Fresno-Kings-Madera Regional Health Authority

CalViva Health QI/UM Committee Meeting Minutes

February 19th, 2026

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 McDivitt,** 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 Sihota, 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, MD, Chair	The meeting was called to order at 10:03 AM. A quorum was present.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#2 Approve Consent Agenda Committee Minutes: November 20, 2025 - A&G Inter-Rater Reliability Report (Q4 2025) - A&G Classification Audit Report (Q4 2025) - A&G Member Letter Monitoring Report (Q4 2025) - Customer Contact Center DMHC Expedited Grievance Report (Q4 2025) - Concurrent Review IRR Report (Q4 2025) - Member Incentive Programs Semi-Annual Report (Q3 & Q4 2025) - Call Center Inquiry Audit Report (Q4 2025) - Enhanced Care Management and Community Supports Performance Report (Q3 2025) - Provider Office Wait Time Report (Q4 2025) - Provider Preventable Conditions (Q4 2025) - County Relations Quarterly Report (Q4 2025) - California Children's Services Report (Q4 2025) - SPD HRA Outreach (Q3 2025) - TurningPoint Musculoskeletal	The November 20th, 2025, QI/UM minutes were reviewed and highlights from today's consent agenda items were reviewed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	**Motion:** *Approve* Consent Agenda (Quezada/Cardona) 5-0-0-3

<table>
<tr><th>AGENDA ITEM / PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td>Utilization Review (Q3 2025)
- Access Work Group Minutes from 9/30/2025, 12/02/2025

(Attachments A-P)

Action
Patrick Marabella, MD, Chair</td><td></td><td></td></tr>
<tr><td>#3 QI Business
- A&G Dashboard (December 2025)
- A&G Executive Summary (Q4 2025)
- A&G Quarterly Member Report (Q4 2025)

(Attachments Q-S)

Action
Patrick Marabella, MD, Chair</td><td>The Appeals & Grievances Dashboard through December 2025, Appeals & Grievances Executive Summary Q4 2025, and Appeals & Grievances Quarterly Member Report Q4 2025 were presented. Appeals and Grievances can be submitted via phone, fax, email, or online. Appeals and Grievances are categorized and reported on the dashboard, with supportive narratives in the separate quarterly reports. Monthly Excel files include the logs identifying each member who submitted a grievance during the monthly reporting period with a narrative description of the grievance and resolution (as applicable).
Overall, grievances continue to increase 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. In Q4 2025, a total of 659 grievances were received, with 222 categorized as Access to Care. The top five Access to Care grievance categories, representing 26.1% of all grievances, were identified with their corresponding opportunities for improvement:
1. Prior Authorization Delay
o The provider should keep the member informed of prior authorization and the timeline of approval.
o Continue providing live and recorded provider training webinars to address prior authorizations on a regular basis.
2. Network Availability
o Expand telehealth services, offering diverse payment options, and utilizing data analytics to optimize network design and ensure equitable access to care.
3. Transportation Missed Appointment
o Request feedback from the vendor on how they will address complaints related to no-show transportation and make reliable transportation accessible to members.</td><td>Motion: Approve
- A&G Dashboard (December 2025)
- A&G Executive Summary (Q4 2025)
- A&G Quarterly Member Report (Q4 2025)

(Quezada/Waugh)
5-0-0-3</td></tr>
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	4. PCP Referral for Services
	    o Establish or reassess the current referral process and turnaround approval times.
	5. Availability of Appointments with a Specialist
	    o Expand specialist network in rural areas through the Provider Network team.
	    o Leverage contract language to incentivize provider groups to increase volume, as well as meet member experience expectations.
	In Q4 2025, CVH observed a decrease in appeal volume, with 150 total appeals. 81.3% (122 appeals) were classified as Not Medically Necessary. Overall, 42% of appeals were upheld, 43% overturned, 9% partially upheld, and 6% were withdrawn.
	The top 52% of appeals fell into the following categories:
	• Self-injectable Medications
	• Outpatient Procedures
	• Inpatient Admission
	• DME-Other
	• Diagnostic MRI
	• Housing Deposits (50% of appeals were upheld).
	• Medically Tailored Meals (All appeals were upheld 100%).
	Improvement opportunities include:
	• Not Medically Necessary:
	    o Educate providers on the criteria for medical procedures coverage and what needs to be submitted to avoid unnecessary denials and procedure delays.
	    o Ensure providers are submitting all needed information prior to medically necessary procedures.
	• Community Supports – Medically Tailored Meals:
	    o Educate providers on the criteria to qualify for medically supportive meals.
	• Community Supports – Housing Deposits:
	    o Educate providers – particularly Community-Based Organizations on the requirements for Housing Deposit benefits. Emphasize the importance of including a comprehensive individualized Housing Plan and submitting all required documentation to prevent unnecessary submissions and avoidable denials.	

