Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

September 18th, 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	✓	**Morgan Simpson,** Senior Director of Compliance
	Carolina Quezada, M.D., Internal Medicine/Pediatrics, Family Health Care Network	✓	**Maria Sanchez,** Senior Compliance Manager
✓	**Joel Ramirez, M.D.,** Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Nicole Foss, RN,** Medical Management Services Manager
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA **(Alternate)**	✓	**Zaman Jennaty, RN,** Medical Management Nurse Analyst
		✓	**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: July 17,	The July 17th, 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	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2025 - A&G Classification Audit Report (Q2 2025) - A&G Inter-Rater Reliability Report (Q2 2025) - Quarterly A&G Member Letter Monitoring Report (Q2 2025) - A&G Validation Audit Summary (Q1 2025) - CCC DMHC Expedited Grievance Report (Q2 2025) - Call Center Inquiry Calls Audit (Q2) - Member Incentive Programs – Semi-Annual Report (Q1&Q2 2025) - PA Member Letter Monitoring Report (Q2 2025) - Performance Improvement Project Updates – PIPs - California Children's Services Report (Q2 2025) - Initial Health Appointment (IHA) Quarterly Audit (Q1 2025) - Concurrent Review IRR Report (Q2 2025) - County Relations Quarterly Update (Q2 2025) - MedZed Report (Q2 2025) - Evolent (NIA) Report (Q2 2025) - Provider Office Wait Time Report (Q2 2025)	discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Ramirez) 6-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
-ECM & Community Supports Performance Report (Q2 2025) - Access Workgroup Committee Minutes 5/27/25, 6/24/25 - Medical Policies Updates (June, July) - Pharmacy Provider Updates (Q3) - Disparities Analysis and Actions Report (2025) (Attachments A-V) **Action** Patrick Marabella, M.D., Chair		
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (July 2025) - A&G Executive Summary (Q2 2025) - A&G Quarterly Member Report (Q2 2025) - Root Cause Analysis Member Satisfaction Mid-Year 2025 (Attachments W-Y) **Action** Patrick Marabella, M.D., Chair	The **Root Cause Analysis: Member Satisfaction Mid-Year 2025** was presented, which summarized data from the Appeal & Grievance Dashboard and Turnaround Time Report (Q2 2025), the Appeal & Grievance Executive Summary (Q2 2025), and the Appeal & Grievance Quarterly Member Report (Q2 2025). • **Background:** The root cause analysis report aims to highlight member satisfaction based on the resolved appeal and grievance cases quarterly to better understand CAHPS results, rate movement, and areas of improvement. • **Year-Over-Year Comparison – Q2 2025 Appeals & Grievances Volume by County** o Compared to Q2 2024, appeal volume increased by forty-one-point six percent (41.6%) in Fresno County, sixty percent (60%) in Kings County, and fifteen-point eight percent (15.8%) in Madera County. o Grievance volumes also rose during the same period: Fresno County up three-point one percent (3.1%), Kings County up twenty-eight-point five percent (28.5%), and Madera County up three-point five percent (3.5%). • **One Year Look Back of Appeals & Grievances Volume Comparison by County** o In Q2 2025, appeal volume increased by fifteen-point six percent (15.6%) in Fresno County and fourteen-point two percent (14.2%) in Kings County, while Madera County	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (July 2025) - A&G Executive Summary (Q2 2025) - A&G Quarterly Member Report (Q2 2025) - Root Cause Analysis Member Satisfaction Mid-Year 2025 (Waugh/Faulkenberry) 6-0-0-1

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	demonstrated a twenty-one-point four percent (21.4%) decrease compared to the previous quarter. o Grievance volumes also rose across all three (3) counties compared to Q1 2025: Fresno County up thirteen-point six percent (13.6%), Kings County up nineteen-point five percent (19.5%), and Madera County up nine-point two percent (9.2%). • **Year-Over-Year Comparison - Q2 2025 Top Appeals & Grievances Trends by Classification Codes** o In Q2 2025, appeals related to the 'Not Medically Necessary' classification increased by 9.9% compared to Q2 2024. o For grievances, three (3) of the top five (5) classifications saw increases: ▪ Access to Care ▪ Balance Billing ▪ Transportation o Meanwhile, two (2) categories demonstrated declines compared to Q2 2024: ▪ Quality of Care ▪ Administrative Issues • **One Year Look Back of Appeal & Grievance Trends by Classification Codes** o In Q2 2025, appeals related to the 'Not Medically Necessary' classification increased slightly compared to the previous quarter. o Among Grievances, four (4) of the top five (5) classifications saw volume increases compared to the prior quarter: ▪ Access to Care: up twenty-eight-point nine percent (28.9%) ▪ Balance Billing: up twenty-six-point six percent (26.6%) ▪ Quality of Care – PCP: up forty-two-point one percent (42.1%) ▪ Transportation: up three percent (3%) o Meanwhile, the Administrative Issues category demonstrated a three-point one percent (3.1%) decline. • **Trending Appeals (volume) by Category** o In Q2 2025, in the 'Not Medically Necessary' classification, increased trends were observed in four out of the six (4/6) categories. Diagnostic 0 MRI and Diagnostic – CAT Scan were the only two (2) categories with a decrease of ten-point five percent (10.5%) and thirty-five-point three percent (35.3%), respectively, compared to Q2 2024.	

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	○ Compared to the previous quarter, Q2 2025 showed decreases in two of the six (2/6) categories. However, Diagnostic – MRI, DME-CPAP Machine, and Diagnostic – CAT Scan demonstrated increases relative to Q1 2025 ○ Diagnostic – Genetic Testing remained unchanged from the previous quarter. • **Trending Grievances (volume) by Category** ○ Compared to Q2 2024, several grievance categories showed increases: ▪ Prior Authorization Delay ▪ PCP Referral for Services ▪ General Complaint ○ In contrast, the following categories demonstrated decreases in volume: ▪ Referral Process ▪ Health Plan: • Inappropriate Payment Demand (PAR)**Summary for Appeals** ○ Appeals volume continues to rise in 2025 ○ In Q2 2025, we observed an increase in appeal volume. ○ Seventy-eight percent (78%) were classified as Not Medically Necessary ○ Appeals Outcomes Breakdown: Upheld forty-eight percent (48%), Overturned forty-four percent (44%) ○ Medically Tailored Meals: Upheld ninety-five percent (95%), Overturned five percent (5%) • **Summary for Grievances** ○ Grievances have increased year over year, with Access to Care services remaining the most frequently cited category – particularly due to issues such as prior authorization delays and missed transportation appointments. ○ Top Drivers of Grievances (approximately 80% of grievances fall under the following categories) ▪ Prior Authorization Delay ▪ PCP Referral for Services ▪ Transportation Missed Appointment ▪ Prescription Delay ▪ Network Availability ▪ Specialist Referral for Services ○ Some of the Areas for Improvement and Potential Actions Identified were:	

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	▪ Prior Authorization Delay: o The provider should keep the member informed of prior authorization of the timeline of approval. o Continue providing live and recorded provider training webinars to address prior authorizations on a regular basis. ▪ Transportation Missed Appointment: o Request feedback from the vendor on how they will address complaints related to no-show transportation. ▪ PCP Referral for Services o Establish or reassess the current referral process and turnaround approval times. ▪ Network Availability o Expand telehealth services and utilize data analytics to optimize network design and ensure equitable access to care. ▪ Specialists' Referral for Services o Enhance relationships with referring physicians and streamline the referral process. *Discussion:* *Dr. Cardona inquired regarding the appropriate path for the distribution of grievances related to Community Supports. Who should handle these grievances since the PCP doesn't refer patients to these services?* *Dr. Marabella stated that the ECM and Community Supports departments are the providers for these types of services with contracted vendors (providers). They identify members in need, provide services, and reevaluate for continuation or cancellation of the services. The medical directors are in discussions about who should be adjudicating these cases. Meal providers and the ECM/CS teams should understand the rules and to whom the grievance or appeal should be directed. It should not be given to the PCP.*	
#3 **QI Business** - Potential Quality Issues (Q2 2025)	**The Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or Peer Review activity. Peer Review activities include cases with a severity code level of III or IV, or any case that the CVH CMO requests to be forwarded to Peer Review. Data for Q2 2025 was reviewed for all case types,	**Motion**: *Approve* - Potential Quality Issues (Q2 2025)

