Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
July 17th, 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 a.m. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: May 15, 2025	May 15th, 2025, QI/UM minutes were reviewed, and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member.	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Specialty Referrals Report (Q1 2025) - Standing Referrals Report (Q1 2025) - Provider Preventable Conditions (Q1 2025) - County Relations Quarterly Report (Q1 2025) - Initial Health Appointment (IHA) Quarterly Report (Q1 2025) - Enhanced Care Management and Community Supports Performance Report (Q1 2025) - Evolent (NIA) (Q1 2025) - SPD HRA Outreach (Q1 2025) - TurningPoint Musculoskeletal Utilization Review (Q1 2025) - Medical Policies Provider Updates (Q2 2025) - Pharmacy Provider Updates (Q2 2025) - Accessibility of Service Report (Primary, BH, & Specialty Care) - Assessment of Network Adequacy (BH & Non-BH) - Access Work Group Minutes from 1/28/25, 3/25/25 (Attachments A-O) **Action** Patrick Marabella, M.D., Chair	A link for the Medi-Cal Rx Contract Drug List was available for reference. *Dr. Pascual arrived at 10:05 a.m.	(Ramirez/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business/A&G:** - A&G Dashboard (May 2025) (Attachments P) **Action** Patrick Marabella, M.D., Chair	The **Appeals & Grievances Dashboard Report through May 2025** was presented and reviewed. 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 the resolution. Grievances: • A total of 177 grievances were received during May 2025, a decrease from April (192) and March (225), respectively. • During this quarter, 185 grievances were categorized as Quality of Service (QOS), primarily due to issues with prior authorizations and network access. • Administrative issues decreased since March, largely due to changes in staff behavior, correcting eligibility issues, and correctly filing paperwork. • Balanced Billing/no ID cards remains an issue, and hospitals need improvement on prior authorizations, provider disputes, and provider appeals. • Transportation Access – Missed appointments remain an issue at eight (8) this month. • There were eighteen (18) Quality of Care (QOC) grievances in May. • 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 decreased to 155 in May. Appeals: The total number of Appeals has increased (56) in May. • A new category we are tracking is CalAim: five (5) were related to medically tailored meals, and two (2) were for housing assistance. • DME has increased with more requests made for pediatric skull molding helmets and other prostheses. • Advanced Imaging in both Cardiac and Non-Cardiac categories has increased. • The Upholds (37.5%) and Overturn (54.2%) rates are upside down for May.	**Motion:** *Approve* - A&G Dashboard (May 2025) (Faulkenberry/ Ramirez) 6-0-0-2
#3 **QI Business/A&G:** - Behavioral Health Performance Indicator Report (Q1 2025) (Attachments Q) **Action**	The **Behavioral Health Performance Indicator Report Q1 2025** indicates behavioral health risk rating and authorization of decision timeliness metrics, which reflect current performance and reveal emerging patterns over time. • In Q1 2025, all metrics met or exceeded their targets. • CalViva membership in Q1 2025 was 432,972 (a 0.7% decrease from the previous quarter). • The Q1 2025 utilization rate for behavioral health is not available due to reporting issues. This data will be available later in Q2 2025.	**Motion:** *Approve* - Behavioral Health Performance Indicator Report (Q1 2025) (Waugh/Ramirez) 6-0-0-2

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Patrick Marabella, M.D., Chair	• Appointment availability met the target at 100%, and there were two (2) Urgent cases. • Authorization timeliness is reported at 100%, with a breakdown of 48 non-ABAs and 1,424 ABAs for Q1 2025.	

#3 **QI Business/A&G:**
- Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2024)
 	
(Attachments R)
 	
Action
Patrick Marabella, M.D., Chair
	The **Facility Site & Medical Records and PARS Reviews (Q3 and Q4 2024) Report** displays completed activity and results of the DHCS required PCP Facility Site (FSR) and Medical Record Reviews (MRR) for CVH in all contracted Medi-Cal counties, using the DHCS APL 22-017 for FSR/MRR. The new FSR/MRR tools and standards began on 7/1/22, including Policy Letters 12-006 and 15-023 for Physical Accessibility Review Survey (PARS) assessment of providers. The results are analyzed for the purpose of monitoring and improving the performance of PCPs against DHCS and CVH standards.
	• Fifteen (15) FSRs and eighteen (18) MRRs were completed during Q3-Q4 2024.
	  o The FSR mean rate for Q3-Q4 2024 was 97%.
	  o The MRR mean rate for Q3-Q4 2024 was 92%.
	  ▪ The Adult Preventive Care mean score over all counties for Q3-Q4 was 89%.
	  ▪ The Pediatric Preventive Care mean score over all counties for Q3-Q4 was 89%.
	• Interim Review is a DHCS-required monitoring activity to evaluate the PCP site between the three (3)-year periodic FSR cycle. In Q3-Q4 2024, one (1) interim review was completed in the three (3) CVH counties.
	• Two (2) "dirty office" complaints were received. The FSR department conducts a site visit for provider sites that have three (3) complaints in a rolling six (6) month period per FSR and Credentialing policies.
	• One (1) MMR required an on-site focused review to verify corrections. One (1) failed review occurred during this period.
	• Six out of the eight (6/8) MRR metrics measured in Q4 2024 had a compliance score of 93% to 100%. WCV scored 83% and Blood Lead Screening scored 79%.
	• Corrective Action Plans (CAPs) have three (3) components: FSR Critical Element (CE) CAP, FSR CAP, and MRR CAP. CE CAPs are due in ten (10) business days from the date of the FSR. FSR and MRR CAPs are due in thirty (30) calendar days from the date of the review. PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal to 90% do not have to submit a CAP (exempt pass).
	• Thirteen (13) PARS were completed in Q3-Q4 2024, with seven of the thirteen (7/13) PARS
		Motion: Approve
		- Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2024)
		
