Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
October 16th, 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 10:03 am.	
#2 **Approve Consent Agenda** Committee Minutes: September	The September 18th, 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	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
18, 2025 - QI/UM Committee Meeting Calendar 2026 (Draft) - Standing Referrals Report (Q2 2025) - Specialty Referrals Report- HN (Q2 2025) - Provider Preventable Conditions (Q2 2025) - TurningPoint Musculoskeletal Utilization Review (Q2 2025) - SPD HRA Outreach Report (Q2 2025) - Access Workgroup Minutes 07/29/2025 - Behavioral Health Performance Indicator Report (Q2 2025) (Attachments A-I) **Action** Patrick Marabella, M.D., Chair	for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Ramirez/Cardona) 6-0-0-2
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (August 2025) (Attachments J) **Action** Patrick Marabella, M.D., Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through August 2025 were presented. The total Grievances received for August 2025 were 204, with one (1) Ack letter out of compliance. • There were 192 Quality of Service Grievances: twenty-two (22) Balance Billing; five (5) Community Supports (meals); and sixteen (16) Transportation Access for missed appointments. • There were six (6) Quality of Care Grievances, which are lower than the previous months. • There were 170 Exempt Grievances, sixty-four (64) were requests to change PCP Assignment, one (1) Transportation No Show, and thirty (30) Balance Billing. There were 45 total Appeals received in August, which remains consistent with recent months. • There were sixteen (16) Community Supports (housing and rental assistance).	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (August 2025) (Quezada/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• There were twelve (12) Advanced Imaging (non-cardiac). A new vendor will start next month. • The uphold rate was 38%, the full overturn rate was 48%, and the partial overturn rate was 12%.	

#3 **QI Business**
- Facility Site & Medical Records and PARS Review Report (Q1 and Q2 2025)
 	
(Attachment K)
 	
Action
Patrick Marabella, M.D., Chair
	The Facility Site & Medical Records and PARS Reviews (Q1 and Q2 2025) report displays completed activity and results of the DHCS-required PCP Facility Site (FSR) and Medical Record Reviews (MRR). All CVH counties are using the DHCS APL 22-017 for FSR/MRR; however, with new FSR/MRR tools and standards that began 7/1/22, and Policy Letters 12-006 and 15-023 for Physical Accessibility Review Survey (PARS) assessment of providers. The results are analyzed for monitoring and improving the performance of PCPs against DHCS and CVH standards.
	• Thirty (30) FSRs and thirty (30) MRRs were completed during the 1st and 2nd Quarters of 2025.
	• The FSR mean rate for Q1-Q2 2025 was 96%.
	• The MRR mean rate for Q1-Q2 2025 was 91%.
	  o The Adult Preventive Care mean score over all counties for Q1-Q2 was 85%.
	  o The Pediatric Preventive Care mean score over all counties for Q1-Q2 was 90%.
	• Twenty-seven (27) PCP PARS were completed in Q1 and Q2 2025 with 17/27 PARS having Basic level access.
	• Interim Review is a DHCS-required monitoring activity to evaluate the PCP site between the 3-year periodic FSR cycle; the minimum review includes the fourteen (14) Critical Elements. In the 1st and 2nd Quarters of 2025, thirty-four (34) interim reviews have been completed in the three (3) CVH counties.
	• There was one (1) "dirty office" complaint received. The FSR department conducts a site visit for provider sites that have three (3) complaints in a rolling 6-month period per FSR and Credentialing policies.
	• Certified Site Review Nurses provide educational training prior to the actual FSR/MRR evaluation. Educational Trainings allow provider sites to become familiar with the DHCS regulations and FSR/MRR processes and can be done on-site if requested. There were twenty-two (22) onsite educational trainings completed in the 1st and 2nd Quarters of 2025.
	