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(Attachment Z) **Action** Patrick Marabella, M.D., Chair	including the follow-up actions taken when indicated. • There was one (1) non-member-generated Fresno County Physical Health (PH) PQI in Q2. • Member-generated PQIs increased based on previous quarters, with a total of forty-one (41) PH cases and two (2) Behavioral Health (BH) cases. The majority of cases were scored level zero (0) to two (2). • Twenty-three (23) Peer Review cases were generated (none were BH). Sixteen (16) cases are closed, and seven (7) cases are open. • Nineteen (19) Peer Review cases reviewed from April through June needed Further Action. The Further Action cases required notification or action due to the Medical Director/CMO's direction. The cases are closed to track and trend; if at any time the practitioner meets Peer Review Policy criteria, a new case will be generated for investigation and submitted to the Peer Review Committee for review, determination, and action. All cases scored level zero to two (0-2).	(Ramirez/Waugh) 6-0-0-1
#3 QI Business - Lead Screening Quarterly Report (Q1 2025) (Attachment AA) **Action** Patrick Marabella, M.D., Chair	The **Lead Screening Quarterly Report (Q1 2025)** is a quarterly assessment of Blood Lead Screening in Children compliance to ensure that CVH's members receive blood lead level testing and follow-up when indicated, and that parents/caregivers receive anticipatory guidance from providers related to blood lead poisoning prevention. The Q1 2025 report provides CVH's performance on blood lead level screenings and anticipatory guidance monitoring from Q2 2024 – Q1 2025. • In Q1 2025, the overall compliance was twenty-two percent (22%), which is a slight decrease from Q2 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. • In Q1 2025, the overall compliance for CPT Code 83655 (only) was approximately twenty-two percent (21.90%), which is less than a one percent (0.8%) decrease compared to Q2 2024. • In Q1 2025, the overall compliance for Anticipatory Guidance was two-point eight percent (2.80%), which is a one-point two percent (1.20%) increase compared to Q2 2024. Due to the persistent low compliance, the QI team continues to explore potential barriers and solutions. <u>Barrier Analysis:</u> • Incorrect coding used by the providers. • Low point of care (POC) LSC testing in provider offices. • Members do not want to go to lab locations for services due to the impeded process and lack	**Motion:** *Approve* - Lead Screening Quarterly Report (Q1 2025) (Faulkenberry/ Cardona) 6-0-0-1

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	of transportation. • Members do not show up for scheduled appointments. • Providers need to implement the workflow process and get regulatory approval for setting up the complete capillary screening at the provider's office. • Identifying an effective and efficient method for documentation of anticipatory guidance. <u>Next Steps:</u> • Meet with the QIRA team to identify a better method of documenting and reporting on anticipatory guidance. *Discussion:* *Dr. Marabella asked for input from the Committee members on how lead testing is going in their practices.* *Dr. Faulkenberry indicated that twenty (20) minutes is not enough time to cover all twenty-two (22) anticipatory guidance points in addition to a physical exam and document all of them correctly.* *Dr. Marabella agreed that twenty (20) minutes is a limited amount of time. The state may not consider the practical implications of implementing certain policies.* *Dr. Ramirez indicated that code documentation was the hurdle in his system. Documenting certain codes can conflict with the WCV codes. A simpler system is needed.* *Dr. Faulkenberry commented that even though the anticipatory guidance is the same for lead testing, there are multiple codes to remember depending on the child's age.* *Dr. Marabella and Amy Schneider agreed that streamlining this process is needed and will continue to push the state and Health Net to think about workflow practicality when implementing policies.*	
#4 **Key Presentations** - RY2025 HEDIS® Results & Quality Improvement Update (Attachment BB) **Action** Patrick Marabella, M.D., Chair	The **RY2025 HEDIS® Results & Quality Improvement Update** was presented and reviewed. HEDIS® Measures: The Managed Care Accountability Set (MCAS) is a set of performance measures that DHCS selects for annual reporting by Medi-Cal Managed Care health plans (MCPs). These are generally HEDIS® measures. • High Performance levels (HPLs) are used as performance goals and to recognize MCPs for outstanding performance, national Medicaid 90th percentile. • Minimum Performance Levels (MPLs) are set at the national Medicaid 50th percentile. MCPs are contractually required to perform at or above MPLs. DHCS will impose sanctions on MCPs that fail to meet the MPLs. • For RY2025 (MY2024), MCPs were required to meet the MPL on eighteen (18) measures in	**Motion**: *Approve* - RY2025 HEDIS® Results & Quality Improvement Update (Pascual/Ramirez) 6-0-0-1

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	each county in four (4) Domains: o Children's Health o Reproductive Health & Cancer Prevention o Behavioral Health (BH) o Chronic Disease Management • Fresno County did not meet the Minimum Performance Level (MPL) for RY25 in two (2) Domains (Children's and BH) in the following measures: FUM, FUA, W30-6+, and W30-2+, but met the High-Performance Level (HPL) for GSD. • Kings County did not meet the MPL for RY25 in the Children's Domain in the following measures: CIS-10, DEV, WCV, W30-6+, and W30-2+ but met the High-Performance Level (HPL) for BCS-E, AMR, CBP, PPC-Pre, and PPC-Pst. • Madera County did not meet the MPL for RY25 in the BH Domain in the following measures: FUM and FUA, but met the HPL for CCS, GSD, IMA-2, LSC, and W30-6+. • Performance Improvement Projects (PIPs) o PIP #1: Improve Well Child Visits (WCV) for African American/Black (AA/B) Children 0 to 15 months in Fresno County with two (2) interventions: 1. Refer all caregivers/mothers of B/AA children to Black Infant Health to encourage and facilitate WCV. 2. Promote use of the CDC Milestone Tracker App to engage parents in WCV and encourage appointment attendance. ▪ Statistically significant improvement in WCV rate for B/AA infants after first year. ▪ PIP ends 12/31/2025. Final data submission due to HSAG/DHCS in August 2026. o PIP #2: Improve Follow-up with Provider after ED Visit for Behavioral Health/Substance Use in Fresno and Madera Counties with three (3) interventions: 1. Working with Saint Agnes Medical Center in Fresno County on Educational Intervention for staff (SMART Phrases to capture services provided). 2. Hispanic-focused Cultural Competency. 3. Increase referral resources with the Resiliency Center. ▪ Statistically significant improvement after the first year. ▪ PIP ends 12/31/2025. Final data submission due to HSAG/DHCS in August 2026. • Three (3) DHCS County Projects in Progress: o #1: Lean Health Equity Quality Improvement Projects in Madera County based on RY24	