		(Pascual/Cardona)
		6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	having Basic level access. • Certified Site Review Nurses provide educational training prior to the actual FSR/MRR evaluation. Educational Trainings allow provider sites to become familiar with the DHCS regulations and FSR/MRR processes and can be done on-site if requested. Sixteen (16) onsite educational trainings were completed in Q3-Q4 2024.	
#3 **QI Business/A&G:** - Lead Screening Quarterly Report (Q4 2024) (Attachments S) Action Patrick Marabella, M.D., Chair	The **Lead Screening Quarterly Report (Q4 2024)** was presented to monitor the assessment of Blood Lead Screening in Children. Screening compliance describes clinical guidelines for blood lead screening, reporting requirements related to blood lead screening and ensures Medi-Cal members receive anticipatory guidance related to lead poisoning prevention, blood lead level testing, and follow-up services from providers. The Q4 2024 report provides CVH's performance on blood lead level screenings and anticipatory guidance monitoring from Q1 2024 – Q4 2024. • In Q4 2024, the overall compliance rate was 32.72%, which is a 17.27% increase from Q1 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. • The Q4 2024 overall compliance for CPT Code 83655 (only) was 32.68%, which demonstrates a 17.92% increase compared to Q1 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. • The Q4 2024 overall compliance for Anticipatory Guidance was 4.09%, which is a 3.57% increase compared to Q1 2024. Due to the persistent low compliance, the QI team continues to explore potential barriers and solutions. • Barriers to increasing rates include: o Incorrect coding used by the providers. o Low point of care (POC) LSC testing in provider offices and a delay in receiving testing equipment due to a manufacturer backorder. o Members do not want to go to lab locations for services due to the impeded process and lack of transportation. o Members do not show up for scheduled appointments. o Providers need to establish new workflow processes and obtain regulatory approval before implementing complete onsite point of care screening. o An effective and efficient method for documenting that anticipatory guidance was provided still needs to be established.	**Motion:** *Approve* - Lead Screening Quarterly Report (Q4 2024) (Faulkenberry/ Ramirez) 6-0-0-2