	Discussion:
	As the Blood Lead Anticipatory Guidance rates are low for all MCPs, Dr. Marabella opened a
		Motion: *Approve*
		- Facility Site & Medical Records and PARS Review Report (Q1 and Q2 2025)
		
		(Cardona/Quezada)
		6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	discussion with the Committee regarding their use of the CPT Code in conjunction with Blood Lead testing during WCV exams. A CAP has been issued to HN regarding the use of this code, but Dr. Marabella wanted to know how the Committee members document the provision of anticipatory guidance and what computer system they use in their individual practices. *Dr. Faulkenberry stated that they use Athena's templates, but they must manually enter the code used. It does not alert the provider to document.* *Dr. Quezada uses the template in their E. Clinical Works system.* *Dr. Ramirez (Camarena Health) gives their patients a paper handout, but providers do have to remember to document it in their Athena system.* *Dr. Cardona must check a box in the EPIC system, but unfortunately, his EMR system is not connected to his billing system, so a code is not picked up.* *Dr. Marabella thanked committee members for this information as we work toward improving compliance with this process.*	
#4 Key Presentations - Health Equity 2025 Work Plan Mid-Year Evaluation & Executive Summary (Attachment L) Action Patrick Marabella, M.D., Chair	The Health Equity 2025 Work Plan Mid-Year Evaluation & Executive Summary was presented and reviewed. By June 30th all activities were on target for end-of-year completion, with some already completed. All the Work Plan activities are on target for completion by the end of the calendar year 2025. Will continue to assess circumstances to modify plans as needed in order to continue to implement, monitor, and track Health Equity-related services and activities. The 2025 Work Plan is divided into five (5) Categories: 1. Language Assistance Program 2. Compliance Monitoring 3. Communication, Training, and Education 4. Health Literacy, Cultural Competency & Health Equity 5. CVH-specific internal activities Some Completed Activities Include: • Completed audit requirements for Behavioral Health and Health Equity Oversight. • Amended three (3) language vendors' contracts, the amendments include DEI training for interpreters and updates on rates. • Fifty-two (52) staff completed bilingual assessments or were reassessed. • Fifteen (15) grievance cases reviewed with one (1) intervention and five (5) interpreter complaints. • 1,279 referrals were made in Findhelp, with 157 closed-loop referrals, 37 members got help,	**Motion:** *Approve* - Health Equity 2025 Work Plan Mid-Year Evaluation & Executive Summary (Quezada/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	and 375 new programs were added to the platform. • Provider materials were made available in the Provider Library, including the LAP program and "Findhelp How-To" guide. • English material review was completed for a total of 31 materials. • W30-6+ Project: 23 (15.54%) members self-reported taking their babies to their IWC visit. CDC's Milestone Tracker App scans for BIH members: 50 Apple Store, 28 Google Play. Member incentives distributed up to June 2025 included 287 $25 gift cards and 36 gift baskets. CVH Internal Equity Activities Include: • NCQA Health Equity Accreditation in June 2025. • Health Equity training for all staff (Cultural Competency, Implicit Bias, Historical Trauma and How it Influences Modern Medical Practices, CVH members, and How They Are Impacted) – planned for 12/5/25. • Completed Network Improvement Committee (NIC) Activity, involving the support of Fresno County Superintendent of Schools and their cohort students reading on grade level affected by SDoH. • Perimenopause/Menopause pilot project campaign in Kings County was launched in September. The first focus group will be hosted by Kings County Action Organization in October. *There were no questions or comments from committee members.*	
#3 **QI Business** - Health Equity 2025 Language Assistance Program Report (Semi-Annual) (Attachment M) **Action** Patrick Marabella, M.D., Chair	The **Health Equity 2025 Language Assistance Program Report (Semi-Annual)** provides information on the language service utilization by CVH members from January 1st to June 30th, 2025, as well as updates on the Language Assistance Program (LAP) areas. This report also incorporates Behavioral Health language utilization by CVH members for the same reporting period. Member Services Department representatives handled a total of 81,375 calls across all languages during this reporting period. Of these, 54% (44,136) were handled in Spanish and Hmong languages (CVH's threshold languages). Behavioral Health's (BH) Member Services Department representatives handled 2,294 calls across all languages, and an increase in calls handled in a language other than English of 17% (381). • As of June 30, 2025, CVH membership totaled 431,963 members with 68% Latino/Hispanic, 10% White/Caucasian, 9% Asian/Pacific Islander, and 4% African American/Black. 