Fresno-Kings-Madera
Regional Health Authority

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

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

Attachment A

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

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

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D Chair	The meeting was called to order at 10:05 am. A quorum was present.	
#2 Approve Consent Agenda Committee Minutes: February 20, 2025	February 20th, 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 (Q4 2024) - Standing Referrals Report (Q4) - Lead Screening Quarterly Report (Q3) - SPD HRA Outreach (Q4) - Evolent (NIA) (Q4) - MedZed Integrated Care Management Report (Q4) - Behavioral Health Performance Indicator Report (Q4) - Pharmacy Provider Updates (Q4 2024, Q1 2025) - Performance Improvement Project Updates – Non-Clinical - Performance Improvement Project Updates – Clinical - PA Member Letter Monitoring Report (Q4) -CVH QIUM Committee Charter 2025 (Attachments A-M) **Action** Patrick Marabella, M.D Chair	A link for the Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Pascual) 5-0-0-3
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (January 2025) - A&G Validation Audit Summary (Q3 2024)	The **Appeals & Grievances Dashboard and Turnaround Time Report** through January 2025 were presented. 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. A total of 184 grievances were received during Q1 2025. During this quarter, 130 grievances were categorized as Quality of Service (QOS), most commonly for prior authorizations and network access.	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (January 2025) - A&G Validation Audit Summary (Q3 2024)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments N, O) **Action** Patrick Marabella, M.D Chair	• Administrative issues increased, largely due to changes in PPG contracting and network access issues. • Balanced Billing/no ID cards remains an issue, and we will continue to monitor for improvement. • A new category we are tracking is CalAim: three (3) were related to medically tailored meals, and one (1) was for housing assistance. • Transportation Access, particularly no-shows, remains an issue (only two this month). There were 15 YTD 2025 Quality of Care (QOC) grievances. 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 183 in Q1 2025. • The Attitude/Service Provider remains a category to monitor. • ID cards and balance billing issues continue to cause grievances, though improvements are being made in addressing these. The total number of Appeals has increased (68) in Q1 2025. • The CalAim category has been added to Appeals. Similarly to QOS Grievances, most appeals in this category were related to medically tailored meals. The Upholds (60%) and Overturn (40.9%) rates have improved. One (1) letter was out of compliance for turnaround time. ModivCare provided staff with additional training and adjusted the frequency at which they run reports, which will subsequently increase the range of case lookback from 24 hours to 24-48 hours in order to reduce the risk of future late acknowledgement letters. The **Appeals & Grievances Validation Audit Report Q3 2024** was presented. CVH conducts weekly A&G case validations to ensure each Grievance or Appeal case contains the appropriate documentation and evidence necessary for standard and expedited Quality of Service (QOS), Quality of Care (QOC), and Appeal cases. • Ninety-three percent (93%) of cases (665/714) met compliance standards upon receipt. Documents were missing primarily in the Standard QOS and QOC categories. o Of the variety of document types identified as missing, most commonly: Translated Resolution Letters (24) and Case Review forms (10). Q3 2024 counts were consistent with Q2 2024. o Four (4) cases were found to be missing evidence of the DMHC script being read to the	(Pascual/Ramirez) 5-0-0-3

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	members, an increase from zero (0) in Q2 2024. o Five (5) cases were created/transferred in error in Q3 2024. Moving forward, continued collaboration with A & G leadership to refine processes, enhance document tracking systems, and provide additional staff training on these critical areas will be essential to sustaining the positive trends and resolving any emerging challenges. All documents identified to be missing from the cases were obtained and inserted to complete the files before closing out the quarter.	
#3 **QI Business** - Initial Health Appointment (IHA) Quarterly Report (Q3 2024) (Attachment P) **Action** Patrick Marabella, M.D Chair	The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an **Initial Health Appointment** (IHA) completed within the first 120 days of enrollment. The Q3 2024 IHA Quarterly Report demonstrates CalViva Health's performance on IHA compliance monitoring from Q4 2023 through Q3 2024. The current approach to monitoring has three components: • Primary Care Physician Facility Site (FSR) and Medical Record Review (MRR) via onsite (or virtual) provider audits. o Facility Site Review/Medical Records Review results show that 97% of pediatric patients and 100% of adult patients completed their IHAs for the providers audited during Q3 2024. For providers who were found non-compliant during the review period, follow-up occurs via provider notification of IHA requirements and corrective action when indicated. • Monitoring of claims and encounters data. o IHA visit rates within 120 days of enrollment in Q3 2024 (30.87%) demonstrate a downward trend of 5.20% from Q2 2024 (36.07%). • Member outreach utilizes a three-step methodology. Outreach Compliant [three (3) attempts completed, two (2) + phone and one (1)+ mail]. o Member outreach completed by the Plan in Q3 2024 demonstrates a slight decline of 0.75% from Q2 2024. The denominator for Q3 2024 is 17,259, with a 74% rate for welcome packets mailed during Q3 2024. ***Discussion:*** *Dr. Ramirez asked if the decline in mailing outreach was due to having incomplete addresses for members.* *Dr. Marabella indicated it was an administrative issue, the timeliness of mailings.* *Amy Schneider indicated that the "Staying Healthy Assessment (SHA)" is no longer technically*	**Motion:** *Approve* - A&G Classification Audit Report (Q3 2024) (Cardona/Ramirez) 5-0-0-3

