Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
January 17, 2013

CalViva Health
1315 Van Ness Avenue, Building 103
Fresno, CA 93721

Attachment A

Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	**Patrick Marabella, M.D.**, CalViva Chief Medical Officer, Chair	✓	**Mary Beth Corrado**, Chief Compliance Officer (CCO)
✓	**Aftab Naz, M.D.,** At-large Appointee, Madera County	✓	**Amy Schneider, RN,** Director of Medical Management Services
	David Glossbrenner, M.D., Adventist Health	✓	**Morgan Essenheimer**, Compliance Analyst
	David Cardona, M.D., Fresno County At-large Appointee, Family Care Providers	✓	**Alex Rocha**, Quality Specialist
✓	**Jonathan Forncrook, D.O.**, Camerena Health Center	✓	**Brandi Leyva**, Medical Administrative Coordinator
✓	**Conrad Chao, M.D.**, Fresno County At-large Appointee, UCSF/CCMG		
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
Guests/Speakers			
✓	**Maria Ortega**, Health Net		
✓	**Claudia Sicairos**, Administrative Assistant, Health Net		

➢ = in attendance

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D, Chair	The meeting was called to order at 11:10 am.	
#2 **Approve Consent Agenda** -Committee Minutes 11/15/12 -National Medical Policies (August through December 2012) Attachments A, B) **Action** Patrick Marabella, M.D, Chair	All items on the Consent Agenda were approved as submitted.	Motion: Approve Consent Agenda 4-0 (Naz/Chao)
#3 **QI Business** -2012 QI Work Plan Annual Evaluation Executive Summary and Work Plan (Attachment C) **Action** Patrick Marabella, M.D	QI Work Plan Annual Evaluation Executive Summary and Work Plan. The QI Work Plan Annual Evaluation provides evidence of the overall effectiveness of the QI activities and identifies barriers and opportunities for improvement for 2013. Initiatives: ➢ The QI Department planned eight initiatives and/or projects for 2012. All eight activities were completed by the due dates as planned with some activities to be included in the 2013 work plan. Key Accomplishments: ➢ Developed and implemented the Provider Access Survey and the Provider Satisfaction Survey to assess compliance with office access standards and identify opportunities for improvement. The goal	Motion: Approve QI Work Plan Annual Evaluation and Summary 4-0 (Chao/Forncrook)

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	was met in all counties for primary care appointments. Educational opportunities for CalViva Health providers will be made available in 2013. ➢ A three pronged approach to reach new members was utilized The Initial Health Assessment outreach attempts reached 99% compliance to meet DHCS Contract requirements. ➢ Outreach initiatives were implemented to improve post-partum visits. Outreach efforts demonstrated contact with 2,411 postpartum members to encourage scheduling a postpartum visit within 3-6 weeks after giving birth. This project continues to be an ongoing effort. 2013 QIP Initiatives: Department of Health Care Services (DHCS) requires two QIP projects per health plan per year: an individual project (IQIP) and the DHCS statewide collaborative QIP: 1) Comprehensive Diabetes Care-Eye Exam (IQIP) 2) All Cause Readmissions Discussion: ➢ Dr. Chao inquired about extending the post-partum visit metric to an outcome measure beyond simply reaching members by phone calls. This process measure will evolve to an outcome measure after success with the process has been established. The next step of assessment will include an assessment of outcome.	
#3 QI Business Appeals and Grievances Dashboard (Attachment D) **Information** Patrick Marabella, M.D, Chair	Appeals and Grievances Dashboard. This report is current as of November and is broken down into two major categories: Appeals and Grievances. This report provides monthly data to facilitate monitoring for trends in the number and types of cases over time. Grievances: A grievance is defined as an expression of dissatisfaction (oral or written). ➢ The grievances are broken down into two categories: Expedited and Standard. ➢ Grievance metrics are reported according to cases received and cases resolved within the time period. There were fifty grievances received for quarter four and thirty-eight grievances were resolved for quarter four. ➢ Grievances are further broken down into two categories: Quality of Service QOS (Administrative), and Quality of Care QOC (Clinical). There were twenty-eight QOS resolved grievances for quarter four. There were ten QOC resolved grievances. ➢ Grievances are also broken down by county. ➢ The trend remains flat. No significant issues to report. Appeals: An appeal is defined as a request for reconsideration; an oral or written request to change a previous decision or adverse determination. ➢ The appeals are broken down into two categories: Expedited and Standard. ➢ Appeal metrics are reported by received date and resolved date. There were fifteen appeals received	