230,861 members self-identify as female, and 201,102 self-identify as male. • A total of 2,300 interpreter requests were fulfilled for CVH members, predominantly 79% (1,820) of these requests were fulfilled utilizing telephonic interpreter services, with an 18%	**Motion:** *Approve* -Health Equity 2025 Language Assistance Program Report (Semi-Annual) (Quezada/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(419) increase for in-person services, 3% (61) for sign language interpretation, and no requests for video remote interpreting. • Of the BH calls handled in Q1-Q2 2025, 97% (489) were handled in Spanish, 3% (13) were in other non-English languages, and 0% (0) were handled in Hmong. • Two hundred fifty-three (253) requests for interpreter services were fulfilled for BH. Of these requests, 28% (71) were fulfilled with in-person, 60% (151) with sign language interpretation, 0% (0) with telephone interpretation*, and 12% (31) with Video Remote Interpretation. *Unable to gather telephone interpretation requests from our BH Member Service Dept. due to recent integration between medical and BH telephone services. Will be able to better collect data in 2026. • A total of fifteen (15) grievance cases were reviewed by the Health Equity Department between January – June 2025 (14 Medical & 1 BH). o Of the fourteen (14) medical cases, eight (8) were coded as "culture perceived discrimination", one (1) was coded as "culture non-perceived discrimination", none were coded as "linguistic perceived discrimination", and five (5) were coded as "linguistic non-perceived discrimination". • One (1) provider-related case required intervention, prompting collaboration with the Provider Engagement Department to deliver targeted tools and training on cultural competence, sensitivity, and language services. • One (1) grievance involved behavioral health services, and five interpreter complaints were received and resolved during the same period. *There were no questions or comments from committee members.*	
#4 Key Presentations - Quality Improvement and Health Equity Transformation Program (QIHETP) 2025 (Attachment N) Action Patrick Marabella, M.D., Chair	The **Quality Improvement and Health Equity Transformation Program (QIHETP) 2025** was presented and reviewed. QIHETP is an overarching guiding document that describes how the various components of Quality Improvement, Health Equity, and Population Health function together as an efficient integrated system to continuously improve upon and facilitate equitable, high-quality care and services for all CVH members. **QIHETP:** • Meets the DHCS Contract Standard D.0022. • Requires an Annual DHCS Submission. • Requires a CVH Website Publication. • Requires the Allocation of Resources.	**Motion:** *Approve* - Quality Improvement and Health Equity Transformation Program (QIHETP) 2025 (Ramirez/ Faulkenberry)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Assigns Responsibility to the RHA Commission and the QI/UM Committee. o The QI/UM Committee is responsible for reviewing, analyzing, evaluating, and acting on the results of QI and Health Equity activities and ensuring appropriate follow-up on performance deficiencies and gaps in care. **QIHETP & Established Programs:** Existing Programs: o Quality Improvement Program & Work Plan o Health Equity Program & Work Plan o Performance Improvement Projects (PIPs, Lean Projects, and Collaboratives) o Population Health Management Strategy Description & PHM Reports The QIHETP describes each of these programs and integrates them. Utilizes the Health Equity Model to reduce Disparities. **Other Components of QIHETP:** • Delegated & Downstream Delegated Subcontractors. o How the Plan ensures delegated functions such as Utilization Review, Credentialing, and Case Management meet standards. o Including Annual Oversight Audits of Delegates. • External Quality Review (EQRO) Technical Report o Health Plans must address findings from HSAG's publicly available Annual Technical Report. • Requires NCQA Accreditation- evidence of Health Plan and Health Equity accreditation must be shared with DHCS and posted on our website. The QI/UM Committee is charged with identifying health disparities while monitoring medical management services, and the quality of care and services provided to members from several data sources: • Encounter Data • Grievances and Appeals • Utilization Data • Satisfaction Surveys (CAHPS) From various data sources, the QI/UM Committee must identify and select opportunities for improvement and monitor and evaluate the effectiveness of interventions with an emphasis on: • Member & Family Engagement	6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Community Engagement • Reducing Disparities **Health Equity Model:** Disparity reduction efforts are implemented through a model that integrates across QI, Provider Engagement, Health Equity, Community Engagement, Health Education, and Public Programs. **Updates for 2025:** • Section 4.1C. (page 6) Added specific reference to the Annual and Mid-Year QI & Health Ed Work Plan and Work Plan Evaluations. • Section 4.2 B. (page 6) Simplified description of the 6 content areas of the Health Equity Work Plan. • Section 5.1 C. (page 7) Added description of the annual review process of the EQRO Technical Report. • Section 6.B. (page 8) Added Long Term Care to Services covered. • Section 7A. (page 10) Clarified CAHPS goal is to "...meet or exceed the Quality Compass 25th percentile benchmark or demonstrate greater than a 1% year-over-year improvement". • Section 7.1.A (page 11) Updated and clarified language regarding the CAHPS survey data breakdown and analysis. • Section 7.1.C (pages 12-13) Described the revised Population Needs Assessment process to include: o Participating in the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions. o Continue to develop a PHM Strategy Description describing how member needs are met along the continuum of care to meet NCQA standards. o Complete an Annual Assessment of member needs and characteristics, including identification of subpopulations. o Work with other Managed Care Plans in the region to develop a unified planning process, including staffing, funding, data sharing, and communication. Including continued involvement in Community Reinvestment and engagement with the Public Policy Committee (PPC). • Section 9.A (page 14) Updated language to indicate CVH has obtained Health Equity Accreditation.	