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	required but asked members of the Committee if it was clear what the IHA requirements are. *Dr. Cardona stated that he still performs a modified SHA with his new members.* *Dr. Pascual indicated that OBGYNs use different assessments.*	
#4 **Key Presentations** - QI/HE Program Description and Change Summary 2025 (Attachment Q) **Action** Patrick Marabella, M.D Chair	The **2025 Quality Improvement/Health Education Program Description** was presented to the committee for approval. Updates include: • **Updated and removed reference to the Annual Scaled-back Access Survey.** It has been replaced with the annual CAHPS survey (throughout). • **Updated ECHO Survey to Behavioral Health Member Experience Survey.** The survey tool is changing (throughout). • **Clinical Practice Guidelines** (pg. 10): Updated provider communication fax to include provider updates. • **Health Education Programs** (pgs. 11-13): Updated Health Promotion Programs to Health Education Programs, revised contact information, adjusted Weight Management and Diabetes Prevention resources, removed outdated programs, added Teladoc Mental Health, and updated Health Program Incentives to include both QI/Health Education. • **MemberConnections® Program** (pg. 14): Added Post Partum Assessment /Edinburgh Postnatal Depression Scale, Notification of Pregnancy as part of the assessments the MemberConnections representatives conduct. • **Transition of Care Services** (pgs. 16-17): Expanded Transitional Care Services to detail post-discharge activities, including risk assessments, health evaluations, care coordination, and follow-ups, while removing the Member Impact section. • **Health Plan Performance** (pg. 19): Added Health Plan accreditation information for CalViva (NCQA). • **Health Equity and Cultural and Linguistic Needs** (pgs. 24-26): Added information on the Diversity, Equity, and Inclusion Training Program. Updated non-discrimination statement to include "language". • **Satisfaction** (pg. 26): Added HSAG CAHPS survey details, renamed Population Needs Assessment to Population Analysis Report, and updated Provider Relations to Provider Engagement for CAHPS improvement. • **Telehealth Services** (pg. 28): Added how the Plan supports Member access to a Provider	**Motion:** *Approve* - QI/HE Program Description and Change Summary 2025 (Ramirez/Pascual) 5-0-0-3

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	through telehealth. CalViva now provides telehealth services to members. • **Health Education** (pg. 39): Revised description to include Health Education resources and framework. • **Provider Network Management** (pg. 41): Clarified that contractual issues that PNM resolves with providers are related to terms and conditions and payment rates for services. • **Program Accreditation** (pg. 42): Added additional scope of the Program Accreditation team's role in Quality Evaluating Data to Generate Excellence (EDGE) program efforts. • **Provider Communication** (pg. 42): Updated description to include specifics on Provider Communication resources and channels. • **Other minor edits.** *Dr. Cardona left the meeting at 10:29 a.m. and returned at 10:32 a.m.*	
#4 Key Presentations - QI/HE & W Work Plan 2025 (Attachment R) **Action** Patrick Marabella, M.D Chair	The **2025 Quality Improvement/Health Education and Wellness Work Plan** was presented for approval. The Work Plan is divided into Three Sections: *I.* ***Work Plan Initiatives:*** *Implement activities to improve performance measures. Includes program objectives, monitoring, and evaluation for the year. Each section has specific initiatives for a total of 13.* 1. *Behavioral Health:* Improving Behavioral Health (Mental Health and Substance Use) Outcomes Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile. (FUA-30) Follow up w/in 30 days after ED Visit for substance use (target 36.18). (FUM-30) Follow up w/in 30 days after ED Visit for mental health (target 53.82). MY2023: FUA-30: (0%, 0/3 objectives met) FUM-30: (0%, 0/3 objectives met) 2. *Chronic Conditions:* Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile for Blood Pressure & Diabetes. Diabetes: CDC >9 – HbA1c to below 9 (MY 2023: 3/3 objectives met, 100%) Heart Health: Control Blood Pressure (MY 2023: 3/3 objectives met, 100%) 3. *Hospital Quality/ Patient Safety:* monitoring of hospital-acquired conditions (infections & c-section rates). Objective: Improve reporting and Directional Improvement based upon scores (5 Hospitals Report). <u>MY2023 Results</u> • Catheter-Associated Urinary Tract Infections (CAUTI): SIR*; 75% of reporting	**Motion:** *Approve* - QI/HE Work Plan 2025 (Ramirez/Pascual) 5-0-0-3

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	hospitals met the measure. • Central Line Associated Blood-stream Infection (CLABSI): SIR; 0% of reporting hospitals met the measure. • C. Diff Infection: SIR; 100% of reporting hospitals met the measure • Methicillin-Resistant Staphylococcus Aureus Infection (MRSA): SIR; 75% of reporting hospitals met the measure. • Colon Surgical Site Infection (SSI-Colon): SIR; 25% of reporting hospitals met the measure. • Nulliparous Term Singleton Vertex (NTSV) C-section Rate; 60% of reporting hospitals met the measure. *SIR = Standardized Infection Ratio 4. *Member Engagement and Experience:* Objective: Improve New Member Completion Initial Health Appointment (IHA) in under 120 days by 1-5% over the prior year. MY2023: IHA: 57.26% 5. *Pediatric and Maternal Health Programs:* Objective: 1-5% improvement over prior year or the MCAS 50th percentile for all measures except Prenatal & Postpartum is 75th percentile*. • Topical Fluoride (TFL-CH) (MY2023: 33%, 1/3 Objectives met) • Well-Child Visits (WCV, W30) (MY2023: 67%, 2/3 Objectives met) • Childhood Immunization (CIS-10, IMA-2) (MY2023: 33%, 1/3 Objectives met) • Prenatal and Postpartum Care*(PPC-Pre, PPC-post) (MY2023 pre: 33% 1/3 Objectives met, post 66% 2/3 Objectives met) • Lead Screenings (LSC) (MY2023: 33%, 1/3 Objectives met) • Developmental Screening (CDEV) (MY2023: 33%, 1/3 Objectives met) Providers are supported to engage with immunization registries and the Vaccines for Children Program. 6. *Pharmacy:* Asthma Medication Ratio (AMR) Objective: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile. (MY 2023: 33%, 1/3 Objectives met) (target 66.24%) 7. *Preventive Health*: Cancer Screening & STI (MCAS) Objective: 1-5% improvement over the prior year or maintain above the 50th percentile.	