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	○ Conflicting guidance has been given to us by the state, as using a specific code invalidates the LSC when combined with a WCV code. Next steps include: • Identify high-volume low-performing providers who are not conducting POC blood lead level screenings. • Establish a process to order blood lead analyzers for providers who are high-volume and low-performing. • Meet with the QIRA team to identify a better method of documenting and reporting on anticipatory guidance. *Discussion: The doctors agreed that it is difficult to document anticipatory guidance with conflicting directions from the State. Clarification is needed.*	
#4 Key Presentations - Care Management Program Evaluation & Executive Summary 2024 (Attachment T) **Action** Patrick Marabella, M.D., Chair	The **Care Management Program Evaluation and Executive Summary for 2024** was presented and reviewed. The Care Management (CM) Program encompasses Physical Health (PH), Behavioral Health (BH), Perinatal Wellness, and Transitional Care Services (TCS). The program's purpose is a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Its goal is to provide quality health care along a continuum, decrease fragmentation of care across settings, enhance the member's quality of life, and efficient utilization of patient care resources. The Goals for 2024 were both met: • Increase the number of cases managed: Total 3,649 cases in 2024, compared to 3,571 in 2023. Or 0.93% of the entire population managed within physical, behavioral, or perinatal case management. • Maintain 90% Compliance for Documentation in the medical record: Each program scored 90% or greater on file reviews in 2024. CM Quarterly Audit Results of Complex & Non-complex File Reviews by Program in 2024 (Overall Average Scores: PH = 98%, BH = 94%, Perinatal = 98%, and TCS = 93%. There was a 2.3% reduction in readmissions and a 23% reduction in ED visits (per 1,000 Members per year) for those members enrolled in CM. Inpatient, Outpatient, and Pharmacy Claim volume all decreased for those in CM when compared to the 90 days prior to CM enrollment. Clinical Outcomes for High-Risk OB:	**Motion**: *Approve* - Care Management Program Evaluation & Executive Summary 2024 (Ramirez/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• First Prenatal Visit in 1st Trimester - improved 6.3% (Goal 5%) • Reduction in Pre-term Deliveries by 1.0% (Missed - Goal 2%) • Timely Post-partum Visit – improved 8.0% (Goal 5%) Member Satisfaction Survey Results for 2024: 72 respondents with twelve of the fourteen (12/14) questions answered. • The goal of a 90% positive response (very satisfied – satisfied) was met. • 86% are satisfied with the ability to reach their CM. • 83% reported CM helped them to reach their health goals. • 89% reported CM helped to organize care with their MD and other caregivers. • There were two (2) complaints in 2024. • *It was noted that a BH Satisfaction Survey should be added for 2025.* Key Accomplishments for 2024: • Successful coordination of CalAIM ECM member self-referrals. • Successful CalAIM Community Supports referrals. • Filled open CM positions. • Managed more members compared to 2023 in the BH, Perinatal, TCS, and FYOL programs. • Enhanced the TCS program to meet Population Health requirements: o Outreach for all Acute Inpatient Admissions. o On-site staff at Community Regional Medical Center. o Increased engagement in programs. o Enhanced coordination with Telehealth Care (telehealth docs) for post-discharge follow-up referrals. Program Goals for 2025: • Increase member enrollment in the TCS program. o Increase the number of hospitals with onsite staff presence. • Manage more members across CM programs. • Launch texting program with members. • Reduce further the readmission rate and ED visits for members in CM. • Increase Prenatal and Postpartum visit goals for the Perinatal program. • Support CalAIM Community Supports programs and referrals for members through FindHelp. *The Committee had no further questions or recommendations.*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#4 **Key Presentations** - 2024 Provider Satisfaction Survey Results (Attachment U) Action Patrick Marabella, M.D., Chair	The **Provider Satisfaction Survey RY2025 Results & Approach** were presented and reviewed. Provider satisfaction impacts the Plan's ability to create robust networks and partner with providers to care for members and reach quality performance goals. Provider network, claims operations, call center, commercial sales, and provider engagement teams are all impacted by this. The goal is to reach the 90th percentile in overall provider satisfaction by 2027, measured by the annual Provider Satisfaction Survey. The strategy includes collecting provider feedback (including Satisfaction Surveys), identifying key initiatives for improvement, designing and implementing projects, and monitoring experience and performance metrics. <u>Key Values for Provider Satisfaction – Tenets:</u> • Align on best practices with a provider-centric mindset. • As a data-driven organization, we continuously listen to provider feedback to improve. • We collaborate across Departments. No one department owns the end-to-end experience. • We all impact the provider experience, whether we work directly with providers or not. <u>Survey Methodology – Annual Survey</u>: • Completed Q4 of 2024 (Sept-Nov) • Surveyed PCP, Specialist, and BH offices • Administered via mail, phone, & internet • Response Rate: ~8% o Response rate increased by 4 pts, but is still low. o 137 total responses • Main Question Areas Include: o Overall Satisfaction o Likelihood to Recommend o Comparative Rating to All Other Plans o Finance Issues o Utilization and Quality Management o Network/Coordination of Care o Pharmacy o Health Plan Call Center Service Staff o Provider Relations o Bonus/Custom Question Areas: ▪ Discharge Planning	**Motion:** *Approve* - 2024 Provider Satisfaction Survey Results (Cardona/Ramirez) **6-0-0-2**