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	for quarter four and seventeen appeals were resolved in this quarter. ➢ Resolved appeals are broken down into two categories: Pre-service and Post service. There were seventeen Pre-service appeals for quarter four and no Post service appeals were reported. No trends were identified.	
#3 QI Business Appeals and Grievances Executive Summary (Attachment E) **Information** Patrick Marabella, M.D, Chair	Appeals and Grievances Executive Summary. The CalViva Health QI/UM Committee reviews appeals and grievances quarterly to assess emerging patterns, compliance to turnaround time and volume, and to formulate potential plan policy/process changes and/or procedural improvements to improve care and service. Findings/Outcomes: Member Appeals and Grievances- ➢ There were a total of eighteen appeals. All eighteen appeals were pre-service appeals. There were no Post-service appeals reported in third quarter for the tri county area. ➢ There were seventy four grievances. Grievances are divided into two major categories: Administrative/Quality of Service (QOS) and Clinical/Quality of Care (QOC). No trends identified. Turnaround Time and Volume- ➢ There were a total of eighteen Appeals and seventy four Grievances for a total of ninety two cases received and closed within compliance standards. No actions necessary for quarter three. One hundred percent compliance was achieved. Access Grievances- ➢ The majority of Access to Care Grievances were related to PCP-Referral for services and Wait-time-Provider. Cases were reviewed with no trends identified. Appeals and Grievances Inter-rater Reliability- ➢ For the audit period of July through September, results for the appeals and grievances case reviews averaged on an overall score of ninety seven percent. ➢ Compared to quarter one to quarter two of 2012, the audit scores have slightly decreased due to a new regulatory requirement in regards to adding a synopsis to a case file.	
#3 QI Business Appeals and Grievances Quarterly Summary (3rd Qtr 2012) (Attachment F) **Information** Patrick Marabella, M.D, Chair	Appeals and Grievances Quarterly Summary for third quarter 2012. The record of appeals and grievances are reviewed quarterly by the QI/UM Committee to assess emerging patterns, and to formulate potential plan policy/process changes and/or procedural improvement. Data/Results: ➢ In Fresno County, thirteen out of seventeen appeals were for services deemed not medically necessary. ➢ In Fresno County twenty six out of seventy one grievances were Quality of Care grievances related to the PCP. ➢ In Madera County there were no appeals and three grievances. ➢ In Kings County there was one appeal and no grievances.	