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	• BCS – Breast Cancer Screening (MY2023: 100%, 3/3 Objectives met) • CCS - Cervical Cancer Screening (MY2023, 100%, 3/3 Objectives met) • CHL – Chlamydia Screening women (MY2023, 100%, 3/3 Objectives met) • Flu Campaign (MY2023, 100%, 3/3 Objectives met) *8. Provider Engagement:* 1. Improve the Member Experience (CAHPS) – Provider and Plan Focus 2. Improve Provider Access & Availability Survey Results (PAAS & PAHAS) *II.* ***Ongoing Work Plan Activities:*** *Includes ongoing monitoring of cross-functional activities – work performed by or with other Departments. Ensures activities are timely and documented often to meet regulatory or accreditation requirements. Previously called the "Crosswalk".* Multiple activities under each category: Each category has specific activities (46 total). *1. Access, Availability, & Satisfaction* *2. Behavioral Health* *3. Continuity & Coordination of Care* *4. Credentialing/Recredentialing* *5. Disease Management/Chronic Conditions* *6. Quality & Safety of Care and Service* *7. Compliance* *8. QI Infrastructure* *9. Wellness/Preventive Health* *III.* ***Quality Improvement Tracking System Activities Log.*** *Lists the Quality Improvement Tracking System activities that support meeting program objectives for the year identified in Section 1. Some of these activities include, but are not limited to, the following:* 1. Behavioral Health: Conduct live outreach using ADT reports to identify members who had an ED visit for MH, SUD, or Drug Overdose to close care gaps for follow-up care. Improve Teledoc Mental Health Digital Program oversight and management (replaces myStrength). 2. Member Engagement: Identify dual-eligible members and verify they qualify to utilize Community Health Worker (CHW) benefits to support Health Risk Assessment (HRA) completion. Annual member newsletter. 3. Chronic Conditions: Through a vendor partnership, we mail HbA1c home test kits to	

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	members due for a test. 4. Health Education: Create a PowerPoint presentation for Providers that uses QR Codes to link to credible health education resources (Krames & others) to share with their patients. Topics will be focused on MCAS measures. 5. Hospital Quality/Patient Safety: Identify new ways to engage hospital leadership to improve quality metrics related to hospital-acquired infections and equitable maternal health metrics. Produce Hospital Quality Scorecards. 6. Pediatric/Adolescents: Support blood lead screening with in-office analyzer initiative (27 distributed in 2024). Utilize the Transitional Care Team to enroll members in the First Year of Life Program before hospital discharge. Promote the CDC Milestone Tracker app. 7. Pharmacy: Evaluate expanding "Kick It California" (KIC) Smoking Cessation outreach to include the distribution of nicotine replacement therapy kits. Increase awareness of Asthma Remediation Services. 8. Preventative Care: Launch in-home Chlamydia screening. Expand cancer screening, testing, and partnerships with local Community-Based Organizations (CBOs). *Discussion: Dr. Ramirez asked if the in-home Chlamydia screening was a urine test or self-swab. Dr. Marabella indicated it was most likely a urine test, but he will confirm.* *The Committee had no further questions or recommendations.*	
#4 **Key Presentations** - PHM Strategy Description 2025 & Change Summary (Attachment S) **Action** Patrick Marabella, M.D Chair	The **PHM Strategy Description & Change Summary 2025** was presented. The Population Health Management (PHM) Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Changes to the **2025 Strategy Description** include: • Basic Population Health Management (BPHM) (pg. 10) Updated information regarding the establishment of collaborative partnerships within Fresno, Kings, and Madera counties' LHJs/LHDs to reflect the present state. • Transitional Care Services (pgs. 12-13) Removed "single point of contact" language, removed care section on "Care Manager Responsibilities". Updated the TCS interventions and removed the minimum TCS requirement of 30 days. • PHM Programs and Services (pgs. 14-22) o Changed "Transitional Care Management" to "Transitional Care Services," (TCS).	**Motion:** *Approve* - PHM Strategy Description 2025 & Change Summary (Cardona/Waugh) 5-0-0-3

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	○ Updated age eligibility, program goals, outreach methods, and minor grammatical errors (flu). ○ Removed heart failure and added Sickle Cell Disease (Chronic). ○ Additional eligibility criteria included, updated program services, and stats (Diabetes). ○ Removed SHAPE program. ○ Removed Fit Families for Life program. ○ Updated language for Initial Health Appointment. ○ Updated name to Teladoc, updated oncology list, and eligibility criteria (Oncology). ○ Updated program services for Tobacco Cessation, updated stats. ○ Updated eligibility criteria for BCS Screening to 40-74 years and updated outreach methods (BCS). ○ Updated program goals. • External Partnerships (pg. 25): Removed several entities: local Continuum of Care (COC), Caregiver Resource Centers (CRCs), and Home and Community-Based Services (HCBS) waiver agencies. • Delivery Systems sharing with Practitioners (pgs. 27-28): Fixed grammatical and spelling errors and added information on Closed-Loop Referrals. • Delivery Systems sharing with Members (pg. 29): Removed TCM, updated services names, updated IHA language. • Other minor edits and grammatical corrections. *Discussion: Dr. Cardona asked how the Closed-Loop Referrals system worked. Amy Schneider indicated that the ECM and CS programs will be the first to implement a process to electronically track services provided based upon referrals, and this information will be communicated back to the referring providers (close the loop). Behavioral Health services currently follow a similar process, but without some of the technology and software to simplify tracking. Mary Lourdes Leone indicated that the Plans and counties will have a joint policy on how this Closed-Loop system will be administered, and include system liaisons to monitor and provide oversight.* *There were no additional questions or recommendations from the Committee.*	
#4 Key Presentations - Continuity & Coordination Medical Care Report - Continuity & Coordination	The purpose of the **Continuity & Coordination Medical Care Report 2024** is to promote collaboration among medical health providers and CVH leaders and managers. CVH monitors certain aspects of continuity and coordination of medical care, and by initiating actions to reduce miscommunication and improve care coordination, we will improve patient safety and decrease	**Motion:** *Approve* - Continuity & Coordination Medical Care Report