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Access & Availability <u>Provider Satisfaction Performance:</u> • BH providers had a high response rate and were about ~30% of responses, indicating a group needing additional attention. • BH Providers brought the overall satisfaction score lower. • Overall Satisfaction (CVH only): 81.3% • High Performance in the following areas: Access & Availability: o Referral and/or prior authorization process necessary for patients to access covered services. o Access to urgent care. o Access to non-urgent primary care. o Access to non-urgent specialty services. o Access to non-urgent ancillary diagnostic and treatment services. o Access to current and accurate provider directory data. Health Plan Call Center Service Staff: o Overall satisfaction with the Plan's call center service. Discharge Planning: o Assistance with appropriate discharge planning referrals. • Need to Maintain Performance in the following areas: Discharge Planning: o Assistance with transitioning patients to alternate levels of care. Utilization and Quality Management: o Access to knowledgeable UM staff • Low Performance in the following areas: Provider Relations (BH Providers*): o Ability to answer questions/solve problems related to core business functions. o Quality of online tools supporting the delivery of patient-centered, quality care. o Quality of online tools supporting core business functions. Health Plan Call Center Service Staff: o Helpfulness of health plan call center staff in obtaining the resolution of claims issues. * Survey overlapped the transition period from MHN to HN BH. Gaps should be rectified.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2025 Focus: Goal: Overall Satisfaction 79% by: • Mirror Winning Approaches from Medi-Cal in Sharing Information: o Obtaining member information. o Obtaining referrals. o Answer questions on quality/Value-Based Care (VBC). • Provider Support and BH Integration: o Answer questions/solve problems for core business functions. o Online tools supporting the delivery of patient-centered care. o Messaging and change management supporting core business functions. • Claims Support and Issue Resolution: o Continuing support of claims issue resolution. 2025 Strategy – Project Snapshot: Highlights from several areas as we continue to work through project implementation and process improvements. • Enhanced Coordination and Messaging o Reviewing website messaging and instructions for clarity. o Implementing auto-reply messaging to external email addresses to confirm receipt. • Issue Resolution o Increased provider engagement staffing, and structure to support BH providers. o Reviewing Pulse survey data monthly for continuous improvement and follow-up. • Provider Data Management o Improving workflows for intake and validation of provider data changes, including integration with the state-wide registry Symphony. • Provider Services o Rolled out a new Availity platform to support providers online with enhanced and new self-service tools. o Completed CC training on the ability to handle claims resolution without the need for additional escalation. *Discussion:* *Dr. Pascual commented that she recently met her Provider Engagement representative but hadn't had any previous interaction with the Provider Engagement team.*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Marabella agreed that the model is not as robust as it could be. Provider Engagement meets with those who are available during their visit, which may often be only the front office staff. *Dr. Ramirez asked how the Voice of the Customer (VOC) program would work.* *Amy Schneider reported that discussions are just beginning in this area, so details on specific programs have not yet been shared, but provider and member satisfaction are components of NCQA Accreditation, and now that CalViva is accredited, there will be greater emphasis in this area. The Plan is up for reaccreditation in 2027: preparations begin now and continue through next year. We're currently in our "look back period." We will update the Committee as we learn more from the HN Management team.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (May 2025) - UM Concurrent Review (Q1 2025) (Attachments V, W) **Action** Patrick Marabella, M.D., Chair	The **Key Indicator Report and Turnaround Time Report May 2025** and the **Utilization Management Concurrent Review (CCR) Report Q1 2025** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Membership remained relatively stable for May 2025. • Pre-service Routine Deferral Notification TAT Non-Compliance (66%): Seventeen out of the fifty (17/50) cases reviewed failed to meet the required TAT for deferral notifications. Fifteen (15) letters were not sent in the members' preferred language. The root cause of most of these delays is the failure of new staff to allow adequate time for translation of letters into languages other than English. Steps have been taken to address this issue and improve compliance. • MCE o Admissions and utilization are up slightly, suggesting a gradual rise in acute care needs. o Bed days remain stable, indicating that the ALOS (Average Length of Stay) or care has not changed significantly. o Next steps include Monitoring for Continued Increases: ▪ Track Q2 2025 data to see if the upward trend continues. ▪ Once Q2 data is in review for any changes in demographics, provider access, or high-cost utilizers. o 30-Day Readmission Trends: Declined in Q1 2025, representing an 11% reduction. This improvement indicates potential success in post-discharge care coordination and follow-up. • TANF o Volumes and utilization are flat, with minimal change across all metrics.	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (May 2025) - UM Concurrent Review (Q1 2025) (Faulkenberry/ Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Indicates a stable population with consistent care patterns. ○ Next steps include maintaining current oversight: Given its stability, no immediate action is needed. ○ 30-Day Readmission Trends: Saw the most substantial improvement, a 37% reduction, suggesting effective management of low-acuity populations and reduced preventable returns to the hospital. • SPD ○ Sharp decreases in admissions, admits, ALOS, and bed days. ○ Next steps include: ▪ Evaluate Quality and Outcomes to ensure reduced utilization is not negatively affecting member outcomes. ▪ Engage CM and Population Health Teams, align strategies to ensure high-risk members are receiving appropriate care levels. ○ 30-Day Readmission Trends: Also improved significantly, marking an 18% reduction. • Next steps for ALOS include: ○ Correlate ALOS with Quality Metrics: Examine 30-day readmission rates, discharge destinations, and patient outcomes to ensure reduced ALOS is appropriate and not compromising care quality. ○ Monitor for Sustainability: Continue tracking ALOS quarterly to ensure reductions remain stable and aligned with clinical appropriateness. ○ Explore Further Optimization: Consider enhanced coordination with SNFs, home health, or Community Supports for sustained impact. *Discussion:* *Dr. Pascual asked which document is not being translated (regarding the TAT report)?* *Dr. Marabella explained that it was specifically the deferral letter to members, explaining in their preferred language (most often Spanish) that more information is needed to decide their case. The issue was not with the translation company's TAT; it was with the new UM staff requesting the translation promptly.* *Dr. Cardona asked how CVH's quality and utilization metrics compare with other plans.* *Dr. Marabella stated that CVH is comparable to other HN-run plans. CVH also monitors PPG benchmarks for the region.*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 **UM/CM Business** - UM Report – Top 10 Inpatient Diagnoses MY2024 (Attachment X) **Action** Patrick Marabella, M.D., Chair	The **UM Top 10 Diagnoses Report 2024** provides an annual evaluation of the hospital admissions per one thousand (Adm/k), bed days per one thousand (Days/k), and ALOS (Average Length of Stay) for the top ten (10) diagnoses, among the TANF (Temporary Assistance for Needy Families), SPD (Seniors and Persons with Disabilities), and MCE (Medicaid Covered Expansion) populations. Identification of utilization trends provides a source from which to establish opportunities for collaboration and outcome improvement. • Sepsis: Remained the leading diagnosis with a 16% increase in admissions and a 4.5% increase in bed days per thousand members. However, the ALOS was reduced by nearly 10% from 2023 to 2024. • Diabetes: Admissions increased by 1.4%, and the ALOS increased by 5.9%. • Cardiac Diagnoses (Hypertensive heart and chronic kidney disease and Hypertensive heart disease): Showed a 7.7% reduction in admissions and days per thousand members from 2023 to 2024. • Respiratory Diagnoses (Respiratory failure, not elsewhere classified, and Pneumonia, unspecified organism): Showed a 9% increase in admissions per thousand members and a 0.8% reduction in the bed days per thousand members. • Each population (SPD, TANF, MCE) exhibited variations in its top diagnoses for 2024.	Motion: *Approve* - UM Report – Top 10 Inpatient Diagnoses MY2024 (Faulkenberry/ Waugh) 6-0-0-2
#5 **UM/CM Business** - Care Management & CCM Report (Q1 2025) - MedZed Integrated Care Management Report (Q1 2025) (Attachments Y, Z) **Action** Patrick Marabella, M.D., Chair	The **Care Management and CCM Report Q1 2025** 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 (FYOL) activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness. • From Q4 2024 to Q1 2025, the referral volume for PH CM increased by 20%, while TCS referrals decreased by 23%, and BH CM referral volume increased by 38%. Referrals also increased for PCM and FYOL programs in Q1. The volume of managed cases decreased across all programs in Q1, except FYOL. • TCS has shown a decrease in the volume of members referred in Q1 2025, but the engagement rate has increased this quarter to 91%, up from 54%. • While there hasn't been a major shift in the percentage of PCP visits within 7/14/30 days post-discharge, the performance is considered acceptable at 57% in Q4 2024. • BH CM referrals have increased in Q1 2025, but the engagement rate decreased slightly (70%).	Motion: *Approve* - Care Management & CCM Report (Q1 2025) - MedZed Integrated Care Management Report (Q1 2025) (Cardona/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• PCM's total referral numbers are up compared to last quarter, with an increase in engagement rate (from 49%to 61%). All outcome measures for PCM showed improvement for enrolled members compared to those not enrolled. • FYOL referrals have increased in Q1 2025, but the engagement rate decreased slightly (96%). • The Readmission rate was 2.3% lower ninety (90) days following CM enrollment compared to ninety (90) days prior to CM. • ED claims per 1,000 members per year decreased by 599 (23.9% for Q4) after CM enrollment. • Thirty-seven (37) members completed a Member Satisfaction Survey, with 92% being satisfied with the CM program. Going forward, the team will work to obtain accurate contact information and increase participation in the satisfaction survey. The **MedZed Integrated Care Management Report Q1** was presented to monitor the volume and engagement of members referred to the MedZed Care Management Program, as well as key service-level agreements (SLAs). Over the past six (6) months, MedZed has experienced a decline in its performance and the quality of services to members enrolled in the program. For Q1 2025, one (1) out of four (4) SLAs has met the target. The health plan will terminate the MedZed agreement effective June 30, 2025. Care Management (TCS) will perform outreach to ensure members have an established relationship with a primary care provider (PCP) for medical needs, behavioral health needs, and to provide resources and support. • Engagement (engaged/# of qualified referrals) has decreased in Q1 2025 to 24% from 32% in Q4 2024 (Table 1). • Post-discharge visits did not meet the goal at 38% for the first time in six (6) quarters (Table 3). • Medication reconciliation met the goal at 98% for Q1 2025, an increase from 85% in Q4 2024 (Table 4). • The timely response to member calls on the provider triage line continues below goal at 94%; however, it increased from 84% in Q4 2024 (Table 5). • Member graduation did not meet the goal at 82%, a decrease from 84% in Q4 2024 (Table 6). Dr. Cardona left the meeting at 11:10 a.m. and returned at 11:11 a.m.	
#6 **Policy & Procedure Business** - Quality Improvement Policy	The **Quality Improvement Policy & Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with **no changes made:**	Motion: *Approve* - Quality