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	Appeals: Pre-Service Appeals- ➢ Pre-service appeal types across all three counties are too low in volume to identify trends and patterns. Post Service Appeals- ➢ There were no Post-Service appeals in the third quarter of 2012 for the tri county area. Grievances: Quality of Service- ➢ Access to Care – Primary Care Physician Referral for Services – no trends identified. ➢ Administrative Issues – Majority of complaints were related to the perceived delay in member obtaining pain medications. Quality of Care- ➢ In Fresno County, one provider had multiple complaints. These cases have been forwarded for further analysis per policy. No other trends were identified. ➢ There was one validated Potential Quality Issue (PQI). All other QOC grievance types are too low in volume per county to identify other trends or patterns. Access to Care- ➢ No trends identified.	
#3 QI Business Appeals and Grievances TAT & Volume Report (Attachment G) **Information** Patrick Marabella, M.D, Chair	Appeals and Grievances TAT & Volume Report. This report provides a record of appeals and grievance compliance to turnaround time standards.. Data/Results: Appeals- ➢ 100% compliance with all eighteen cases Grievances- ➢ 100% compliance with all seventy four cases ➢ No follow up required for quarter three. Future Turn Around Time and Volume metrics will be reported as part of the Quarterly Appeals and Grievance Summary Report.	
#3 QI Business Appeals and Grievances IRR Report 3rd Qtr 2012 (Attachment H) **Information** Patrick Marabella, M.D, Chair	Appeals and Grievances Inter-Rater Reliability Report (IRR). Quality audits of post finalized transactions are completed by the Appeals and Grievance Department to measure compliance with regulatory requirements, adherence to policies and procedures, as well as to assess the customer's experience. Data/Results: ➢ Twenty five cases are reviewed monthly ➢ For the audit period of July through September 2012, results for the Medi-Cal appeals and grievance case reviews averaged an overall score of ninety-seven percent. Analysis/Findings: ➢ Compared to quarter one and quarter two, the audit scores have slightly decreased due to new	

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	regulatory requirements regarding adding a synopsis to the case file. ➢ Ninety-seven percent compliance was achieved for July through September Appeals and Grievance audit scores. Actions Taken: ➢ All findings will be addressed with staff on a case by case basis and incorporated into general training as appropriate. Additional training for the synopsis requirement was completed.	
#3 QI Business QFL and Kids & Teens Challenge Incentive Quarterly Report Qtr 3 2012 (Attachment I) **Information** Patrick Marabella, M.D, Chair	QFL and Kids & Teens Challenge Incentive 3rd Quarter Report. This reports CalViva Health member participation and winners in the Quit For Life (QFL), Kids & Teens Challenge (KTC), Fit Families For Life (FFFL), and Member Orientation Class (ME) programs for quarter three 2012. Analysis/Findings: QFL- ➢ There were a total of thirty-eight participants for the tri-county area. There was a slight increase in participation (five percent) from quarter two 2012 to quarter three 2012. Alere Wellbeing will continue reaching out to CalViva Health members who are taking smoking cessation medication to inform them of the QFL program. KTC- ➢ There were a total of twenty-seven CalViva Health participants in the tri-county area. KTC participation increased from quarter two to quarter three associated with the distribution of the CalViva Health newsletter to members in early August. There were three KTC CalViva Health member raffle winners; two from Fresno County and one from Madera County. FFFL- ➢ A total of forty-six members enrolled in the program during quarter three, slightly higher than that of quarter two. ME- ➢ Member orientation classes were scheduled and promoted for English and Spanish-speaking members. Promotional efforts included direct mailing of flyers to three-hundred and fifty members residing within a one mile radius of the Community Solutions Center, and were available at high-volume providers/clinics, pharmacies, community-based organizations (CBOs), and health education classes. Actions Taken : ➢ Continue outreach calls to CalViva Health members regarding the QFL program. CalViva specific quit rates will be available in 2013. ➢ Distribute the FFFL Provider Update. ➢ Coordinate and implement member orientation sessions in partnership with CBOs/schools within high member residence areas. ➢ Promote member orientation sessions in member newsletter and CalViva Health's website.	CVH staff will follow up with the Health Education Department and report back to the QI/UM Committee.