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Medical & Behavioral Healthcare Report (Attachments T, U) **Action** Patrick Marabella, M.D Chair	the risk of errors in the healthcare system. • Measure #1 Timeliness of Postpartum Care (HEDIS® measure) was met in all three (3) Counties and will continue current strategies. • Measure #2 Eye Exam for Patients with Diabetes (HEDIS® measure) was met in two (2) of three (3) Counties, and actions for improvement to include: o Not all patients have a primary care physician, so information if reported by eye specialists can go without being placed in the member's medical record. Therefore, CVH will utilize COZEVA® reports - a reporting and analytics platform that displays performance in clinical quality and risk measures – for providers and participating provider groups (PPGs) to identify members who need an eye exam. This platform is important as it offers CalViva, as well as medical groups, real-time data on members who have care gaps and missing specialist visits. o Members do not fully understand the need for a retinal eye exam. CVH will provide education to members about what a diabetic retinal eye exam is and its importance. • Measure #3 Pharmacotherapy for Opioid Use Disorder (HEDIS® measure) was not met in two (2) Counties; one (1) County sample was too small (data issue). Barriers and actions for improvement include: o The first barrier is: Lack of coordinated communication about opioid prescriptions among prescribers. CVH will proactively identify high-use members and send provider/provider groups opioid high utilization reports and educate providers on the risks of overuse. o Secondly, members don't fully understand the risks of overusing opioids. CVH will develop educational materials for members and distribute educational materials to providers to share with members. • Measure #4 Plan All-Cause Readmissions (within 30 days) (HEDIS® measure) was met in all three (3) Counties and will continue with current strategies. *There were no questions or recommendations from the Committee.* The **Continuity & Coordination Medical & Behavioral Healthcare Report** promotes collaboration among medical and behavioral health providers and CalViva leaders and managers. The purpose of this presentation is to review and discuss performance results from the activities selected for 2024, and review and confirm activities selected for 2025. The committee will also discuss specific barriers to improvement and share information/brainstorm applicable initiatives or potential	- Continuity & Coordination Medical & Behavioral Healthcare Report (Pascual/Ramirez) 5-0-0-3

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	actions that should be executed. • In 2023, the QI/UM Committee reviewed BH data from provider and member satisfaction surveys and HEDIS® Compliance results from BH measures. • Recommendations were made to select measures to focus on for improvement. • We reviewed initial results and made further recommendations in May 2024. • We have results from RY2024 (MY2023) now to reassess and make additional recommendations for the future. **2023 Review: Antidepressant Medication Management** Acute Phase of Treatment – 60.79% RY24/MY23 (Numerator: Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). Denominator: Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication.) Opportunity #1: Appropriate diagnosis, treatment, and referral of BH disorders commonly seen in primary care. • Effectiveness: Observing year-over-year directional improvement for CVH for both metric components, but not meeting the goal. Due to ongoing reporting issues, MY2023 interventions were stopped mid-year. • Actions: Continued live member outreach only for a portion of the year due to reporting and technical issues. • Opportunities/Next Steps: Identify a new metric/measure for MCL quantifying improvement in this Opportunity Area that aligns with changes in priority and retirement of metric. Continuation Phase of Treatment—38.45% RY24/MY23 (Numerator: Percentage of members who remained on an antidepressant medication for at least 180 days (6 months). Denominator: Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication.) **2023 Review: Depression Screening and Follow-up for Adolescents and Adults (DSF-E)** 14.90% RY24/MY23 (Numerator: Percentage of members who were screened for clinical depression using a standardized instrument. Denominator: Members 12 years of age and older.) Opportunity #2: Preventive BH Program Implementation. • Effectiveness: Large improvement seen in initial depression screenings in MY23 over MY21/22. No National Benchmarks for MY23; goal was directional improvement. Leveraging mobile	

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	digital tools for initial depression screenings likely contributed to the rate increase. • Actions: Improve utilization of myStrength for CVH membership through Call Center, social media, and email. • Opportunities/Next Steps: Maintain current improvement actions. Continue provider education about including LOINC information for gap closure. **2023 Review: Follow-up after Depression Screening for Adolescents and Adults (DSF-E)** 73.27% RY24/MY23 (Numerator: Percentage of members who received follow-up care within 30 days of a positive depression screen finding. Denominator: Members 12 years of age and older from the Initial Population who screened positively.) Given that there are no national benchmarks, the internal goal is achieving directional improvement. CalViva Health did show directional improvement from RY2022 to RY2023, but a decrease was seen in RY2024. We are improving initial screening rates but have not seen the same increase in follow-up screenings after a positive score. Due to relatively small initial screening rates, the eligible populations for this metric remained small in RY2024. *The following quality metrics and goals were met with an improved directional change:* • Timeliness of Information Received from Behavioral Health Practitioners on the Provider Survey • HEDIS® Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) • Depression Screening –ages 12 and older (DSF-E) ^ • HEDIS® Diabetes Screening for Members diagnosed with Bipolar Disorder or Schizophrenia prescribed Antipsychotic Medications (SSD) *The following quality metrics did not meet the goal with an improved directional change:* • HEDIS® Antidepressant Medication Management: Acute (AMM) • HEDIS® Antidepressant Medication Management: Continuation (AMM) *The following quality metrics did not meet the goal with a downward directional change:* • Timeliness of information received from Primary Care Physicians on the MHN Provider Survey • HEDIS® Follow-Up Care for Children Prescribed ADHD Medication: INT (ADD) • HEDIS® Follow-Up Care for Children Prescribed ADHD Medication: C&M (ADD) Depression Screening Follow-Up – ages 12 and older (DSF-E) **^Two opportunities recommended for 2025 with potential actions:** #1 Appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in	