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
& Procedure Annual Review (Attachment AA) Action Patrick Marabella, M.D., Chair	QI-006 Annual HEDIS Production and Reporting QI-007 Health Equity Quality Review and Engagement Strategies QI-008 Data Collection and Disparity Analysis QI-010 Medical Records Documentation Standards QI-012 Physical Accessibility Review Survey QI-013 Medical Record Confidentiality & Release of Information QI-014 Potential Quality Issues (PQI) Management Process QI-017 Provider Preventable Conditions Program QI-018 Initial Health Appointment (IHA) QI-019 Childhood Blood Lead Screening **The following policies were presented for annual review and were approved with the following changes:** QI-005 Quality Improvement and Health Equity Transformation Program (QIHETP) Requirements: Updated the Consumer Satisfaction Survey Requirements to include DMHC, along with DHCS. QI-011 Medi-Cal PCP Facility Site Medical Record Review: Updated attachments for FSR Standards and Guidelines, FSR Tool, MMR Standards and Guidelines, and MMR Tool. *Committee members agreed with the policy changes as stated and voiced no questions or concerns.* Dr. Pascual left the meeting at 11:18 a.m. and returned at 11:25 a.m.	Improvement Annual Policy & Procedure Review (Ramirez/ Faulkenberry) 6-0-0-2
#7 **Oversight Audit Business** - Behavioral Health MY2024 - Quality Management MY2024 - Credentialing MY2024 (Attachments BB-DD) Action Patrick Marabella, M.D., Chair	The **2025 Behavioral Health Oversight Audit Results** were presented and reviewed. CVH Medical Management staff conducted an oversight audit of Health Net Community Solutions' Behavioral Health (HNCS BH) functions (formerly MHN) for the period January 1 to December 31, 2024. The audit, performed April 10 through June 10th, 2025, encompassed nine categories: Access & Availability of BH/SUD Services; Challenges Finding In-Network Providers; Utilization Management; Customer Service; Appeals & Grievances; Provider Referral Practices; Quality Assurance; Network Adequacy; and Health Equity & Cultural Competence. Health Net Community Solutions demonstrated **95% compliance with the 114 standards evaluated** (107 out of 113 met, one N/A) for the Behavioral Health function. The following case types were reviewed with their associated results: • Case Management of ABA Cases (Autism) = 8 (100%) • Prior Authorization Case Denials = 8 (100%)	Motion: Approve - Behavioral Health MY2024 - Quality Management MY2024 - Credentialing MY2024 (Ramirez/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Inbound Calls = 8 (100%) • Referral Request Calls = 8 (100%) • PQI Case Files = 3/3 (100%) • Crisis Call Management = 8 (100%) The initial report of opportunities for improvement includes: • 1B-3 Call Wait Time: The review of call statistics revealed that there were multiple instances where wait times exceeded 10 minutes, particularly during peak hours. The data indicates inconsistent performance in maintaining the required wait time threshold. • 1D-4 Appointment Availability: Appointment availability survey results indicated that, in multiple instances, urgent BH appointments did not meet the required wait time standards. • 2A-4 Timely Out-of-Network Services: The review of documentation revealed that there are efforts to secure out-of-network services, there were instances where follow-up services were not adequately arranged after the initial out-of-network visit. In some cases, members reported delays in receiving necessary follow-up care due to coordination issues between in-network and out-of-network providers. • 2B-2 Network Capacity-ED Length of Stay: The review of documentation revealed that there are efforts to secure out-of-network services; there were instances where follow-up services were not adequately arranged after the initial out-of-network visit. In some cases, members reported delays in receiving necessary follow-up care due to coordination issues between in-network and out-of-network providers. • 3A-2 Annual Review of BJ UM Criteria: The Medical Advisory Committee (MAC) minutes indicate some discussion regarding UM criteria updates, but there is insufficient evidence to demonstrate that a comprehensive annual review was conducted for all BH UM criteria. • 9B-2 BH Call Center Staff CLAS Training: There is no evidence of BH Call Center staff completing CLAS training during the audit period. This overlapped the transition from MHN to HN. Behavioral Health is preparing its initial response. *Discussion:* *Dr. Waugh commented that MH/SUD patients would likely leave the ED if asked to wait for an extended time (8 hours). The actual number of patients seen in the ED may be deflated.* *Dr. Marabella indicated that HN will need to reassess network contracting to ensure there is adequate coverage. The Plan uses Community Health Workers (CHWs) or Substance Use*	