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	MCAS results. ▪ Madera County (Behavioral Health Domain) Focusing on the Hispanic population to improve follow-up care after ED Visit for BH/SUD. ▪ Support use of Community Health Workers (CHWs) at FQHCs in collaboration with Camarena Health to link patients to BH services after an ED visit. ▪ Utilize LANES ADT data to facilitate timely follow-up (7 days/30 days) after ED visit. o #2: Comprehensive Health Equity Quality Improvement Projects in Kings County (RY24 results). ▪ Kings County Improve Children's & Chronic Disease Domains. ▪ Children: Focused on increasing provider/member access to pediatric digital health education resources and data reconciliation for well child visits (W30) and Developmental Screening (DEV) measures. ▪ Chronic: Improve Asthma Medication Ratio (AMR) HEDIS® rates through best practices, including prescribing Formoterol/ICS combo. o #3: Transformational Health Equity Quality Improvement Projects in Fresno County (RY24 results). ▪ Improve Children's, Chronic, and Behavioral Health Domains in Fresno County. ▪ Implement strategies in Fresno County as outlined for Children's and Chronic Domains in Kings County and participate in a Transformational Project. ▪ Transformational Project in collaboration with Anthem Blue Cross and United Health Centers to improve access to pediatric services at two (2) targeted UHC clinics to improve all eight (8) Children's Domain measures. DHCS coaching. • Two (2) Institute for Healthcare Improvement (IHI) Collaborative Projects. (Phase 1 of these IHI Lead Collaboratives was from April 2024 to March 2025): o #1: IHI WCV Collaborative focused on testing of five (5) interventions with a provider (Clinica Sierra Vista Elm St. Clinics) to improve WCV rates for Hispanic Children zero to fifteen (0-15) months in Fresno County. ▪ Ending with an emphasis on Community Partnerships and collaboration with Community-Based Organizations, including Centro La Familia and WIC. o #2: IHI BH Collaborative focused on improving referrals to outpatient BH providers after an ED Visit for SUD/MH issues by working in collaboration with Anthem Blue Cross,	

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	Community Regional Medical Center, and Fresno County Department of Behavioral Health. Phase 2 is scheduled to begin September 25th: o #1: CVH will continue the WCV Collaborative with Clinica Sierra Vista to build upon progress made in Phase 1. o #2: Status of the BH Collaborative is unclear at this time. CVH may continue efforts in Fresno County or move to Madera County. Of note: • RY2025 MCAS results showed improvement in all counties. • MY25 (RY26) results are on track to maintain positive results with ongoing improvements. • Medical Management Team is starting to schedule Annual Clinic Visits at CalViva's larger FQHCs in each county to share RY25 results and discuss opportunities for improvement and collaboration. *Discussion:* *Dr. Cardona asked if the state has plans for increasing the number of BH clinicians in the area. If there are not enough people to refer to, then additional measures will continue to go unmet.* *Dr. Marabella indicated that the state does not have an intentional plan to add clinicians at this time. CVH has recently expanded BH services via telehealth although there are still challenges. MCAS measures both in quantity and scope are a big topic of debate amongst Medical Directors and MCPs at this time.* Dr. Cardona left the meeting at 10:40 A.M. and returned at 10:40 A.M.	
#4 Key Presentations - Quality Improvement and Health Education Work Plan Mid-Year Evaluation and Executive Summary 2025 (Attachment CC) **Action** Patrick Marabella, M.D., Chair	The **Quality Improvement and Health Education Work Plan Mid-Year Evaluation 2025 and Executive Summary** were presented and reviewed by the Committee. Planned Initiatives and Eight (8) Areas of QI Focus for 2025 include: • Behavioral Health, Chronic Conditions, Hospital Quality and Patient Safety, Member Engagement and Experience, Pediatric/Perinatal/Dental, Pharmacy and Related Measures, Preventive Health, and Provider Engagement/Communication. **Objectives**: There is a total of eighty-three (83) measurable objectives for the QI and Health Education 2025 Work Plan. Ongoing activities continue.) • Seventy-two (72) objectives completed at mid-year. • Sixty-two of seventy-two (62/72) objectives were met.	**Motion:** *Approve* - Quality Improvement and Health Education Work Plan Mid-Year Evaluation and Executive Summary 2025 (Cardona/Ramirez)

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	• Ten of seventy-two (10/72) objectives were not met. • Eleven (11) additional objectives scheduled for Q3-Q4 2025 and on track at mid-year. The programs that did not meet their objectives were Pediatric/Perinatal/ Dental, Preventive Health, and Provider Engagement/Communication. **Eighty-five (85) Total Activities** planned for the year: • Eighteen of nineteen (18/19) mid-year activities completed. • One (1) activity under Pediatric/ Perinatal/Dental was off track and not completed. • Sixty-six (66) additional activities are planned for July to December. Of those, four (4) activities were cancelled. Of note, some activities are initiated in the first 6 months of the year, but they do not conclude until some time during the second half of the year. These activities are all counted at the year-end. QIHEd Mid-Year Performance Progress (refer to Table 1 in the PowerPoint presentation): • Behavioral Health, Chronic Conditions, Member Engagement and Experience, and Pharmacy and Related Measures have one hundred percent (100%) of their objectives met. • Hospital Quality/Patient Safety (N/A at mid-year 11 objectives), Pediatric/Perinatal/Dental, Preventive Health, and Provider Communication/Engagement have not yet met their objectives but have year-end activities planned. QIHEd Mid-Year Work Plan Activities (refer to Table 2 in the PowerPoint presentation): • Chronic Conditions, Pediatric/Perinatal/Dental, and Preventive Health have multiple year-end activities planned. **Access, Availability, and Service:** Access to Care: o Provider Appointment Availability Survey – PAAS ▪ PCP Urgent and Non-Urgent exceeded the seventy percent (70%) threshold. ▪ Specialist Urgent & Non-Urgent improved but did not meet the seventy percent (70%) threshold. ▪ Ancillary non-urgent exceeded the seventy percent (70%) threshold. o Provider After Hours Access Survey – PAHAS ▪ Appropriate Emergency Instructions and Ability to Contact On-Call MD both exceeded 90%. Access Actions: o All non-compliant providers will receive Corrective Action Plans in July 2025.	6-0-0-1

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	○ Ten (10) Mandatory Provider Training Webinars from July to December. **Member Satisfaction:** Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey was conducted by Press Ganey in May 2025. ○ Report will be available in August. ○ Quarterly Root Cause Analysis of A & G Data. ○ Sullivan Luallin Webinar Trainings are available for Providers. **RY2025 HEDIS® Results** (Refer to the chart on page nine (9) of the PowerPoint): • Fresno County did not meet the Minimum Performance Level (MPL) for RY25 in the following measures: FUM, FUA, W30-6+, and W30-2+, but met the High-Performance Level (HPL) for GSD. • Kings County did not meet the MPL for RY25 in the following measures: CIS-10, DEV, WCV, W30-6+, and W30-2+ but met the High-Performance Level (HPL) for BCS-E, AMR, CBP, PPC-Pre, and PPC-Pst. • Madera County did not meet the MPL for RY25 in the following measures: FUM and FUA, but met the HPL for CCS, GSD, IMA-2, LSC, and W30-6+. **Performance Improvement Projects (PIPs) and Other Projects - All On Track** Two (2) PIPs: • Clinical - Well Child Visits in First Thirty (30) Months of Life, Fresno County. • Non-Clinical – Improve Provider Notifications after ED Visit for SUD/MH, Fresno and Madera Counties. **Other Projects:** • IHI Well Child Visit Collaborative • IHI Behavioral Health Collaborative • DHCS Lean Project Madera County (BH Domain) • DHCS Comprehensive Project Kings County (Child and Chronic Domains) • DHCS Transformational Project Fresno County (BH, Chronic, and Child Domains) **Health Education Activities and Actions** (July to December 2025): • Continuing Member incentive strategy for all priority MCAS measures. • Promote Digital Resources, including QR Codes and Links. • Member Services to inform Members of Health Education programs and materials that are	