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	primary care. Quantifiable Metric: • HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM) • HEDIS® Follow-Up After Emergency Department Visit for Substance Use (FUA) Barriers: • Timely provider notification of MH/SUD ED visits. • Lack of provider/member awareness of best practices for follow-up after MH ED visits • Limitations to relying on ADT reports for MH ED visits: too many notifications, difficulties when prioritizing outreach. • Member's resistance to BH or SUD treatment. Potential Actions: • Continue BH live member outreach calls after the MH ED visit. o Leverage internal MoCAT files to improve the member reach rate by offering additional phone numbers for outreach. • Implement Cozeva enhancements to increase and improve prioritized provider notifications about MH ED visits. • Embed staff (CHW, Substance Use Navigators, etc.) in high volume EDs to conduct MH and SUD assessments and referrals that close HEDIS gaps. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® Follow-Up After Emergency Department Visits for Mental Illness & Substance Use (FUM & FUA). #2 Primary or secondary preventive behavioral healthcare program implementation. Quantifiable Metric: • HEDIS® Depression Screening & Follow-Up (DSF-E) Barriers: • The primary barrier is the inability to obtain LOINC coding information to appropriately close gaps. • Ambiguities around sharing information with privacy regulations. • The provider believes that patients may be sharing the necessary information with the other provider. • Lack of time to exchange information timely.	

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	Potential Actions: • Leverage alternate data sources to obtain LOINC code information (Cozeva, EHRs, etc.) • Distribute revised provider tip sheets that include LOINC coding info and scoring. • Leverage supplemental data streams/digital applications to close gaps internally (Teladoc Mental Health (Digital Program) and ShareCare. • Leverage internal HN CM outreach calls for follow-up screening gap closures. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® (Depression Screening & Follow Up for Adolescents & Adults (DSF). *Discussion:* *Dr. Marabella asked the Committee for suggestions on how to measure member participation in follow-up referrals.* *Dr. Waugh indicated that the no-show rate for follow-up referrals is about 50%, and in general, the CVH population has a negative association with seeing a mental health provider. Communication regarding a referral is better between the PCP and the BH provider if they are in the same clinic/building and have a relationship. This is not the case with outside provider referrals.* *Dr. Cardona agreed that his patients would rather see their PCP and receive a prescription from them than a BH provider.* *Dr. Marabella pointed out that another barrier to follow-up care is the ability to see members within 30 days of an ED visit or depression screening.* *Dr. Ramirez asked if the Plan was not meeting the measure because of not performing the screening or not doing a follow-up within 30 days? Dr. Marabella will follow up with a data request and will share this discussion with the HN Internal Collaboration Team, as NCQA Standard Q13 was modified in 2025 and is currently under review. This is a good time to make a request.* *Dr. Ramirez confirmed that seeing members within 30 days is challenging as they don't have enough BH providers, which reduces access and availability within the 30-day timeframe.* *There were no further questions, and the Committee agreed to proceed with the two (2) recommended actions.*	
#4 **Key Presentations** - NCQA Behavioral Health Member Experience Report	**NCQA Behavioral Health Member Experience Report 2024 (MY2023)** monitors member experience data for Behavioral Health populations. Member Survey data is evaluated along with appeal and grievance data to identify member pain points and opportunities for improvement	**Motion:** *Approve* - NCQA Behavioral Health Member

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2024 (MY 2023) (Attachment V) **Action** Patrick Marabella, M.D Chair	(NCQA ME.7) The Experience of Care and Health Outcomes (ECHO®) annual survey is used to assess member satisfaction with the Behavioral Health population. • The survey was conducted in 2024 to assess MY2023. • All member grievances and appeals are also evaluated. • Significance testing was conducted to test the significance between MY2023 and MY2022 ECHO survey results because of the history of ECHO surveys and barrier analysis. • No significance testing is performed for appeals and grievances. • The BH grievances, appeals, and ECHO survey data point to similar opportunities. • The volume of data is small, and while patterns may not be identified for CalViva Health, the general trend is that the most impactful member pain points are around Access and Billing/Financial (authorization of care & balanced billing) issues. • There is a strong focus on member outcomes (clinical improvement), as demonstrated by the high response rates to the questions related to "perceived improvement." • The ECHO results specifically indicate that the areas of greatest opportunity are related to Getting Treatment Quickly and Perceived Improvement. Through a barrier analysis of the ECHO results, several opportunities were identified with the following actions taken (or being implemented): Actions to grow the BH Network include: • Increase rates for newly contracted providers and providers willing to accept new patients. • Focus growth in areas of need – the highest numbers of OON requests. • Focus on telehealth options to eliminate geo-access challenges. • Improve Provider Satisfaction through improved speed and accuracy of claims processing and immediate feedback on member complaints/concerns. • Give more feedback to CalViva Health BH providers about member experience and provide resources to make improvements. Barriers being addressed include: • Reduction in stigma leading to greater demand, and the BH network options are not growing at the same rate. • Delays in routine access to care/appointments are rooted in member preference, compatibility, and scheduling needs, and insufficient options.	Experience Report 2024 (MY 2023) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Network availability issues limit provider choice and provider-member compatibility. • Providers might need more frequent reminders or feedback about member perception/experience. Actions to increase resources for PCPs treating BH: • Greater promotion of Collaborative Care Model options and resources. • Improve provider directory accuracy. Barriers being addressed include: • Reduction in stigma leading to greater demand, and the BH network options are not growing at the same rate. • No BH provider "assignment" and limited value-based payment and/or incentives for BH Providers. • Inaccuracies in the provider directory information can lead to delays in finding a provider accepting new patients. Actions for system migration and integration: • Leverage the staggered roll-out of the BH system migration to test/learn and improve process documentation, learn/apply best practices, and minimize negative impacts. • Eliminate/reduce silos between medical and BH. • Greater collaboration and BH data exchange with Medi-Cal counties without violating privacy Rules. Administrative barriers being addressed include: • Members cannot find information about the BH care they need or the BH care they obtained without calling the Plan or provider. • Systemic silos between medical and BH do not help members obtain information and options in an easy, seamless manner. • Privacy regulation concerns limiting collaboration and BH data exchange between Medi-Cal service delivery entities. *There were no questions or recommendations from the Committee.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (January 2025)	The **Key Indicator Report & Turnaround Time Report** through January 2025 were presented. • Utilization for Acute Admits (adjusted PTMPY), for expansion, and adults have increased in Q1 2025. • Utilization for Acute Length of Stay and Readmissions (all adjusted PTMPY) for TANF, MCE, and	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (January