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.	• Other minor edits throughout, including updates to Health Equity Department Staff Roles and Responsibilities in Appendix 1. *There were no questions or comments from committee members.*	
#4 **Key Presentations** - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q2 2025) (Attachment O) Action Patrick Marabella, M.D., Chair	The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q2 2025)** was presented and reviewed. The 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 (ED and inpatient), DHCS Supplied WQIP Data- scoring system that uses a combination of metrics across workforce, clinical quality and equity domains to determine incentive payments for skilled nursing facilities. Publicly Available Data is also used (CMS & CDPH data including survey and complaint data, and critical incident – never events), and MCAS/HEDIS® Long Term Care measures. 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 rates • Pressure ulcers • UTI rates	**Motion:** *Approve* - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q2 2025) (Cardona/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• 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 is used 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 scale using metrics in Quality Categories for Q2 2025: o Top Ten (10) SNFs in CVH Service Region by Unique Member Utilization. o Overall Top and Bottom Performing SNFs in CVH Region. o Lowest and Highest Five (5) Performing SNFs serving CVH members. 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 and Falls. They have shown improvement in their rate of UTIs. This facility is implementing the following to improve its quality outcomes: • Hydration Rounds • Pharmacy Education • Physical Therapy Team Rounds 2. Madera Rehabilitation & Nursing Center: Analysis of publicly available data shows a higher-than-state-average use of Antipsychotic Medications and Falls. They have shown improvement in their prevalence of Pressure Ulcers. This facility is implementing the following to improve its quality outcomes:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Emergency Department Companion Program (Q4) • Pharmacy Education • Physical Therapy Team Rounds 3. Community Subacute & Transitional: Analysis of publicly available data shows a better-than-average Fall rate and Antipsychotic Medication use. Rates of UTI and Pressure Ulcers are higher than the state averages, resulting in higher-than-expected ED utilization and inpatient admissions. This facility is implementing the following to improve its quality outcomes: • Hydration Rounds • Physical Therapy Team Rounds Barrier Analysis: • Staffing Challenges in the Central Valley: Facilities report challenges with recruiting and retaining qualified Certified Nursing Assistants. • Unreported Falls – Data analysis reveals under-reporting of patient falls at SNFs according to "Nursing Homes Failed to Report 43% of Falls": MDS 3.0 assessments are used to capture patient changes in conditions resulting in the identification of a fall as the cause for a change in condition. ***Discussion:*** *Dr. Cardona asked if the UTI cases are reported from the facility or the ED?* *Dr. Marabella stated that the data comes from the ED claims.* *Dr. Quezada asked what happens if the SNFs don't show improvement in rates in Q3 and Q4?* *Dr. Marabella stated that additional actions will need to be taken. The Quality Team from HN, who put this report together, will continue to track and monitor the SNFs and report these results to us. If initial strategies aren't successful, they will reassess and modify the improvement plan. They can implement and modify ideas like hydration rounds, Case Management rounds, work with contracting and corporate management, and issue CAPs, etc.* *This committee is responsible for overseeing this and ensuring appropriate actions are taken.* *Mary Lourdes Leone asked at what point would the State Licensing Board indicate rates are unacceptable?* *Dr. Marabella said that the state is monitoring and also has the responsibility to oversee SNFs and that it is a collaborative process with the MCPs. Some of the data we are using to prepare this*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	report comes from the state auditing and complaint reporting, based upon onsite surveys and for-cause visits. LTC was mostly Medicare's responsibility until recently.	
