PCP: The DMHC PCP standard was met for Kings County. Fresno (99.2%) and Madera (99.7%) Counties do not meet the standard, access percentages remain the same from Q1 2024 to Q2 2024. The Standard was met through an approved Alternative Access Standard. o Specialties by Combined Counties: All specialties in all counties met the internal standard of 90% or higher. o Specialties by County: All specialties in Fresno and Madera Counties met the internal standard. Anesthesiology, Cardiovascular Surgery, Geneticists, HIV/AIDS, Maternal/Fetal Medicine, and Neonatology specialties are below standard in Kings County. Two of the six specialties above that did not meet the 90% standard had minor percentage increases. Cardiovascular Surgery went from 80.8% to 80.9%. Geneticists went from 89.3% to 89.4%. **DHCS Analysis:** Primary Care Physicians: The access percentages for PCPs in Fresno, Kings, and Madera County remained the same from Q1 2024 to Q2 2024. o Adult PCP: The DHCS standard was not met in Fresno (98.6%) and Madera (99.7%)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Counties. Kings County met the standard at 100%. o Pediatric PCP: The DHCS standard was not met in Fresno (98.6%) and Madera (99.7%) Counties. Kings County met standards at 100%. Adult Specialties and OB/GYN: o Fresno: One adult specialty of Psychiatry met standards. Sixteen adult specialties do not meet the standards. Access percentages ranged from 99% to 95%. o Kings: Fifteen adult specialties met standard. Two adult specialties of HIV/AIDS Spec/Infectious Disease (96.4%) and Ophthalmology (98.2%) do not meet the standards. o Madera: All adult specialties except for Psychiatry and Dermatology in Madera County met standards. Psychiatry remains at 99.9%. Dermatology remains the same from Q1 2024 to Q2 2024 at 99.9%. Pediatric Specialties: o Fresno: All pediatric specialties do not meet access standards. Access percentages range from 99% to 94%. o Kings: Fourteen pediatric specialties met the standard. Two pediatric specialties of HIV/AIDS Spec/Infectious Disease (92.8%) and Ophthalmology (98.2%) do not meet the standard. o Madera: All pediatric specialties except for Psychiatry (98.7%) and Physical Medicine and Rehab (99.2%) in Madera County met standards. Both specialties remain at the same percentages from Q1 2024 to Q2 2024. • **MY2023 Access & After-Hours Evaluation** The following provider types did not meet the DMHC appointment time standards: o Five (5) Tier 1 PPGs and six (6) Direct Network providers received Corrective Action Plans (CAPs). o Nine (9) Tier 2 PPGs and four (4) Direct Network providers received Educational Packets (Ed. Packets). • **Call Center Exempt Grievance/Access to Care Report – Q2 2024** Exempt, or informal, grievances that are related to access to care are tracked and monitored, to assess access to care issues and identify opportunities for improvement. In Q2 2024, there was a total of 28 access-related Exempt Grievances. The top three types of access grievances were:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Availability of Appointment with PCP -14 ○ Panel disruption -6 ○ Wait Time too long on the phone - 5	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is February 20th, 2025.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 11:47 p.m.	

NEXT MEETING: February 20th, 2025

Submitted this Day: February 20th, 2025

Submitted by: Amy B Schneider RN

Amy Schneider, RN, Senior Director Medical Management

Acknowledgment of Committee Approval:

X Peter B Marabella

Patrick Marabella, MD Committee Chair