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments W) **Action** Patrick Marabella, M.D Chair	SPDs shows a decline in Q1 2025. • Behavioral Health, Perinatal, Physical Health, Transitional Care Services (TCS), and First Year of Life Care Management referrals and member engagement rates have all increased in Q1 2025 compared to Q4 2024. • Timely Pre-service Routine Deferral letters requiring language translation were delayed. In response, team members received additional training. Leadership is actively involved in achieving the goal of full operational compliance.	2025) (Pascual/Ramirez) 5-0-0-3
#5 **UM/CM Business** - Care Management & CCM Report (Q4 2024) (Attachment X) **Action** Patrick Marabella, M.D Chair	The **Care Management and CCM Report Q4 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. • From Q3 to Q4 2024, the referral volume for Physical Health Care Management (PH CM) decreased by 3.8%, while TCS referrals increased by 19%, and Behavioral Health Care Management (BH CM) referral volume declined by 12.5%. Managed cases declined in PH CM and Perinatal CM but rose in BH CM and TCS in Q4. Although referrals decreased, cases managed for the First Year of Life increased in Q4. • Care Management has had success in preventing re-hospitalizations. Referrals to the appropriate case management personnel and the use of ECM and Community Supports have been effective. • PH CM numbers are stable, showing similar performance compared to the previous year. No significant changes were noted. • TCS has shown an increase in the volume of members served this year due to changes in operations. All members discharged from acute care go to TCS first. • 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 51% in Q3 2024. • BH CM performance is positive with no major concerns. • PCM's total numbers are up compared to last year, with a notable increase in engagement (from 1,000 to 1,300). Key metrics show improved post-enrollment outcomes, such as reduced readmissions, fewer emergency department visits, better prenatal visits, fewer preterm births, and an increase in postpartum care.	Motion: *Approve* - Care Management & CCM Report (Q4 2024) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Seventy-two (72) members completed a Member Satisfaction Survey, with 90% being satisfied with the Care Management program. Going forward, the team will work to obtain accurate contact information and increase participation in the satisfaction survey.	
#5 **UM/CM Business** - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2024 (Attachment Y) **Action** Patrick Marabella, M.D Chair	**InterQual Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2024** were presented. UM staff apply InterQual® Clinical Decision Support Criteria along with other evidence-based medical policies, clinical support guidelines, and technical assessment tools approved by the Medical Advisory Council to ensure consistent and standardized medical criteria review across all cases. Following InterQual (IQ) IRR preparatory training in Q3 2024, InterQual IRR modules were administered to the physician reviewers and the non-physician clinical staff, requiring a minimum score of 90% to pass. Below are the results of testing completed in Q4 2024. • The initial overall pass rate was 90%. Following remediation and retesting, the majority of staff and physicians scored at or above 90%. • Lead & Senior Clinical Review Clinicians (Appeals and Concurrent Review) achieved near-perfect scores. • Utilization Management Managers and Medical Directors showed high competency in their respective domains, with most scoring 95-100%. • External Consultants and Prior Authorization Reviewers scored 100%. • Sub-Acute Skilled Nursing Facility: Several Senior Clinical Review Nurses and Concurrent Reviewers scored below 80%, with one dropping from 85% to 60% on a retest. • Behavioral Health: Some Medical Directors and Psychologists initially scored 75-90%, requiring additional training.	Motion: *Approve* - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2024 (Pascual/Ramirez) 5-0-0-3
#5 **UM/CM Business** - Enhanced Care Management (ECM) & Community Supports (CS) Performance Report (Q4 2024) (Attachment Z) **Action**	**Enhanced Care Management & Community Supports Performance Report (Q4 2024)** summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system with program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) are responsible for administering both ECM and CS services. • For ECM, of 14,934 members who were assigned in the three (3) CVH counties, 1,437 were successfully enrolled, accounting for a 9.6% enrollment rate.	Motion: *Approve* - Enhanced Care Management (ECM) & Community Supports (CS) Performance Report (Q4 2024) (Pascual/Ramirez)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	• The average assignment to enrollment percentage for each county is: Fresno (10%), Madera (5.8%), and Kings County (10.9%). • For CS, a total of 35,229 authorizations were submitted between January to Dec 2024. • The total paid CS claims were for services related to Medically Tailored Meals/Medically Supported Foods (71%), followed by Housing Transition/Housing Sustaining/Housing Deposits Services (21%), Short-Term Post-Hospitalization Housing (3%), and Asthma Remediation, Day Habilitation Services, and Personal Care and Homemaker Services (1%). • Fresno (82.8%) accounted for the most referrals, followed by Madera (8.6%) and Kings (8.55%). Barriers to ECM and CS uptake continue to be focused on a lack of accurate or available member contact information, difficulty finding members to refer into the program, and a lack of awareness by members and other providers of the program. CS referrals can be made through two routes, either directly to the contracted CS provider or through the Findhelp website. (Findhelp is a closed-loop community resources and referrals online platform used to identify local resources and support staff and community partners when searching for local social services, including plan-contracted CS providers.) • A total of 1,154 CS referrals were made through Findhelp between January through December 2024 to a total of 20 CS providers. Fresno (90%) accounted for the most referrals, followed by Kings (7%) and Madera (3%).	5-0-0-3
#5 **UM/CM Business** - Medical Policies (January 2025) (Attachment AA) **Action** Patrick Marabella, M.D Chair	The **Medical Policies (January)** 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 January 2025 include, but are not limited to: • CP.MP.62 – Hyperhidrosis Treatments • CP.MP.70 – Proton and Neutron Beam Therapies • CP.MP.107 – DME • CP.MP.142 – Urinary Incontinence Devices and Treatments • CP.MP.168 -- Biofeedback • CP.MP.173 -- Implantable Intrathecal or Epidural Pain Pump • CP.MP.180 -- Implantable Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	Motion: *Approve* - Medical Policies (January 2025) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CP.MP.190 -- Outpatient Oxygen Use	