#5 **UM/CM/PHM Business** - Key Indicator Report and Turnaround Time Report (August 2025) (Attachments P) Action Patrick Marabella, M.D., Chair	The **Key Indicator Report and Turnaround Time Report** through August 2025 were presented. • Utilization has remained consistent over the previous months. Expansion, TANF, and SPD utilization have been on a downward trend. • Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for all categories remain low with a slight increase. • Perinatal Case Management referrals have a 68% engagement rate for 204 referrals. • Physical Health Case Management referrals have a 63% engagement rate for 402 referrals. • Transitional Care Services' (TCS) engagement rate is 83%, a slight decrease from the beginning of the year. Referral numbers have steadily increased from the beginning of the year to 642 for August. TCS receives all the Care Management cases initially and then refers them to the different departments accordingly. • Behavioral Health Case Management referrals have a 69% engagement rate with 121 referrals. • First Year of Life Case Management referrals have demonstrated variation, but they have a 97% engagement rate for the thirty-seven (37) referrals for August. • A CAP was issued for Health Net for the Turnaround Times (TATs) regarding Preservice Urgent Deferrals and Preservice Routine Deferrals. A decline in compliance was noted in Deferral turn-around times in the first six months of the year, and gradually improved to 93% and 94% respectively, for August. The model for nursing staff changed from a mix of LVNs and RNs doing the prior authorizations and appeals to a staff of all RNs. The hiring and onboarding of new RNs took longer than anticipated, and we hope to see improvement in TAT rates once everyone has been fully trained, at which point we will close the CAP.	**Motion:** *Approve* - Key Indicator Report and Turnaround Time Report (August 2025) (Faulkenberry/ Quezada) 6-0-0-2
#5 **UM/CM/PHM Business** - Medical Policies (August 2025) (Attachments Q) Action Patrick Marabella, M.D., Chair	The **Medical Policies (August)** 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 August 2025 include, but are not limited to: • CP.MP.165 – Selective Nerve Root Blocks and Transforaminal Epidural Steroid Injections • CP.MP.166 – Sacroiliac Joint Interventions for Pain Management	**Motion:** *Approve* - Medical Policies (August 2025) (Ramirez/Quezada) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CP.MP.247 – Transplant Service Documentation Requirements	
#6 **Policy & Procedure Business** - Public Health Policy & Procedure Annual Review (Attachments R) Action Patrick Marabella, M.D., Chair	The **Public Health Policy & Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with no changes made: • PH-001 Electronic Visit Verification • PH-002 In-Home Operations Waiver and Home and Community-Based Alternatives (HCBA) Waiver • PH-003 Adult Preventive Services • PH-004 Pediatric Preventive Care Services • PH-006 Vision Care • PH-009 School-Based Health Programs • PH-010 Dental Care • PH-013 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services • PH-014 Immunization Program • PH-017 Communicable Disease Reporting • PH-018 Access to Certified Nurse Practitioners • PH-019 Minor Consent • PH-020 Mental Health Services • PH-021 Mental Health Dispute Resolution • PH-022 Alcohol and Drug Treatment Services • PH-023 Non-Specialty Mental Health Services • PH-024 Eating Disorder Treatment Services • PH-027 Dyadic Services • PH-029 Behavioral Health Screening, Assessment, Care Coordination, and Exchange of Information • PH-051 Genetically Handicapped Persons Program (GHPP) • PH-052 Children with Special Health Care Needs (CSHCN) • PH-062 Non-Emergency, Non-Medical Transportation Assistance and Coordination • PH-088 Public Health Coordination • PH-089 Community Health Worker Guidelines • PH-101 Perinatal Care • PH-102 Doula Services	Motion: Approve - Public Health Policy & Procedure Annual Review (Quezada/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• PH-103 Access to Freestanding Birth Centers and the Provision of Midwife Services • PH-104 Family Planning Services • PH-105 Pregnancy Termination The following policies were presented for annual review and were approved with updates to the definition section: • PH-015 Sensitive Services • PH-016 Local Education Agency (LEA) • PH-041 Department of Developmental Services (DDS) Administered Home and Community Based Waiver Program. Updated definition of medical necessity. • PH-050 California Children's Services (CCS). Added definition of CCS Liaison. • PH-053 In-home Supportive Services Program Waiver (IHHS) The following policies were presented for annual review and were approved with the following changes: • PH-008 Early Start Program: Added information about LEA and CHW. • PH-025 Behavioral Health Treatment Services autism spectrum disorder. Added language that requires the Plan to monitor behavioral treatment plans by tracking expiration dates (every 6 months) and notifying providers at least 30 days in advance to prevent gaps in service. • PH-026 Behavioral Health. Revised to be consistent with new APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services. The