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	available. • Review and Update materials following DHCS Guidelines. • Continue partnership and promotion of BCS and CCS screenings at *Every Woman Counts.* • Continue promotion of the "Kick It California" tobacco cessation program. • Diabetes Prevention Program with a new vendor was approved by DHCS in January '25. o One member & one provider outreach campaign launched to promote the program. Enroll members and continue rollout of the program. *Discussion:* *Dr. Cardona asked if the non-compliant providers for access availability include specialists.* *Mary Lourdes Leone indicated that it includes both primary and specialty care providers. Non-compliant providers are given an educational packet to help them improve availability and access.* *Dr. Ramirez asked how the system determines the categorization of specialists versus primary care when a provider could be both? For example, a provider could work as a specialist one day a week and a primary care provider the rest of the week. When responding to surveys, the designations are self-reported.* *Dr. Marabella indicated that in general, it is based on credentialing and how that individual is board-certified. However, for surveys it is self-reported.*	
#4 Key Presentations - Utilization Management/Care Management Work Plan Mid-Year Evaluation & Executive Summary 2025 (Attachment DD) **Action** Patrick Marabella, M.D., Chair	The **Utilization Management/Care Management Work Plan Mid-Year Evaluation 2025 & Executive Summary** were presented and reviewed by the Committee. Utilization Management processes have remained consistent. Case Management & Disease Management continue to monitor the effectiveness of programs to better serve our members. Activities in 2025 Focus on Five Areas. **All Compliance Activities are on target for the Mid-Year except for the following Work Plan Elements (bold). It is too soon to tell whether these metrics will meet their goals by the end of the year:** • **1.4 Periodic audits for Compliance with regulatory standards – Emergency Services Oversight Audit.** <u>Barriers identified:</u> o Improper suspension of regulatory processes o Missed hospital notifications o Incomplete CAP documentation o Inadequate application of post-stabilization requirements to both contracted and non-	**Motion:** *Approve* - Utilization Management/Care Management Work Plan Mid-Year Evaluation & Executive Summary 2025 (Waugh/Ramirez) 6-0-0-1

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	contracted hospitals. Actions Taken: o A dedicated team was established to manage post-stabilization cases. o Fax-based authorization requests were eliminated, and a single telephone number was put in place. o Providers received targeted education and formal communication about the changes. o Internal policies and procedures were updated. o Enhanced tracking and reporting tools were implemented. • **1.7 Annually review, approve, and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making.** Barrier identified: o Behavioral Health transitioned to Health Net from MHN, causing a shift in committee structure. The BH criteria did not complete the annual review process in 2024. Actions Taken: o Updated UMCM workplan rationale and planned interventions to include Behavioral Health criteria. o BH utilization review criteria are scheduled to be presented for approval in Q4 2025. • **2.2 Timeliness of Processing the Authorization Request** Barrier identified: o In Q1, translation of deferral letters missed TAT, causing the below ninety-five percent (95%) result. o In Q2, this continued to be an issue with not ensuring the translation process is completed within the required timeframe. Actions Taken: o Targeted staffing initiatives are in progress. o Comprehensive training for the Prior Authorization team was conducted to reinforce updated workflows and expectations. o Regular performance reviews and compliance tracking are planned to sustain improvements and identify emerging issues proactively. • **3.3 PPG Profile – Turnaround Times** Barrier identified: o Specialty access continues to be a challenge for PPGs.	

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	o PPG A: Member Notification TAT was non-compliant due to workflow issues with the mailroom vendor and inadequate staffing. CAP remains open. o PPG B: Increase in authorization requests led to delays. o PPG F: Decision TAT was non-compliant due to workflow management, high volume of requests, and inadequate staffing, and remained open at the end of Q2. Actions Taken: o The Plan continued monitoring of open PPG CAPs. o PPG A/B: staffing ratios were reassessed, which resulted in hiring additional coordinators, onboarded by 1/1/2025. o PPG F: increased staffing and automated workflows to accommodate volume and address TAT. • **4.1 Care Management (CM) Program- Reducing Readmissions (Goal 5%)** Barrier identified: o Admissions and readmissions experienced a smaller sample in Q1, which skewed the results due to one (1) member with multiple re-admissions. o Fewer than expected number of satisfaction surveys completed. Actions Taken: o CMs to encourage members to conduct surveys and obtain the preferred contact method by members for the survey. **4.2 Perinatal Care Management Timely First Prenatal Visit (Goal 8%)** o Greater compliance in completing the first prenatal visit (one-point four percent 1.4% achieved). Goal is 8% higher completion of timely prenatal visit when in CM. Barrier identified: o Small Q1 sample size makes it difficult to determine if we are on target or not. o Members entering the program after the first trimester impacts our ability to achieve completion of the first prenatal visit in a timely manner. Actions Taken: o In Q3, we will prioritize members in the first trimester for outreach to improve compliance with completing the first prenatal visit. There were no questions or comments from committee members.	
#4 Key Presentations - Population Health	The **Population Health Management Program Effectiveness Report 2025** was presented and reviewed. This report provides an annual summary of the CVH Population Health Management	**Motion: Approve** - Population Health

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Management Program Effectiveness Report 2025 (Attachment EE) Action Patrick Marabella, M.D., Chair	program successes and opportunities. It focuses on assessing the impact of key interventions related to: Care process or outcome, Cost/utilization, and Overall member experience. Thirteen (13) measures were included in the PHM analysis and whether each measure met the goal for 2024 or not. The following programs are not yet meeting the established goals to improve care process or outcome, cost/utilization, and/or member experience. • Follow-up care after Mental Health Emergency Department Visits (FUM) • Follow-up care after Substance Use Disorder Emergency Department Visit (FUA) • Care Management Member Experience Analysis has identified the following barriers negatively impacting our ability to meet our goals: • Timely follow-up for FUM and FUA. • Accurate reporting/identification of members for FUM and FUA. • Care Coordination to improve the continuity of care for FUM and FUA. • Members' satisfaction with the ability to reach a care manager fell below the ninety percent (90%) goal. The Care Manager is on a call with another member or away when members call. Three (3) Measures used to assess effectiveness: • HEDIS Follow-up After Emergency Department Visit for Mental Illness (FUM-30) Results • HEDIS Follow-up care after Substance Use Disorder Emergency Department Visit (FUA-30) Results • Depression Screening and Follow-up Care (DSF) Results CVH implemented the following actions to address the identified barriers and improve behavioral health measures: • Follow-up Outreach Team is making member outreach calls with the use of daily ADT reports to close care gaps for FUA/FUM measures. • Supplemental member contact info is being fed directly into CVH ADT reports to improve reach rates for Medi-Cal memberships for FUA/FUM measures. • Educated SUNs, CHWs, and Social Workers on "Smart Phrases" rather than codes to document assessments and referrals made for individuals with MH/SUD. • Provide culturally appropriate education and outreach strategies to SUNs, CHWs, and Social Workers for MH/SUD to increase follow-up care. • Educated providers (SUNs, CHWs, and Social Workers). • SAMC to use "Smart Phrases" to supplement ICD-10 codes to better capture and document	Management Program Effectiveness Report 2025 (Faulkenberry/ Ramirez) 6-0-0-1