#6 **Pharmacy Business**
- Pharmacy Executive Summary (Q4 2024)
- Pharmacy Operations Metrics (Q4 2024)
- Pharmacy Top 25 Prior Authorizations (Q4 2024)
- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2024)
- Pharmacy Quality Assurance Results 2024
 	
(Attachments BB-FF)
 	
Action
Patrick Marabella, M.D Chair
	The **Pharmacy Executive Summary Q4 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 Q4 2024.
	  o Overall, TAT for Q4 2024 was 97.8%.
	  o PA volume was lower in Q4 2024 compared to Q3 2024 and there were some drug-specific differences. October had a higher volume compared to all other months in Q4 2024.
	
	The **Pharmacy Operations Metrics Q4 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 Q4 2024** identifies the most requested medications to the Medical Benefit PA team for CalViva Health members and assesses potential barriers to accessing medications through the PA process. The top 25 PA requests in Q4 2024 were mostly consistent with the top 25 drugs reviewed in Q3 2024, with a few placement variations. Pegfilgrastim and IV Iron continue to drive PA volume due to the existence of preferred products in the PA polices versus the branded products.
	
	The **Quality Assurance Reliability Results (IRR) for Pharmacy Q4 2024** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten (10) prior authorizations [four (4) approvals and six (6) 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 92.50%.
		Motion: *Approve*
		- Pharmacy Executive Summary (Q4 2024)
		- Pharmacy Operations Metrics (Q4 2024)
		- Pharmacy Top 25 Prior Authorizations (Q4 2024)
		- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2024)
		- Pharmacy Quality Assurance Results 2024
		