full policy was included in the meeting materials for committee approval. • PH-028 Responsibilities for Behavioral Health Treatment Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. Added language that requires the Plan to monitor behavioral treatment plans by tracking expiration dates (every 6 months) and notifying providers at least 30 days in advance to prevent gaps in service. • PH-042 HIV Testing and Counseling. Policy updated to be consistent with APL 25-011. Updated CPT codes allowed for use by non-contracted providers to be reimbursed for confidential HIV testing and counseling without prior authorization. • PH-043 Sexually Transmitted Diseases (STD) Services. Formatting updates throughout and language updates to Out of Network Coordination. • PH-048 Regional Centers Coordination. Removed MHN and replaced with Health Net Behavioral Health.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The following is a new policy that was approved: • PH-049 Child Welfare Liaison Requirements – The full policy was provided in the packet.	
#7 **Oversight Audits** - Appeals and Grievances Oversight Audit (Attachment S) Action Patrick Marabella, M.D., Chair	The **Appeals and Grievances Oversight Audit** was presented and reviewed. The overall compliance rate for HNCS for the Appeal and Grievance function is 96% based upon the number of compliant standards divided by those reviewed in the audit grid 26/27, including positive overall file review results of 97% compliance (122/125). One area of opportunity for improvement was identified related to the reconciliation of Discrimination-related grievances between CalViva and HealthNet. There was a discrepancy of three (3) cases between our Plans. Following the 8/30 rule, a review of 125 randomly selected digital and audio cases was completed from the audit period of January 2024 to December 2024. The breakdown of cases is as follows: • Twenty-Nine (29) Exempt Appeal & Grievance Cases o Eight (8) Exempt Grievance Cases - 100% compliance (8/8) o Eight (8) Exempt HIPAA compliance verification audio files (CCC) - 100% compliance (8/8) o Eight (8) Exempt Grievance Cases – ModivCare - 100% compliance (8/8) o Five (5) Exempt Grievance Cases- HN BH - 100% compliance (5/5) • Thirty (30) Standard Appeal & Grievance Cases - 100% compliance (30/30) • Two (2) Independent Medical Review (IMR) Overturn Cases - 100% compliance (2/2) • Twenty (20) Expedited Grievances- HN - 100% compliance (20/20) • Thirty (30) State Fair Hearing (SFH) Cases - 100% compliance (30/30) • Fourteen (14) Discrimination Grievance Cases - 79% compliance (11/14) **Corrective Action Plan:** On May 23, 2025, the CVH Compliance Department issued a Corrective Action Plan (CAP) to HN after two (2) Discrimination Grievance cases failed to be reported within the required seven (7) calendar day timeframe. HN submitted and implemented a CAP, which was accepted and closed by CVH Compliance on September 8, 2025. Given that the corrective actions have been formally implemented and closed by CVH Compliance, CVH Medical Management will not issue a duplicate CAP for this audit. However, this remains an area of heightened sensitivity and regulatory risk, with potential DHCS sanctions if late or inaccurate reporting recurs.	Motion: Approve - Appeals and Grievances Oversight Audit (Cardona/Ramirez) 6-0-0-2
#8 **Compliance Update**	The **Compliance Report** was presented and reviewed.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Compliance Regulatory Report Mary Lourdes Leone, CCO (Attachment T)	**CalViva Health Oversight Activities: Health Net:** CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings, and discuss any issues or questions during the monthly oversight meetings with HN. CVH and HN also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. The reports cover PPG-level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals etc. **Oversight Audits.** The following annual audits are in progress: Access & Availability, Marketing, Call Center, Claims/PDR, Internal Compliance FWA, UMCM, Privacy and Security, Transportation, and Provider Network. The following annual audits have been completed since the last Commission report: A&G (No CAP), Health Education (CAP issued to HN), and Member Rights (No CAP). **Fraud, Waste & Abuse Activity.** Since the 9/18/2025 Compliance Report to the Committee, there have been no new MC609 filings. **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 continues to await DHCS' 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. The Plan continues to await 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 Plan is in the process of scheduling the Exit Interview for October. **2025 Network Adequacy Validation (NAV) Audit.** The virtual audit was conducted on 8/21/25 by	