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	Discussion: *Dr. Cardona asked whether the main problem with Access is the ability to get an appointment with the member's PCP?* *Dr. Marabella stated that Access Grievance issues are mainly due to prior authorization delay, medication denials, access to Specialists, DME, and missed transportation.*	
#3 QI Business - Behavioral Health Performance Indicator Report (Q3 2025) (Attachment T) **Action** Patrick Marabella, MD, Chair	The **Behavioral Health Performance Indicator Report Q3 2025** provides a summary to evaluate BH risk rating and authorization decision timeliness metrics, which reflect current performance and reveal emerging patterns over time. In Q3 2025, all metrics were met. The non-ABA review timeliness metric met the 100% target. Therefore, a barrier analysis and an improvement plan were not required. • The Q3 2025 BH utilization rate, as reflected in unique members/k, has remained steady over the first half of 2025 at 283.7. • Appointment accessibility by risk rating met the target at 100%, and there were zero (0) Life-Threatening Emergent cases, two (2) Non-Life-Threatening Emergent cases, and one (1) Urgent case. • Authorization decision timeliness is reported at 100% for Non-ABA (122 reviews), and 95.1% for ABA (2,706 reviews). • Overall Q3 2025 timeliness result for CVH BH utilization management was 95.3%, exceeding the threshold for action of 95% by a small margin.	**Motion**: *Approve* - Behavioral Health Performance Indicator Report (Q3 2025) (Quezada/Waugh) 5-0-0-3
#3 QI Business - Potential Quality Issues Report (Q4 2025) (Attachment U) **Action** Patrick Marabella, MD, Chair	The **Potential Quality Issues (PQI) Report Q4 2025** 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. The PQI report also includes behavioral health under SB 850 (parity regulations). Data for Q4 2025 was reviewed for all case types including the follow-up actions taken when indicated. • There were three (3) non-member-generated PQIs in Q4 2025, all scoring a level II. • Member-generated PQIs for Q4 2025 included a total of 47 Physical Health cases and none (0) for Behavioral Health. PCP-related cases were reported at 28, Specialist-related cases were reported at nine (9), Hospital/ER cases were reported at seven (7), SNF reported two (2), and a	**Motion**: *Approve* - Potential Quality Issues Report (Q4 2025) (Cardona/Waugh) 5-0-0-3