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	FUM/FUA population to assess and refer to treatment. Taken from the CVH Medicaid Survey Results 2024, eighty-seven percent (87%) of respondents indicated that they were very satisfied or satisfied with the CM Program, which did not meet the 90% goal. Several areas were identified for improvement, including providing information, ability to reach their CM, feeling more in control of their health, and alignment with beliefs and values. CVH implemented the following actions to address the identified barriers and improve the Care Management measure: • Care Managers arrange follow-up calls with members on a prescheduled date – continue to send the member a reminder via text for the follow-up call. • Completed all staff training on survey results and ensured member values and beliefs are incorporated. • Gave directions at all staff meetings to ensure CMs remind members to complete the survey that they will receive via email or phone. Enter updated contact info in TruCare system to ensure the member gets the survey. This annual summary will be taken into consideration as we prepare our next **Population Health Management Strategy Program Description**. It will assist us in establishing priorities, setting new goals, and identifying future opportunities for improvement. There were no questions or comments from committee members.	
#4 Key Presentations - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q1 2025) (Attachment FF) Action Patrick Marabella, M.D., Chair	The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q1 2025)** was presented and reviewed. Beginning January 1, 2023, DHCS initiated a transition of responsibility for Long Term Care services to Medi-Cal Managed Care Plans from Fee-For-Service: • Starting with Skilled Nursing Facilities (SNF) • Followed by Subacute Care Facilities • Finally, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) The transition was completed in 2024. The new report provides a summary of key quality, regulatory, satisfaction, and performance measures for SNFs serving CVH members for oversight monitoring and identification of opportunities for improvement. The Dashboard will capture data from multiple sources, including claims, DHCS WQIP, Publicly Available Data, and MCAS/HEDIS® results.	**Motion: Approve** - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q1 2025) (Ramirez/Cardona) 6-0-0-1

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	The Dashboard will monitor for: • Preventable ED visits • Preventable admissions/readmissions • Healthcare-acquired infections • Facility staffing issues • Abuse/neglect • Potential quality issues • Adverse events • Member satisfaction/complaints Member Utilization and SNF Performance: • There are thirty-six (36) licensed SNFs in the CVH designated service area. • In the last twelve (12) months, CVH members were admitted to ninety (90) different nursing homes statewide. Metrics used to identify and trend the quality of providers include the following Quality Categories: • Use of anti-psychotic medications • Rate of falls with injury • Pneumococcal vaccine rate • Pressure ulcers • UTI rates • Staffing • Number of state enforcement actions • Infection control deficiencies • Quality of Care deficiencies • Freedom from abuse deficiencies • Overall CMS Star rating • Preventable Emergency Department utilization • Preventable inpatient admission to acute care A weighted five (5)-point scale for the metrics in the Quality Categories (listed above) as indicators of overall quality of care and outcomes for the skilled nursing facilities in Fresno, Kings, and Madera Counties to assign an overall score for each facility. Charts were shown listing the overall top-performing and bottom-performing SNFs in the CVH Region based on a weighted five (5)-point	

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	scale using metrics in Quality Categories. Charts shown ranked SNFs with the following metrics per CVH member Q4 2024 compared to Q1 2025: o Lowest and highest rates of preventable ED visits. o Lowest and highest rates of preventable acute inpatient admissions. The following three (3) SNFs have the highest rates of preventable ED utilization and acute inpatient admissions: 1. Manning Gardens Care Center (managed by Cambridge Health): Analysis of publicly available data shows a higher-than-state-average use of Antipsychotic Medications, Falls, and UTIs with two (2) state citations in the past year. Next steps include offering in-service education and training to staff to address identified barriers (Anti-psychotic Medication Use, Falls, UTIs, Care Plans). 2. Madera Rehabilitation & Nursing Center: Analysis of publicly available data shows a higher than state average use of Antipsychotic Medications, Falls, and Pressure Ulcers. Next steps include meeting with the site's administrator to collaborate on strategies for reducing ED utilization and inpatient admissions, including review of community best practices (ED Companion Program). 3. Rolling Hills Care Center (managed by Sweetwater Care): Initial meeting held with the Director of Nurses and Social Services. Discussed improvement strategies. Next steps include continuing on-site visits to collaborate on discharge strategies to prevent readmissions. *Discussion:* *Dr. Marabella mentioned that the Q2 report will indicate which facilities our members reside in and how many of our members are in each facility.* *Dr. Ramirez asked if the data represented is raw or if it is adjusted for sample size.* *Dr. Marabella indicated it was raw data.* *Amy Schneider explained that we are partnering with the LTC Ombudsman to eliminate the delay in waiting for the data to be posted publicly.* Dr. Pascual left the meeting at 11:31 AM.	
#5 UM/CM/PHM Business - Key Indicator Report and	Dr. Pascual returned to the meeting at 11:36 AM.	**Motion:** ***Approve*** - Key Indicator Report

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Turnaround Time Report (July 2025) - UM Concurrent Review Report (Q2 2025) - Care Management & CCM Report (Q2 2025) (Attachments GG - II) **Action** Patrick Marabella, M.D., Chair	The **Key Indicator Report and Turnaround Time** and the **Utilization Management Concurrent Review Report** present inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness during Q2 2025. • Average Length of Stay (ALOS): o MCE: Acute admissions and utilization remained stable. o TANF: Continued stability with slight declines in admissions and utilization compared to 2024. o SPD: Marked and sustained declines across all acute care metrics in admissions, negative twenty-point three percent (-20.3%) and bed days negative twenty-four-point three percent (-24.3%) versus 2024 benchmarks. • 30-Day Readmission Trends: o MCE: Declined from a 2024 average of thirteen-point five percent (13.5%) to twelve-point seven percent (12.7%) in Q2 2025, representing a six percent (6%) reduction. o TANF: Saw the most substantial improvement, dropping from a four-point eight percent (4.8%) average in 2024 to three-point seven percent (3.7%) in Q2 2025, a twenty-three percent (23%) reduction. o SPD: Also improved significantly, moving from a twenty-point two percent (20.2%) 2024 average to eighteen-point five percent (18.5%) in Q2 2025, marking an eight percent (8%) reduction. • Key Takeaways: The data shows promising progress in reducing 30-day readmission rates across all major populations. These improvements likely reflect targeted care coordination efforts, better discharge processes, and enhanced patient support, especially for high-risk, complex populations. • Next Steps: o Maintain rigorous utilization review practices in alignment with discharge planning. o Continued collaboration between utilization management and case management teams to ensure seamless care transitions. o The TCS team will continue to outreach to other hospitals to begin onsite presence, to improve enrollment of members into the TCS program, and help coordinate care. The **Care Management and CCM Report** for Q2 2025 was presented to provide an overview of	and Turnaround Time Report (July 2025) - UM Concurrent Review Report (Q2 2025) - Care Management & CCM Report (Q2 2025) (Ramirez/Cardona) 6-0-0-1

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	Physical Health Care Management (PH CM), Transitional Care Services (TCS), Behavioral Health Care Management (BH CM), Perinatal (PCM), and First Year of Life activities (FYOL). This includes referral volume, member engagement, and an evaluation of Program effectiveness. • PH CM referral volume increased eighty-six percent (86%) in Q2, and from Q1 to Q2, the engagement rate increased from fifty-four percent (54%) to fifty-seven percent (57%). • TCS total number of referrals increased three percent (3%) to 1638 referrals, from Q1 to Q2, and the engagement rate decreased slightly to ninety percent (90%) in Q2 from ninety-one percent (91%) in Q1. The total cases managed increased by one point sixty-six percent (1.66%) for a total of 1227 managed cases in Q2. • BH CM total number of referrals increased by eleven percent (11%) from Q1 to 429 referrals in Q2. The engagement rate average increased from seventy percent (70%) in Q1 to seventy-six percent (76%) in Q2. The total cases managed decreased by sixteen-point six percent (16.6%) to 282 managed cases in Q2. • PCM total number of referrals increased by seventeen percent (17%) to 908 referrals in Q2. The engagement rate average increased from sixty-one percent (61%) in Q1 to sixty-five percent (65%) in Q2. The total cases managed increased by three-point five percent (3.5%) to 494 managed cases in Q2. • FYOL total number of referrals increased by seventeen percent (17%), from Q1 to Q2. The total cases managed increased by thirteen percent (13%) to 479 cases managed in Q2. The effectiveness of the PH/BH CM programs are evaluated based on the following measures: • Readmission rates, ED utilization, overall health care costs, and member satisfaction • There was a four-point five percent (4.5%) decrease in readmission rate for post-enrollment in BH/PH CM. This was just below our five percent (5%) goal. • ED claims decreased by 74 (22.5% for Q1) post CM enrollment, above our ten percent (10%) goal. • TCS saw a one-point four percent (1.4%) decrease in readmission rate, which was below our five percent (5%) goal. Low reduction is attributed to one member with multiple readmissions. • ED claims per 1,000 members per year decreased by 74 (22.8% for Q1) after CM enrollment. PCM program effectiveness is evaluated based on the following measures: • Prenatal visit, Pre-term delivery, Postpartum visit, and Member Satisfaction • Members enrolled in PCM saw a one-point four percent (1.4%) increase in the first prenatal	