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	Navigators (SUNs) to help with SUD referrals downtown (Fresno) and in Madera at Camarena. The **2025 Quality Management Oversight Audit Results** were presented and reviewed. CVH conducted an Oversight Audit of Health Net Community Solutions' (HNCS) support of the Quality Management function for CVH. Program Descriptions, Annual Work Plans, and Mid-year and Annual Evaluations were reviewed to provide evidence of compliance for several standards. Additionally, several policies and procedures, audits, reports, contracts, and other documentation were reviewed as evidence of compliance with established standards and regulations. Based upon review of these documents and ongoing communication with appropriate leadership and staff from QI, UM, and Population Health, and through the QI/UM Workgroup, QI/UM Committee, and other formal and informal improvement teams, CVH observed overall a **100% compliance rate** for this function. The **2025 Credentialing Oversight Audit Results** were presented and reviewed. CVH conducted an oversight audit of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function. An evaluation of compliance with credentialing system controls to maintain the accuracy and security of practitioner and provider data revealed appropriate application, monitoring, and reporting of credentialing controls. HNCS provided a number of policies and procedures, contracts, reports, logs, and other documentation as evidence of compliance. • Randomly selected practitioner files (201) were reviewed from Health Net (HN), HN Behavioral Health, and the other entities delegated for Credentialing (101)/Re-Credentialing (100), including Santé, La Salle, ASH, IMG, Adventist, Envolve, CVMP, ChildNet, Grow Therapy, Clinica Sierra Vista, and UPN. • Organizational provider files (16: 8 initial credentialing, 8 recredentialing) were randomly selected for review and evaluation to ensure compliance with regulatory requirements. File types included Skilled Nursing Facilities, Outpatient Dialysis Centers, Hospice, Urgent Care Centers, and Acute Care Facilities, etc. • The timeliness of Re-Credentialing within the thirty-six-month (36) criteria was noted to be a factor for IMG in this audit, with one (1) case not meeting the 100% compliance criteria. This case was recredentialed at forty (40) months; however, IMG will require corrective action. Overall, HNCS was found to be compliant with 85 out of 86 standards evaluated (98.8% compliance rate). **The Initial Credentialing and Re-Credentialing file reviews of practitioners were excellent at**	