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	vendor reported one (1). Outcome scores were reported as 29 at level zero, three (3) at level I, and fifteen (15) cases scored at level II. • There were sixteen (16) Peer Review-generated cases (none were Behavioral Health). Eleven (11) cases are closed, and five (5) cases are open. • Eight (8) Peer Review-generated cases required further action (none were Behavioral Health). Zaman Jennaty left the meeting at 10:55 AM.	
#4 QI/UM/CM Business - QI/HE Work Plan End of Year Evaluation & Executive Summary 2025 (Attachment V) **Action** Patrick Marabella, MD, Chair	**The 2025 Quality Improvement Work Plan End-of-Year Evaluation and Executive Summary** were presented and reviewed. The 2025 Quality Improvement and Health Education (QIHEd) End of Year Program Evaluation includes three sections: 1. QI & HEd Work Plan Initiatives 2. Ongoing Work Plan Activities 3. Enterprise Quality Improvement and Performance Tracker Activities Log The QIHEd Oversight Structure was reviewed, noting the roles and frequency of each committee's meetings. Goals and Quality Indicators: The QIHEd 2025 Work Plan includes the following eleven (11) categories: 1. Behavioral Health: 6/6 MY2025 Objectives Met: 100% Rate o Focus on improving follow-up after E.D. visits for substance use or mental health disorders measured by the HEDIS® metrics FUA-7/30 and FUM-7/30. o Overall, CVH did not meet the 50th Percentile Quality Compass performance goal. Kings County did meet the MPL for both measures. ▪ Non-clinical PIP 2023 to 2025 to focus on Fresno and Madera Counties with three (3) interventions on: 1. Smart Phrase education for CHWs/SUNs & social workers 2. Hispanic Cultural Competency (same staff) 3. Collaborate with the Resiliency Center to expand access ▪ The project ended 12/31/2025. ▪ Data gathering continues for final submission due 08/06/2026. 2. Chronic Conditions/Chronic Disease: 6/6 Objectives Met: 100% Rate o Implement strategies to improve performance in Asthma Medication Ratio (AMR), Blood Pressure Control (CBP), and Diabetes (CDC >9):	**Motion:** *Approve* - QI/HE Work Plan End of Year Evaluation & Executive Summary 2025 (Quezada/Cardona) 5-0-0-3

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	▪ Connected via phone calls with members to close care gaps in diabetes management and blood pressure control. ▪ Promoted Best Practice for Asthma Care via modified prescribing practice to include use of Formoterol/ICS combo. Successfully met all measures in all three counties. 3. Hospital Quality/Patient Safety: 8/11 Objectives Met: 73% Rate o CVH has five (5) participating Acute Care Facilities. The goal of this effort is to ensure hospitals provide appropriate, safe care to patients that avoids preventable harm, and to guide members regarding informed choices when selecting a hospital for care and services. ▪ All CVH hospitals submitted sufficient data to develop a scorecard. ▪ Some improvements were shown in hospital-acquired infections (CLABSI, CAUTI, and SSI Colon did not improve). ▪ MRSA did not achieve directional improvement, but Clostridioides difficile (C. difficile) rates declined. ▪ C-section performance declined, with 2/5 hospitals meeting the target rate of 23.5%. ▪ Targeted improvement is the goal for 2026. 4. Member Engagement & Experience: 2/2 Objectives Met: 100% Rate o CAHPS Survey: 3/8 measures met the Outcome Quality Compass (QC) 25th percentile goal. ▪ For MY2024, 90.50% of members felt that the plan provided good customer service. ▪ For MY2024, 87.20% of members felt that the plan provided good coordination of care. ▪ For MY2024, 79.50% of members rated the Health Plan favorably. 5. Pediatric/Children's Health: 28/30 Objectives Met (Pediatric/Perinatal/Dental): 93.33% Rate o Clinical PIP Project: Increase rates of Well-Child Visits for Black/African American members in the first 30 months of life (W30-6+) in Fresno County. o Two Interventions 1. Refer birthing parents and infants up to three (3) months to Black Infant Health for education and encouragement to attend well-child visits.	

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	2. Promotes the use of the CDC Milestone Tracker app by parents/caregivers and providers to educate and engage in the identification of developmental milestones and attend well-child visits. o The project ended on 12/31/2025. o Data gathering continues for the final submission due on 8/6/2026. 6. Perinatal Health/ Reproductive Health o All CVH Counties are exceeding the 50th percentile for timely prenatal care, postpartum care, and Chlamydia screening. o Kings County exceeded the 90th percentile for Postpartum visits. o Fresno and Madera Counties exceeded the 75th percentile for Prenatal visits. o Disparity exists for Black/African American members, and CVH will refer all pregnant women to Black Infant Health (BIH). 7. Preventive Health/ Cancer Prevention: 9/12 Objectives Met (Preventive Health): 75% Rate o Efforts to improve preventive health screening performance included: ▪ Mobile mammography services ▪ Comprehensive provider education on updated screening guidelines paired with updated clinic flow and action planning. ▪ Building effective relationships with screening partners. ▪ Creating culturally responsive patient education and outreach material to support informed participation in preventive care. 8. Provider Engagement: 9/13 Objectives Met: 69.23% Rate o Quality Evaluating Data to Generate Excellence (EDGE): ▪ By 12/15/25, 91 Quality EDGE requests were approved. ▪ Provider Engagement increased operational oversight, and Providers were encouraged to participate in the DHCS Equity and Practice Transformation Payments Program. ▪ A standardized data reconciliation process was fully implemented to address challenges related to data workflows, provider coding practices, and system issues impacting the timely receipt of evidence of member care. 9. Continuity/Coordination of Care (Non-BH/BH) o CVH utilizes NCQA as a roadmap for improvement on how an organization can deliver high-quality care.	