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	visit within the first trimester. This is below our eight percent (8%) goal. • Members enrolled in PCM saw a six-point one percent (6.1%) decrease in high-risk pre-term deliveries. • Members enrolled in PCM saw a fifteen-point three percent (15.3%) increase in the number of postpartum visits between seven (7) and eighty-four (84) days after delivery. *Discussion:* *Dr. Pascual asked if the maternity program was CPSP?* *Dr. Marabella responded, no HN staff are doing CM, CPSP is usually done by the provider. CVH does require that providers follow the CPSP guidelines. Once the Plan gets a Notice of Pregnancy (NOP), HN CM will reach out to enroll members into PCM, as a greater percentage of our population tends to be considered "high-risk" pregnancies.* *Dr. Pascual asked how the NOPs are initiated.* *Dr. Marabella indicated that a form must be filled out, and that comes with an incentive. Our Provider Engagement Team can assist you with this process. Amy will contact Provider Engagement to ask that they follow up with Dr. Pascual regarding this issue.*	
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q2 2025) - Pharmacy Operations Metrics (Q2 2025) - Pharmacy Top 25 Prior Authorizations (Q2 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q2 2025) (Attachments JJ-MM) **Action** Patrick Marabella, M.D., Chair	The **Pharmacy Executive Summary Q2 2025** 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 five percent (5%) of the standard for Q2 2025. o Overall, TAT for Q2 2025 was one hundred percent (100%). o PA volume in Q2 2025 was similar to Q1 2025, with some drug-specific differences. April had a higher volume compared to all other months in Q2 2025. • Provider and Pharmacy Updates o 25-384m Medication Trend Updates and Formulary Changes – 2nd Quarter 2025 • FDA approves first generic GLP-1 Victoza (liraglutide) The **Pharmacy Operations Metrics Q2 2025** provides key indicators measuring the performance of the PA Department in service to CVH members. The turnaround time (TAT) expectation is one	Motion: *Approve* - Pharmacy Executive Summary (Q2 2025) - Pharmacy Operations Metrics (Q2 2025) - Pharmacy Top 25 Prior Authorizations (Q2 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q2 2025) (Ramirez/ Faulkenberry) 6-0-0-1

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	hundred percent (100%) with a threshold for action of ninety-five percent (95%). • Pharmacy prior authorization (PA) metrics were within standard at goal in all months of Q2 2025. The average TAT for Q2 2025 was one hundred percent (100%). PA turnaround time is monitored to identify PA requests that are approaching the required turnaround time limits. • Approval rates are in the mid-sixties (60's) and denial rates are in the mid-thirties (30's). The **Pharmacy Top 25 Prior Authorizations Q2 2025** identifies the most requested medications to the Medical Benefit PA team for CVH members and assesses potential barriers to accessing medications through the PA process. The top twenty-five (25) requests in Q2 2025 were mostly consistent with the top twenty-five (25) drugs reviewed in Q1 2025, with a few placement variations. More variance is seen as we review the top fifteen (15) to twenty-five (25) drugs. Some variances can be explained by intervals between treatment and the length of auth assignment per the criteria. • Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products. • IV iron and granisetron requests had a one hundred percent (100%) denial rate based on non-preferred requests. The **Quality Assurance Reliability Results (IRR) for Pharmacy Q2 2025** 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 ninety-five percent (95%) accuracy or better in all combined areas, with a threshold for action of ninety percent (90%). • Ninety percent (90%) threshold met. The ninety-five percent (95%) goal was met; the overall score was ninety-six percent (96.67%). • No (0) sample cases missed TAT after plan. • One (1) sample case had potential criteria application or documentation issues after plan review. • Three (3) sample cases had letter language that could have been clearer and more concise after plan review.	

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	• No (0) sample cases were determined to have a questionable denial or approval after plan review. • In Q2 2025, clear and appropriate language was an area of concern; however, it did meet the target goal of ninety percent (90%). All other areas met and exceeded the target of ninety-five percent (95%). A more detailed review and QA on cases in Q2 2025 has been performed, and results will be shared with PA management to address concerns. The **Pharmacy Provider Updates (Q3)** were approved in the consent agenda but were additionally discussed here. Please refer to the attachments for the complete lists of PA changes for Medi-Cal fee-for-service physicians and other providers. • HN, on behalf of CVH, started favoring certain biosimilar medications over their brand-name counterparts (or reference products). *Discussion:* *Dr. Marabella commented that one (1) GLP1 will be covered for diabetes only. There are process changes in the formulary due to the national funding atmosphere.* *Dr. Cardona asked how they will handle all the people currently on GLP1 medication for other reasons? Perhaps Grandfather the medication?* *Dr. Marabella did not have an answer but indicated that grievances will likely increase as a result.*	
#7 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q3 2025) (Attachments NN) Action Patrick Marabella, M.D., Chair	The **Credentialing Sub-Committee Quarterly Report** was presented. The Credentialing Sub-Committee met on July 17, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q1 2025 were reviewed for delegated entities, and for Q2 2025 for Health Net (HN) and HN Behavioral Health (BH). A summary of the Q1 2025 data was presented. • The **Credentialing Adverse Actions** report for Q2 2025 for CVH from the HN Credentialing Committee was presented. There were no (0) CVH cases presented for discussion in Q2 2025. • The **Adverse Events Q2 2025** report was presented. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period. o Credentialing submitted zero (0) cases to the Credentialing Committee in Q2 2025. o There were no (0) reconsiderations or fair hearings during Q2 2025. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2025.	Motion: *Approve* - Credentialing Subcommittee Report (Q3 2025) (Cardona/Ramirez) 6-0-0-1

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	○ There were no (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q2 2025. ○ There were no (0) cases requiring reporting for 805 in Q2 2025. ○ NCQA CR5.A.1-2 Reviews completed in April and May identified one (1) practitioner requiring removal from the Plan's network. Notification was provided to the impacted practitioner, as well as the impacted Plan departments, including Claims, Network Management, Delegation Oversight, Special Investigations Team, and Provider Data Management. • The **Access & Availability Substantial Harm Report Q2 2025** was presented and reviewed. This report aims to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) cases related to identified appointment availability complaints. Each case is assigned a severity outcome score, and cases requiring follow-up are tracked to conclusion. This report now includes behavioral health cases in addition to physical health. ○ After a thorough review of all Q2 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 **2025 Credentialing Oversight Audit Results** of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function were presented and reviewed. ○ 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 compliance criteria at the required 100% level. The IMG case was recredentialed at forty (40) months and will require corrective action. ○ Overall, HNCS was found to be consistently compliant with eighty-five of eighty-six (85/86) standards evaluated, with a ninety-eight-point eight percent (98.8%) compliance rate. ○ The Initial Credentialing and Re-Credentialing file reviews of practitioners were excellent, with both at ninety-nine percent (99%) compliance, and the Organizational Provider files demonstrated one hundred percent (100%) compliance. • The **Credentialing Sub-Committee Reports for Q2 2025** were reviewed. The county-specific Credentialing Subcommittee Reports of significant subcommittee activities for April through June 2025 were presented. Three (3) Corrective Action Plans were identified in these reports	