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	99% and 99% respectively, and the Organizational Providers demonstrated 100% compliance.	
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Q2 2025) (Attachment EE) Action Patrick Marabella, M.D., Chair	The **Credentialing Sub-Committee Quarterly Report Q2 2025** was presented. The Credentialing Sub-Committee met on May 15, 2025, to review routine credentialing and re-credentialing reports for both Q4 2024 delegated and Q1 2025 non-delegated entities (Health Net (HN) and HN Behavioral Health (BH)). • The Credentialing Adverse Actions report for Q1 2025 for CVH from the HN Credentialing Committee was presented with no (0) cases presented for discussion for Q1 2025 for CVH. • The Adverse Events Q1 2025 report was presented. o Credentialing submitted zero (0) cases to the Credentialing Committee in Q1 2025. o There were no (0) reconsiderations or fair hearings during Q1 2025. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2025. o There were zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q1 2025. • The Access & Availability Substantial Harm Report Q1 2025 was presented 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 Q1 2025 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1). • The NCQA System Controls CR Oversight Report 2025 was presented and reviewed to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policies describe: o How primary source verification information is received, dated, and stored. o How modified information is tracked and dated from its initial verification. o Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. o Security controls that are in place to protect the information from unauthorized modification.	Motion: Approve - Credentialing Subcommittee Report (Q2 2025) (Pascual/ Faulkenberry) 6-0-0-2

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	○ How the organization monitors its compliance with the policies and procedures at least annually and takes appropriate action when applicable. • Quarterly audits were performed of all CVH credentialing files processed with two (2) modifications to CVH provider records identified in 2024. These two (2) cases were audited against the information management criteria included in the policy and were found to be fully (100%) compliant. Modifications were made by individuals authorized to do so; when and why the modification was made was documented and consistent with policy; what was modified and who made the modification were also documented. Quarterly monitoring will continue with annual auditing and reporting. Appropriate actions will be taken when indicated. • The Credentialing Sub-Committee Charter for 2025 was reviewed and approved by the committee. There were no changes to the Charter this year.	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q2 2025 (Attachment FF) Action Patrick Marabella, M.D., Chair	The **Peer Review Sub-Committee Quarterly Report Q2 2025** was presented. The Peer Review Sub-Committee met on May 15, 2025, to review Q1 2025 data provided in the following reports: • The county-specific Peer Review Sub-Committee Summary Reports for Q1 2025 were reviewed for approval. No (0) significant cases to report. • The Q1 2025 Adverse Events Report was presented to provide a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. ○ There were nine (9) cases identified in Q1 that met the criteria for reporting and were submitted to the Peer Review Committee. Three (3) of these cases involved a practitioner, and six (6) cases involved organizational providers (facilities). ○ Of the nine (9) cases, three (3) were tabled, zero (0) were deferred, one (1) was tabled with a letter of concern, one (1) was closed to track and trend with a letter of concern, zero (0) were closed to track and trend with a letter of education, and four (4) were closed to track and trend. ○ Seven (7) cases were quality of care grievances, two (2) were potential quality issues, zero (0) were lower level, and zero (0) were track and trend. ○ Zero (0) cases involved Seniors and Persons with Disabilities (SPDs), and none (0) involved Behavioral Health. ○ There were no (0) incidents involving appointment availability resulting in substantial harm	Motion: Approve - Peer Review Subcommittee Report Q2 2025 (Faulkenberry/ Ramirez) 6-0-0-2

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	to a member or members in Q1 2025. o Reviews completed in December, January, and February did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. o There were zero (0) cases identified outside of the ongoing monitoring process this quarter in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) o There were thirteen (13) cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. • The Access & Availability Substantial Harm Report for Q1 2025 was also presented to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances, Quality of Care (QOC), and Potential Quality Issues (PQIs) related to identified appointment availability issues, and they are ranked by severity level. o Seventeen* (17) new cases were submitted to the Peer Review Committee in Q1 2025. There were three (3) incidents found involving appointment availability issues without significant harm to a member. Three (3) cases were determined to be related to significant harm to a member, but without appointment availability issues. No cases (0) were related to behavioral health issues. *One (1) case appeared twice (2) in the quarter. • The Q1 2025 Peer Count Report was presented with a total of seventeen (17) cases reviewed with the committee. Ten (10) cases were closed and cleared. Five (5) cases were tabled for further information. No (0) cases were closed/terminated. One (1) case had a CAP outstanding/continued monitoring, and one (1) was pending closure for CAP compliance. • The Peer Review Sub-Committee Charter for 2025 was reviewed and approved by the Committee. There were no changes to the Charter this year.	
#9 **Access Business** - Access Workgroup Quarterly Report (Q2 2025) (Attachment GG) Action	The **Access Work Group Quarterly Report Q2 2025** was presented and reviewed to provide the QI/UM Committee with an update on the CVH 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. Key Report Highlights of the 5/27/25 meeting include: • Q1 2025 Network Adequacy Report: o PCP: DMHC PCP standard met for Kings County and Madera County now meets at 100%.	Motion: Approve - Access Workgroup Quarterly Report (Q2 2025) (Cardona/Ramirez) 6-0-0-2