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	○ Physical Health: CVH has been focused on enhancing member and provider education and utilizing available resources. ○ Behavioral: Throughout 2025, CVH has emphasized opportunities to support the seamless transfer of information between medical and behavioral care to promote safe, high-quality care into 2026. 10. Access, Availability, and Service and Satisfaction ▪ 87.5% of PAAS measures overall met the goal. • Access to Psychiatry: Urgent care services within 96 hours did not meet the 70% goal. • Other BH metrics met the goal. ▪ 50% (3/6) of the Telephone Access Survey measures met goals. ▪ 60.98% (25/41) of Provider Satisfaction Survey (PSS) measures met goals. ▪ 21.74% (5/23) of Enrollee Experience Survey (EES) measures met goals. ▪ 100% (6/6) of Provider After-Hours Availability Survey (PAHAS) measures met goal. 11. Health Education ○ Health Education programs were aimed at increasing participation in: ▪ Well Care Visits ▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Childhood Immunizations and Well Child Visits. ○ Providers and members can order health education materials on many topics. ○ In 2025, the most ordered topics included: lead poisoning, diabetes, nutrition, and weight management/exercise. ○ Health Education Information Phone line remained available in 2025 and received a total of thirteen (13) calls. **FINAL HEDIS® Results RY2025 (MY2024)** **Quality of Care – MCAS (HEDIS®):** Overall, CalViva achieved 76% of MCAS measures above the MPL for MY 2024. **CVH MCAS Measure Results by County RY2021 to RY2025*** • Fresno County did not meet the MPL for measures FUM, FUA, W30-6+, and W30-2+, but met or exceeded HPL for measure G-SD for 2025 (MY2024*).	

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	• Kings County did not meet the MPL for measures CIS-10, DEV, WCV, W30-6+, and W30-2+ but met or exceeded HPL for measures BCS-E, AMR, CBP, PPC-Pre, and PPC-Post for 2025 (MY2024*). • Madera County did not meet the MPL for measures FUM, FUA, but met or exceeded the HPL for measures CCS, G-SD, IMA-2, LSC, and W30-6+ for 2025 (MY2024*). *No further questions or comments were made by Committee members.*	
#4 QI/UM/CM Business - UM/CM Work Plan End-of-Year Evaluation & Executive Summary 2025 (Attachment W) **Action** Patrick Marabella, MD, Chair	The **2025 Utilization Management/Care Management Work Plan End-of-Year Evaluation and Executive Summary** were presented and reviewed. 1. All Accreditation & Regulatory Requirements Objectives Met Except for: • 1.4 Periodic Audits for Compliance with Regulatory Standards (DMHC issued final results from the 05/05/25 Audit and identified that the Post Stabilization CAP was not corrected). • 1.7 Annually review, approve, and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making (CVH issued a CAP to HN because annual review of BHT/CASP utilization review criteria was not completed.) 2. Monitoring the UM Process Objective Met Except for: • 2.2 Timeliness of processing authorization requests o Deferral Cases did not meet turnaround time standards for > 6 months. CAP was issued for HN –still open. o Other measures were inconsistent with meeting timeliness standards. • 2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making. o World Professional Association for Transgender Health (WPATH) SOC8 training or IRR testing was not administered in 2025. o Annual initial testing period was extended by six (6) weeks due to competing priorities. o Anticipate completion by the end of Q1 2026. 3. Monitoring Utilization Metrics Objectives Met: • 3.3 PPG Profile – PPG Performance: o Some variation in performance noted throughout the calendar year for two (2) PPGs. o However, actions taken expeditiously, including hiring new staff, shifting	**Motion:** *Approve* - UM/CM Work Plan End-of-Year Evaluation & Executive Summary 2025 (Faulkenberry/Waugh) 5-0-0-3