		(Ramirez/Cardona)
		5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **Quality Assurance Reliability Results for Pharmacy 2024** reviews the prior authorizations performed on the medical benefit drugs to evaluate the consistency and accuracy with which the MedPharm Pharmacy staff involved in utilization management (UM) review and apply prior authorization criteria in decision-making and communicate the decisions made to providers and patients. • The Quality Assurance (QA) results for all quarters in 2024 show that the Overall (cumulative) threshold was met for the random request reviews in each quarter of 2024 with an average score of 93%. However, the 95% goal was not met. Criteria Application and Clarity of Response seemed to be the largest contributing factors to the overall score meeting the threshold, but not meeting the goal. After each quarterly review, QA results are provided to the Pharmacy Services Management for review to discuss opportunities for improvement based on deficiencies in the individual categories and specific cases. The Health Plan provides ongoing feedback and guidance on all cases reviewed.	
#7 Policy & Procedure Business - Pharmacy Annual Policy & Procedure Review (Attachment GG) Action Patrick Marabella, M.D Chair	The **Pharmacy Annual Policy & Procedure Review** was presented to the committee. The following policies were presented for annual review with **no changes made:** RX-001 Medication Prior Authorization RX-002 Program Metrics Review RX-005 Pharmacy Prior Authorization and Medical Necessity Criteria RX-006 Specialty Pharmacy Program RX-007 Injectable Medication Review RX-008 Mental Health Parity RX-120 Drug Utilization Review **The following policies were presented for annual review and were approved with the following changes:** RX-003 Pharmacy Program: Added section on HN Pharmacy Advisory Committee. *Dr. Marabella stated that HN's Pharmacy oversight committee structure has changed since Centene acquired HN. HN has formed a Pharmacy Advisory Committee specifically for Medicare and MediCal for California, of which Dr. Marabella is a member.*	Motion: *Approve* - Pharmacy Annual Policy & Procedure Review (Cardona/Ramirez) 5-0-0-3
#8 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q1 2025)	The **Credentialing Sub-Committee Quarterly Report Q1 2025** was presented. The Credentialing Sub-Committee met on February 20, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q3 2024 were reviewed for delegated entities, and Q4 2024 for Health Net (HN) and HN Behavioral Health (BH). A	Motion: *Approve* - Credentialing Subcommittee Report (Q1 2025)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment HH) Action Patrick Marabella, M.D Chair	summary of Q3 2024 data was presented. • The **Adverse Events Q4 2024** report was presented. o There were no (0) cases identified in Q4 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 Q4 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 Q4 2024** was presented and reviewed. This report identifies 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 Q4 2024 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 **Credentialing Adverse Actions** report for Q4 2024 for CalViva from the HealthNet Credentialing Committee was presented. o There was one (1) case presented for discussion for Q4 2024 for CalViva Health. The Medical Board of California issued the practitioner a public letter of reprimand, with terms and conditions to include, but not limited to, 1) The practitioner shall complete an education course. 2) The practitioner shall complete a medical recordkeeping course. The case will be monitored to ensure compliance with the Medical Board's terms and conditions.	(Pascual/Waugh) 5-0-0-3
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q1 2025 (Attachment II)	**Peer Review Sub-Committee Quarterly Report Q1 2025** was presented. The Peer Review Sub-Committee met on February 20, 2025. • The county-specific **Peer Review Sub-Committee Summary Reports for Q4 2024** were reviewed for approval. No (0) significant cases to report. • The **Q4 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.	Motion: Approve - Peer Review Subcommittee Report Q1 2025 (Ramirez/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	○ There were 11 cases identified in Q4 that met the criteria for reporting and were submitted to the Peer Review Committee. Four (4) of these cases involved a practitioner, and seven (7) cases involved organizational providers (facilities). ○ Of the 11 cases, six (6) were tabled, zero (0) were deferred, zero (0) were closed to track and trend with a letter of concern, two (2) were closed to track and trend with a letter of education, and three (3) were closed to track and trend. ○ Six (6) cases were quality of care grievances, three (3) were potential quality issues, zero were lower level, and zero (0) were track and trend. ○ Three (3) 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 to a member or members in Q4. ○ There were no (0) cases that met the Peer Review trended criteria for escalation. ○ There was one (1) case 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 23 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 Q4 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. ○ Fifteen* (15) cases were submitted to the Peer Review Committee in Q4 2024. There were four (4) incidents 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 but *without appointment availability issues*. No cases (0) were related to behavioral health issues. *One (1) case appeared twice in the quarter. ○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2024.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The **Q3 2024 Peer Count Report** was presented and discussed with the committee. There was a total of 15 cases reviewed. There were nine (9) cases closed and cleared. There were six (6) cases tabled for further information.	
#9 **Compliance Update** -Compliance Regulatory Report (Attachment JJ)	Mary Lourdes Leone presented the **Compliance Report**. **CalViva Health Oversight Activities: Health Net:** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings, and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access and availability, specialty referrals, utilization management data, grievances, and appeals etc. **Oversight Audits:** The following annual audits are in progress: Credentialing, Call Center, Claims/PDR, and Quality Improvement. The following annual audits have been completed since the last Commission report: Pharmacy (No CAP). **Fraud, Waste, and Abuse:** Since the 2/20/25 Compliance Report, there have been no new MC609 filings with the DHCS. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** As a reminder, on 9/6/24, the Plan received DHCS's final report findings and formal CAP request. There were nine (9) deficiencies in total [four (4) for behavioral health and five (5) for transportation]. The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. The Plan is on track to complete its stated corrective actions and will provide its next monthly update on 4/10/25. **Department of Health Care Services ("DHCS") 2024 Medical Audit:** As a reminder, on 10/3/2024, DHCS sent out the Final Audit Report and CAP request. There were two findings: • The Plan did not ensure that the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten (10) working days. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 4/1/25. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit:** On 1/6/25, the Plan	-Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. All requested documents were submitted on 2/5/25. Awaiting a response from DMHC. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** The 2025 DHCS Audit will be conducted virtually from 6/2/2025-6/13/2025. The Entrance Conference will begin on 6/2/25 @ 10:00 a.m. All Pre-Audit document requests are due to DHCS by 3/17/2025. **Memorandum of Understanding (MOU):** Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOUs, which have been posted to CalViva's website: • Madera County MHP MOU • Amendment No. 1 to Fresno County MHP-DMC-ODS MOU **Annual Network Certifications:** • 2024 Subnetwork Certification (SNC) Landscape Analysis – On 1/3/2025, the Plan submitted the 2024 SNC deliverable. DHCS has followed up requesting additional information. The Plan has submitted all additional documents and is awaiting approval. • 2024 Annual Network Certification (ANC) - The Plan is on track to submit all required documents by the 3/17/2025 due date **Transgender, Gender Diverse, or Intersex (TGI) Training:** DHCS APL 24-017 and DMHC APL 24-018 require Plans to conduct TGI training to staff who are in direct contact with Members. Plans are required to submit evidence of training along with the curriculum. The Plan has been working on deliverables associated with these APLs, such as updating its provider directory to show which providers are offering gender affirming care, monitoring and tracking grievances as they relate to gender affirming care, and updating the Plan's policies and procedures. On 2/28/2025, the Plan submitted P&Ps to DHCS, along with the required attestation regarding the provider directory. The TGI curriculum and various other documents are due to DHCS and DMHC by 3/14/2025. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** On March 11, 2025, the Plan convened its "Kick-Off" meeting for the MY2024/RY2025 Timely Access Report ("TAR") filing, which must be filed with DMHC by 5/1/2025. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2025.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Public Policy Committee (PPC): The Public Policy Committee met on March 5, 2025. The following reports were presented: • Q4 2024 Appeal and Grievance Report • A&G Dashboard review by Dr. Marabella • CalViva Health Annual Report • Semi-Annual Member Incentives • 2024 Annual Compliance Report The next PPC meeting will be held on June 4, 2025, from 11:30 a.m. - 1:30 p.m., CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. *Dr. Cardona left the meeting at 12:03 p.m.*	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is on May 15th, 2025. The Committee agreed that the PowerPoint presentations are helpful and liked the adjusted meeting format. Dr. Marabella announced that Dr. Quezada and Dr. Waugh have agreed to continue serving on the QIUM Committee for another two (2) year term. *Dr. Cardona returned to the meeting at 12:05 p.m.*	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 12:06 p.m.	

NEXT MEETING: May 15th, 2025

Submitted this Day: May 15, 2025

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

Acknowledgment of Committee Approval:

X
Patrick Marabella, MD, Committee Chair