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	for Q2 2025; one (1) in Fresno County and two (2) in Madera County.	
#7 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q3 2025 (Attachment OO) Action Patrick Marabella, M.D., Chair	**Peer Review Sub-Committee Quarterly Report** was presented. The Peer Review Sub-Committee met on July 17, 2025. • The county-specific **Peer Review Sub-Committee Summary Reports for Q2** 2025 were reviewed for approval. No (0) significant cases to report. • The **Q2 2025 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o There were nineteen new (19) cases identified in Q2 that met the criteria and were reported to the Peer Review Committee. ▪ Four (4) cases involved a practitioner, and fifteen (15) cases involved organizational providers (facilities). ▪ Of the nineteen (19) cases, two (2) were tabled, zero (0) were tabled with a letter of concern, two (2) were placed on monitoring, two (2) were placed on pending closure, none (0) were deferred, three (3) were closed to track and trend with a letter of concern, zero (0) were closed to track and trend with a letter of education, and ten (10) were closed to track and trend. ▪ Eighteen (18) cases were quality of care grievances, one (1) was a potential quality issue, none (0) were lower-level cases, and none (0) were track and trend cases. ▪ Six (6) cases involved seniors and persons with disabilities (SPDs). ▪ Zero (0) cases involved behavioral health. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2025. o NCQA.CR 5.A.4: Reviews completed in March and April did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. o NCQA CR 5.A.5: 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. o There were eight (8) 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. o One (1) case referred to peer review for further review. Further review includes an	Motion: Approve - Peer Review Subcommittee Report Q3 2025 (Ramirez/Waugh) 6-0-0-1

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	examination of trended grievances, as well as a review of licenses and sanctions/exclusions. The case did not require escalation for presentation at the Peer Review Committee. o No (0) cases required reporting for 805.01 in Q2 2025. • The **Access & Availability Substantial Harm Report for Q2 2025** 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. o Twenty-three (23) cases were submitted to the Peer Review Committee in Q2 2025. Of the twenty-three (23) cases, two (2) cases were related to appointment availability issues without significant harm, and six (6) were related to significant harm without appointment availability issues. o Behavioral Health cases are included in this report. There were no (0) BH cases for review in Q2 2025. o Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q2 2025. • The **Q2 2025 Peer Count Report** was presented and discussed with the committee. Twenty-three (23) cases were reviewed. Sixteen (16) cases were closed and cleared. Zero (0) cases were closed/terminated. Zero (0) cases were deferred. Three (3) cases were tabled for further information. There were two (2) cases with CAPs outstanding/continued monitoring, and two (2) cases are pending closure for CAP compliance.	
#8 Access Business - Access Workgroup Quarterly Report (Q3 2025) (Attachment PP) **Action**	The **Access Work Group Quarterly Report (Q3 2025)** was presented and reviewed. This report is 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. Access Workgroup meetings were held on 6/24/25 and 7/29/25. A list of all the reports that were reviewed on 6/24/25 and 7/29/25 can be found in Appendix A.	**Motion: *Approve*** - Access Workgroup Quarterly Report (Q3 2025) (Pascual/Waugh) 6-0-0-1

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Patrick Marabella, M.D., Chair	The following are some of the key standing reports/matters approved and discussed: 1. **MY 2024 Integrated Accessibility Report** – This report presents access metrics that fall under two categories: metrics for the access "Rate of Compliance", as required by the Department of Managed Health Care (DMHC) such as the Provider Appointment Availability (PAAS) Survey and the Department of Health Care Services (DHCS) standards, and other metrics CVH uses to monitor access to care that are not part of the Rate of Compliance. Additionally, CVH administered a separate Expanded Appointment Set (EAS) to assess the timeliness of routine care appointments for preventative checkups, physical exams, and prenatal visits. The Integrated Accessibility Report also included results from both the Provider Satisfaction Survey and the Enrollee Experience Survey, and a monitoring of member grievances across all four (4) 2024 quarters. • Timely Access Metrics - MY 2024 PAAS results show that the seventy percent (70%) DMHC compliance threshold was met for both Urgent Care and Non-Urgent appointments across all survey types **when combined across all counties,** even though individual providers may not have met the compliance threshold. County-level results include CVH's providers in the network service area counties (Fresno, Kings, Madera) and all counties adjacent to the health plan's network service area where providers are located. It should be noted that DMHC does not focus on individual specialties, but rather the CAP submitted for the TAR filing was based on a plan-wide aggregate view and not broken down by specialty. • After-Hours Survey - The Provider After-Hours Survey was fielded via telephone to CVH PCPs. The survey collected responses based on two metrics used to measure performance with Access to After-Hours: • Appropriate After-Hours Emergency Instructions: percent of providers who give clear and appropriate instructions for emergency issues. • Ability to contact on-call physician after-hours – percent of providers that can be contacted within thirty (30) minutes for urgent issues. The performance goal of ninety percent (90%) was met in all three (3) CVH counties for both After-Hours Emergency Instructions and the Ability to contact an on-call physician after hours • Provider Satisfaction Survey - Overall results indicate satisfaction rates ranged approximately	

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	between sixty-six percent and seventy-two percent (66% and 72%), which was a decrease from the prior year's results, which ranged between seventy-four percent and eighty-three percent (74% and 83%). • Enrollee Satisfaction Survey - In 2024, CVH conducted its annual enrollee experience survey, the California Timely Access Enrollee Experience Survey (EES). Due to the survey administration methodology, county-level results are not captured. • The CAHPS© Survey - In MY2024, CVH participated in the Health Services Advisory Group, Inc. (HSAG) annual CAHPS© survey. The survey uses standardized NCQA questions to assess member experience with the health plan and health plan providers. The CAHPS® member satisfaction surveys were fielded from February to May for each reporting year (RY). The survey questions are based on the members' experience twelve (12) months prior to the survey date for CAHPS®. • Behavioral Health Survey - CVH also conducted a survey, which included members who used behavioral healthcare services between March 1, 2023, and February 28, 2024. The Experience of Care and Health Outcomes (ECHO) Survey for MY 2024 assessed member satisfaction regarding Urgent and Non-Urgent Appointments. • Member Grievances – For MY2024, CVH monitored member grievances related to access by analyzing the volume and PTMPY rates of two (2) types of grievances – Quality of Service (QOS) and Quality of Care (QOC) grievances. Member grievances reported by service area counties (Fresno, Kings, Madera) are "Resolved" grievances available at the time of data collection. o Fresno County reported six (6) Quality of Care (QOC) grievances. For Quality of Service (QOS) grievances, Fresno saw decreases in all quarters compared to MY 2023, except for Q3. The top three (3) grievances observed in Fresno were related to *Prior Authorization Delay, PCP Referral for Services, and Availability of Appointment with a Specialist.* o Kings County reported two QOC grievances for MY 2024. QOS grievances decreased in all quarters compared to MY 2023, except for Q3. The top three grievances observed in Fresno were related to *Prior Authorization Delay, Transportation-Missed Appointment, and Availability of Appointment w/ PCP.* o Madera County also reported two (2) QOC grievances for MY 2024. For QOS grievances, Madera saw decreases in all quarters compared to MY 2023, except for Q1 and Q4. The top three (3) grievances observed in Fresno were related to *Transportation-Missed Appointment, Prior Authorization Delay, and Availability of Appointment w/ PCP.*	