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	➢ Dr. Forncrook inquired about the process for providing the referring physician with information regarding members' participation in the CalViva Health education programs.	
#3 QI Business Potential Quality Issues Report (Attachment J) **Information** Patrick Marabella, M.D, Chair	Potential Quality Issues Report. This report provides evidence that the quality of care provided to CalViva Health members is reviewed, problems are identified, and action is taken to improve care when indicated. Deficiencies are identified as quality of care (QOC) grievances or potential quality issues (PQI) that may result in substantial harm to members. Cases are scored by severity level, and referred to a Medical Director for clinical assessment and recommendations. These are then forwarded to the CalViva Health Chief Medical Officer (CMO) for review and final recommendations. Summary reports are reviewed and if there is an identifiable trend cases are referred for further assessment and action as indicated. Data/Results: PQIs April thru December 2012 For the tri-county area there were a total of eleven PQIs identified as of December 2012. ➢ There were six PQI cases referred to Peer Review for further action. Actions Taken: The PQIs identified in April through December 2012 are pending further review by peer review staff.	
#4 UM Business Key Indicator Report (Attachment K) **Information** Patrick Marabella, M.D, Chair	Key Indicator Report reflects data as of December 20th, 2012. Areas of Attention: ➢ Inpatient Utilization and SPD Re-admissions demonstrate increasing trends. Initiatives to improve in these areas will begin in 2013. ➢ The ER data will continue to have a ninety day lag due to claims processing. No other trends identified.	
#4 UM Business Authorization Tracking Report (Attachment L) **Information** Patrick Marabella, M.D, Chair	Authorization Tracking Report. This report provides a method to track and monitor prior authorization requests submitted by directly contracted providers. The system includes authorized, denied, deferred or modified referrals, and the timeliness of the referrals. Findings/Outcomes: Excellent performance noted in quarter three 2012. Interventions Taken: ➢ Creation of simplified Notice of Action 101 training documents ➢ Intense re-training and audits of all staff on TAT regulatory compliance requirements ➢ Creation of multi-staff level TAT workgroup consisting of Care Managers, UMC's, and Medical Directors to review processes, identify opportunities for improvement and training, as well as recognition incentives meeting compliance goals. ➢ Ongoing education of providers in the use of "urgent" status.	
#4 UM Business Standing Referrals Report	Standing Referrals Report. The Standing Referrals Report was presented to the QI/UM Committee. This report was created to	

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(Attachment M) **Information** Patrick Marabella, M.D, Chair	develop data regarding the number of medical necessity pre-certification denials for Chronic Conditions. Chronic Conditions include but are not limited to: 1. Congestive Heart Failure (CHF) 2. Asthma 3. Diabetes 4. Chronic Obstructive Pulmonary Disease (COPD) 5. End Stage Renal Disease (ESRD) 6. Coronary Artery Disease (CAD) 7. Human Immunodeficiency Virus (HIV) 8. Hypertension There were no Pre-Certification Denials for Standing Specialty Referrals reported for 2012.	
#4 UM Business Perinatal Statistics Report (Attachment N) **Information** Patrick Marabella, M.D, Chair	Perinatal Statistics Report. This report identifies members with high-risk perinatal conditions who received referrals for resources i.e. CPSP PPG Case Management, home fetal monitoring, health education materials, channel to network facilities for delivery, review for transition of care, and individual case management for the highest risk Medi-Cal members. Analysis/Outcomes: Of the members determined by the Perinatal Case Manager (PCM) to be a "High Risk" category, the PCM makes at least three attempts to contact a member. The PCM addresses any gaps in the care plan that have not been addressed. Actions Taken: ➢ The PCM has developed relationships with physician offices to obtain current and accurate member contact information, and to assist with care coordination and planning. ➢ In order to track the overall outcomes of the home monitoring program, the perinatal case manager has begun following members that are receiving high-risk OB home monitoring directly through Alere. ➢ Results will be reported to the QIUM Committee.	
#4 UM Business CCS Report (Attachment O) **Information** Patrick Marabella, M.D, Chair	CCS Report. The CCS report was reviewed. Rates are improving. There are no significant issues to report.	
#4 UM Business SPD Implementation Report (Attachment N) **Information** Patrick Marabella, M.D, Chair	SPD Implementation Report. Purpose of Activity: To provide an update on the Seniors and Persons with Disabilities (SPD) Be In Charge! Care Coordination Program for the period of April 2012 – June 2012 for newly enrolled SPDs. Results: Approximately thirty-six percent of the high-risk population enrolled in quarter two of 2012 completed a	