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	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 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. CVH submitted its Model of Care (MOC) documents on 9/2/2025. Following its review, DHCS requested clarification on a number of items. The Plan submitted a response on 10/7/2025 and is awaiting final review and approval from DHCS. **Memorandum of Understanding (MOU):** Since the last Commission Meeting, the Plan has not executed any MOUs. **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 9/25/2025. • 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. • 2025 Subnetwork Certification (SNC) Landscape Analysis- On 9/26/2025, DHCS sent guidance for the 2025 SNC Landscape Analysis deliverable. The Plan is preparing a response, which will be submitted by the 10/31/2025 deadline.	

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	(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR): • On 4/18/25, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access standards (i.e., time and distance) for PCPs and Hospitals, and for Provider Data Accuracy. The Plan submitted a formal response on 7/17/25, which indicated a separate Material Modification would be submitted to the DMHC to request new time and distance standards for specific zip codes. • On 8/12/25, the Plan submitted the Material Modification for alternate access standards and on 9/10/25, the DMHC notified the Plan that it was postponing the review due to DMHC having additional comments. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** 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 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.	
#9 **Old Business**	None.	
#10 **Announcements**	The next meeting is on November 20th, 2025.	
#11 **Public Comment**	None.	
#12 **Adjourn**	The meeting adjourned at 11:11 a.m.	

NEXT MEETING: November 20th, 2025

Submitted this Day: November 20, 2025

Submitted by: Amy Schneider RN

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X

Patrick Marabella, MD, CMO, Committee Chair