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	Barriers and Actions for Improvement: CVH has identified potential barriers and taken actions to improve timely access and member satisfaction as follows: • Based on results from the 2024 PAAS, CVH provides deficient PPGs with a CAP and direct network providers with educational packets. • BH providers with low PAAS scores will receive notification of their results along with a provider feedback form to gather additional insight into the barriers they are experiencing. • Provider Updates with alerts of upcoming surveys and results of the surveys are sent. These include recommendations, tips, and tools for improving timely access and after-hours access. • Conduct a series of online provider education webinars on timely access and after-hours standards, best practices, survey readiness, etc. • The Plan has established performance-based incentive programs included in provider contracts to improve timely access standards. • The Plan reviews access-related member grievances continuously and identifies providers/provider groups with a high volume of grievances. Action is taken by the Plan when provider-specific patterns or trends are identified. These activities are coordinated by the Plan's medical review team and Provider Network/Provider Engagement team. 2. MY2024 Integrated Availability Report – This report monitors and evaluates access to medical and behavioral health care providers, hospitals, ancillary services, and member grievances related to time and distance from providers. The goal is to ensure members have sufficient and timely access to the care they need, whether from a practitioner, provider, or healthcare service. The report also assesses the ratio of members to Practitioner/Provider, the percentage of PCPs and Specialists who are open to new members, and the ratio of members to hospital beds. Overall results indicated the Plan is meeting the ratio standards and the time and distance standards. The only exceptions are for Urgent Care Facilities and limited specialists in Kings County. Contracting efforts are ongoing to fill the gaps. **7/29/25 Access Workgroup Meeting:** • MY2024 Provider Access & After-Hours Appointment Availability and Behavioral Health Survey The survey results that were previously presented at the 6/24/25 meeting were reviewed to	

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	indicate which providers were issued CAPS for not meeting the compliance threshold. Seven (7) PPGs were issued CAPs, and six (6) direct network providers were issued CAPs. Twelve (12) PPGs were issued educational packets, and twenty (20) direct network providers were issued CAPs. • CY2024 Alternative Access Network Adequacy - When the Plan does not meet time or distance standards for a particular specialty in a geographic area (i.e., zip codes), an exemption request is filed with the Department of Managed Health Care (DMHC) and with the Department of Health Care Services (DHCS) through an alternative access standard (AAS). Sixteen (16) PCP and thirty (30) Hospital AAS needed to be submitted to the DMHC. 287 AAS requests were submitted to the DHCS across both adult and pediatric measurement categories.	
#9 Compliance Update - Compliance Regulatory Report (Attachment QQ)	Mary Lourdes Leone presented the **Compliance Report.** **CVH Oversight Activities: Health Net:** CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participates in joint work group meetings, and discusses 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 Center, Claims/PDR, A&G, Internal Compliance FWA, UMCM, Member Rights, Privacy and Security, and Provider Network. The following annual audits have been completed since the last Commission report: Health Equity (CAP). **Fraud, Waste & Abuse Activity.** Since the 7/17/2025 Compliance Regulatory Report to the Committee, there were four (4) new MC609 filings: One (1) case was a participating provider who was billing services not rendered and medically unnecessary services; One (1) case is regarding a provider who routinely billed high-level Evaluation and Management (E/M) services at a rate that was significantly higher than their peers; One (1) case is a non-participating provider, allegedly billing for services not rendered; and one (1) case is regarding a non-participating wound care provider who allegedly had excessive high unit prior authorization requests.	

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	Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation. Per DHCS's request, on 8/4/25, CVH submitted an updated/Final CAP summary document to DHCS. The Plan is anticipating DHCS's acceptance and CAP closure. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit.** The DMHC conducted the Follow-Up Audit on May 5, 2025. It has been five months since the DMHC requested any additional information. The Plan is awaiting the DMHC's Final Audit Report. "Inappropriately denying post-stabilization care" is the principal deficiency for which the DMHC must determine whether the Plan had corrected it by the time of the 5/5/25 Follow-Up Audit. **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. The Plan is awaiting both reports. **2024 Network Adequacy Validation (NAV) Audit.** The virtual audit was conducted on 8/21/25 by DHCS's external review organization (HSAG). The Plan submitted follow-up requests on August 26, 2026, and is awaiting a Final Report. Preliminary feedback from the HSAG Auditor was very positive as it relates to the thoroughness of the Plan's systems and processes that support network development, monitoring, and overall integrity. The auditor was particularly impressed with the excellent slide presentations, which clearly and thoroughly described those systems and processes and their various relationships/dependencies in generating the reports that the Plan and the DHCS rely upon for network reporting. **California Advancing and Innovating Medi-Cal (CalAIM).** Transitional Rent is a new Community Support service under CalAIM designed to provide up to six (6) months of rental assistance to Medi-Cal members who are experiencing or at risk of homelessness and meet specific clinical and situational eligibility criteria. Coverage of Transitional Rent was *optional* for Medi-Cal managed care health plans beginning on January 1, 2025, and *required* for plans by January 1, 2026. CalViva submitted its Model of Care (MOC) documents on 9/2/2025 and is awaiting DHCS' review and approval for the Plan's 1/1/26 go-live. **Memorandum of Understanding (MOU):** Since the last Commission Meeting, the Plan has executed	

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	and submitted to DMHC & DHCS the following MOUs, which have also been posted to CVH's website: • Fresno County Local Health Department (LHD) MOU • Kings County First Five (5) MOU As required by the DHCS contract, these MOUs have also been posted on the CalViva Health website under Key Documents and Forms: www.calvivahealth.org/meeting-agenda/procedures-forms/ **Annual Network Certifications:** • 2024 Subnetwork Certification (SNC) Landscape Analysis – On 1/3/2025, the Plan submitted the 2024 SNC deliverable. Within the submission, the Plan reported that CalViva issued Corrective Action Plans (CAPs) to certain providers due to network adequacy deficiencies. As a result, DHCS has requested that the Plan submit quarterly updates on the status of these CAPs until they are fully resolved. The most recent quarterly update was submitted on 7/1/2025. • 2024 Annual Network Certification (ANC) - On 7/22/25, DHCS sent a Preliminary Determination with four AAS denials. The Plan responded to that letter on 7/24/25, and we are awaiting a response. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR)RY 2023 MY 2022.** On 5/1/2025, the Plan submitted the Annual 2025 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 DMHC All Plan Letters (APLs) that have been issued in CY 2025. **Public Policy Committee (PPC):** The Public Policy Committee meeting was on September 3, 2025. The following standing reports were presented: • Q1 and Q2 Semi-Annual Member Incentive Program • Q2 Appeals and Grievance Report, including additional perspective on specific issues/trends from Dr. Marabella. Additionally, information was shared regarding the 2025 EOC Errata, the DHCS Community Reinvestment Plan, and the 2025 Annual New Member Understanding Report. There were no recommendations or action items requiring a response from the Commission.	

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	The next Public Policy Committee meeting will be held on December 3, 2025, 11:30 am -1:30 pm, located at 7625 N. Palm Ave, Suite 109, Fresno, CA 93711.	
#11 Old Business	None.	
#12 Announcements	The next meeting is on October 16th, 2025.	
#13 Public Comment	None.	
#14 Adjourn	The meeting adjourned at 12:18 p.m.	

NEXT MEETING: October 16th, 2025

Submitted this Day: October 16, 2025

Submitted by: Amy Schneider RN

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X

Patrick Marabella, M.D., CMO, Committee Chair