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Patrick Marabella, M.D., Chair	Fresno County increased from 99.2% to 99.6%. For Fresno County zip codes that do not meet, Alternative Access Standards were requested. o Specialties by Combined Counties: All specialties in all counties met internal standards of 90% or higher. • Specialties by County: All specialties in Fresno and Madera Counties met internal standards. For Q1 Anesthesiology, Geneticists, HIV/AIDS, Maternal/Fetal Medicine, and Neurological Surgery specialties now meet in Kings County. • MY2024 Access & After-Hours CAP & Evaluation: It was reported that the identification of non-compliant providers and the corrective action plan (CAP) are expected to be completed by the end of June. • Q1 2025 Behavioral Health Services Triage and Screening Report: After three previous quarters of not meeting the Average Speed to Answer within 30 minutes, 100% of the calls in Q1 2025 were handled within 30 minutes. • Q1 2025 Appeals & Grievances: Access to Care, Prior Authorization Delay remains the top Grievance. • Q1 2025 Transportation Oversight Report: The report showed utilization decreased slightly to 10.3% in Q1 from 10.6% in Q4, with dialysis as the top treatment. The ModivCare CAP for the PCS process was closed due to delegation changes, but the telephone authorization CAP remains open with ongoing validation. Open CAPs from 2024 include denial reasons and exempt grievance resolutions. ModivCare completed remediation, with validation scheduled for April. • Telehealth Activity Report: In addition to the number of e-consults that were reported (232 General Medical/49 BH), the report also provides the number and type of Teladoc visits.	
#10 **Compliance Update** -Compliance Regulatory Report (Attachment HH)	Maria Sanchez presented the **Compliance Report.** **CalViva Health Oversight Activities: Health Net:** 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 and availability, specialty referrals, utilization management data, grievances, and appeals etc. **Oversight Audits**: The following annual audits are in progress: Health Education, Marketing, Call	-Compliance Regulatory Report

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	Center, Claims/PDR, A&G, Health Equity, Member Rights, Privacy and Security, and Provider Network. The following annual audits have been completed since the last Commission report: Behavioral Health (CAP), Credentialing (CAP), Quality Improvement (No CAP) **Fraud, Waste, and Abuse:** Since the 5/8/2025 Compliance Regulatory Report to the Committee, there were three (3) new MC609 filings: One (1) case was a non-participating laboratory with allegations of false representation and billing for services not rendered; One (1) case was a provider who was billing rare CPT codes and didn't seem to be using the treatment appropriately and members' conditions were not improving; One (1) case was a pain medicine specialist that frequently sends requests for trigger point injections with lack of documentation to prove medical necessity. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** The Plan is on track to complete its stated corrective actions and will provide its next and final monthly update by 7/21/25. **Department of Health Care Services ("DHCS") 2024 Medical Audit: Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit:** The Plan responded to all outstanding inquiries, and on May 14, 2025, the Department of Health Care Services (DHCS) formally closed the Corrective Action Plan (CAP). **Department of Health Care Services ("DHCS") 2025 Medical Audit:** The 2025 DHCS Audit was conducted virtually from 6/2/2025-6/13/2025. The Plan submitted all required pre-audit documentation and follow-up requests. The DHCS indicated it would provide a Preliminary Final Report in September 2025 with a Final Report by 10/1/25. **Memorandum of Understanding (MOU): Annual Network Certifications:** Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOUs, which have also been posted to CVH's website: • Amendment to DMC State Plan MOU Kings County **(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR):** On April 18, 2025, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access to PCPs and Hospitals, and Provider Data Accuracy. The Plan is preparing a formal response, which will be submitted by the July 17, 2025, deadline. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** On 5/1/2025, the Plan submitted its Annual TAR filing to DMHC. The Plan is awaiting a response. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and	

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	DMHC All Plan Letters (APLs) that have been issued in CY 2025. **Public Policy Committee (PPC):** The Public Policy Committee met on June 4, 2025, with the following reports presented: • 2024 Health Education EOY Summary Work Plan Evaluation • 2025 Health Education Work Plan • 2024 Health Equity EOY Summary and Work Plan Evaluation • 2024 Language Assistance Program EOY Work Plan Evaluation • 2025 Health Equity Program Description • 2025 Health Equity Work Plan The next PPC meeting will be held on September 3, 2025, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.	
#11 Old Business		
#12 Announcements	The next meeting is scheduled for September 18, 2025.	
#13 Public Comment	None.	
#14 Adjourn	The meeting adjourned at 11:47 a.m.	

NEXT MEETING: September 18th, 2025

Submitted this Day: September 18th, 2025

Submitted by: Amy Schneider RN
Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X
Patrick Marabella, MD, Committee Chair