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	risk assessment. ➢ Dr. Chao inquired about the initial process of identifying high to low risk members: There is a methodology incorporated into the process by the State to determine high to low risk members such as Treatment Authorization Requests (TARs) data and Member Evaluation Tool (METs). These tools are included in the initial member welcome packet. Once completed, the SPD is stratified to low or high risk based on the State guidelines.	
#6 Compliance Update -Public Policy Committee -DMHC Medical Survey **Information** Mary Beth Corrado, CCO	MB Corrado provided a verbal Compliance Update for the committee regarding the Public Policy Committee and the status of various audits that CalViva Health is involved in. Public Policy Committee The Public Policy Committee met on December 5th, 2012. Due to lack of quorum, the meeting was an educational session. A sample of member literature and materials were distributed to those in attendance. Follow Up points: 1. To ensure the Screening Preventative Guidelines are consistent as published in the 2013-2014 EOC handbook 2. To present the success rate of the Quit For Life Health Education program 3. Gather additional information on CalViva Health's Educational activities Audit Status Update Updates for the following audits: 1. The "1115 Waiver Medical Survey" audit is scheduled for March 2013 by Department of Managed Health Care (DMHC). In November, an informal Pre-Audit notification questionnaire was received and all requested documents were submitted to DMHC by December 7th, 2012. Awaiting formal notification of March audit. 2. Quarterly Provider Dispute Resolution – Health Net monitors provider dispute cases on CalViva Health's behalf. First, second, and third quarter 2012 audits have been completed. Minor areas needed clarification or action/explanation. No problems/patterns identified.	A Health Net Oversight Audit summary will be presented at the March QI/UM Committee meeting.
#7 Policy/Procedure Review -Quality Improvement Summary (Attachment Q) -Utilization Management Summary (Attachment R)	Quality Improvement Summary Quality Improvement Policies reviewed with substantial changes: 1. Accessibility of Providers and Practitioners (QI-007) – Revised to reflect updated regulatory requirements and clarification of procedures 2. Availability of Practitioners and Providers (QI-008) – Policy reviewed and revised to be consistent with new regulations and other policies and procedures 3. Medical Record Confidentiality and Release of Information (QI-013) – The information/content related to Minor Consent Services was removed and only the reference was left since CalViva now has a PH-019 Minor Consent policy. Utilization Management Summary Utilization Management Policies reviewed with changes:	

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	1. Precertification and Prior Authorization Request (UM-002) – Revisions made to be consistent with practice. Revised timeframe for concurrent review of treatment regimen already in place per regulations. Attachment A and regulatory references updated. 2. Provision of Nutritional Supplements/Replacements (UM-013) – Policy revised to reflect regulatory changes per All Plan Letter 12-005 regarding guidelines for approval of nutritional supplements and formula for children and adults. 3. Referral to Case Management (UM-108) – Added reference to "Flagging, Tracking and Reporting of CCS Members" (UM-111) policy for case management services provided to members under 21 years of age. 4. Flagging, Tracking and Reporting Eligible CCS Members (UM-111) – Added wording to include the policy applies to members that are 21 year of age or younger. 5. Continued Access to Existing Non-Participating Providers for SPD Members (UM-201) – Revised to be consistent with current SPD regulations in 2012. 6. Referrals to Non-Participating Providers (UM-210) – Update to include guidance associated with religious and ethical issues according to regulation. Updated with regulatory references. 7. CBAS Authorization Process (UM-300) – New policy 8. Patient Centered Planning and Enhanced Case Management for Non-CBAS Eligible Members (UM-301) – New policy	
#8 Old Business	None.	
#9 Announcements	None.	
#10 Public Comment	None.	
#11 Adjourn Patrick Marabella, M.D, Chair	Meeting was adjourned at 12:17pm.	

NEXT MEETING: March 21st, 2013

Submitted this Day: March 21, 2013

Submitted by: Amy B. Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick C. Marabella, MD Committee Chair