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	resources, and modifying team assignments, resulted in a return to acceptable rates, and objectives were met by year-end. 4. Monitoring Coordination with Other Programs and Vendor Oversight Objectives Met: • All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end-of-year evaluation. • Work plan activity 4.6 Behavioral Health (BH) Care Coordination & work plan activity 4.7 BH Performance Measures. These plans will be evaluated for expansion in 2026. 5. Monitoring Activities for Special Populations Objectives Met: (All monitoring activities for this section met goals.) • CCS Tracking ongoing • SPD Tracking ongoing • CBAS Tracking ongoing • Mental Health Tracking ongoing 6. Adequacy of UMCM Program Resources: • CVH has determined that program resources did not fully meet the needs of CVH membership and providers due to staffing challenges associated with element 2.2, Timeliness of Processing the Authorization Requests. • Suboptimal staffing levels contributed to failures to meet turnaround times for prior authorizations. • During the calendar year, new clinical staff were onboarded to ensure turnaround time requirements are met going forward. 7. Program Scope, Processes, and Information Sources: • The scope of services offered to CVH members meets the state of California requirements for Medi-Cal Managed Care Plans • Ongoing outreach and monitoring efforts have successfully engaged members in preventive care and services. • Annual DHCS survey (2025) had only two (2) areas with deficiencies identified (Early and Periodic Screening, Diagnosis & Treatment-EPSDT and Enhanced Care Management - ECM). • CVH and HNCS continually strive to identify opportunities to improve processes, care, and service.	

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	8. Practitioner Participation and Leadership Involvement in the UM Program: • Contracted network providers consistently participated in the QI/UM Committee and Credentialing and Peer Review Sub-Committees. • Providers engaged and actively participated with Medical Management on Quality Improvement Projects and Annual Clinic Visits. • Medical Management consistently participated in Weekly Multi-disciplinary Care Rounds. • Leadership and staff provided reports, participated in improvement activities, and attended monthly meetings. *No further questions or comments were made by Committee members.*	
#4 QI/UM/CM Business - CM Program Description and Change Summary 2026 (Attachments X) **Action** Patrick Marabella, MD, Chair	The **2026 Care Management Program Description and Change Summary** were presented, and changes for this year include: • Pages 10. Updated CVH Org Chart. • Page 13. Updated Caseload requirements for the perinatal team as the team will move from blended perinatal and first year of life caseloads to staff having only perinatal cases or only first year of life cases. • Page 23. Added 'alternative language format' to one of the data types utilized. *No further questions or comments were made by Committee members.*	Motion: *Approve* - CM Program Description and Change Summary 2026 (Quezada/ Faulkenberry) 5-0-0-3
#4 QI/UM/CM Business - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 2025) (Attachments Y) **Action** Patrick Marabella, MD, Chair	The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 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 but not limited to claims (ED and inpatient), publicly available data, and MCAS/HEDIS® Long Term Care measures. The Dashboard monitors eight (8) different issues/events, including preventable ED/hospital admissions, infections, complaints, etc. 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.	**Motion:** *Approve* - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 2025) (Cardona/Quezada) 5-0-0-3

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	A weighted five (5)-point scale is used to evaluate each CalViva facility for quality of care and outcomes by assigning an overall score for quarterly comparisons and ranking over time. Charts presented provided the Quarter 3 2025 results and identified the overall top-performing and bottom-performing SNFs in the CVH Region based on the weighted five (5)-point scale including: 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. Based upon these results, the following three (3) SNFs were selected as having the greatest opportunity to impact care and services provided to CVH members: 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 started on 9/1/25. • Pharmacy Education (scheduled). • Physical Therapy Team Rounds started on 9/1/25. 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 the prevalence of Pressure Ulcers. This facility is implementing the following to improve its quality outcomes: • Emergency Department Companion Program (Q4) • Pharmacy Education (11/6/26). • Physical Therapy Team Rounds (twice monthly). 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:	

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	• Hydration Rounds started on 9/1/25. • Physical Therapy Team Rounds (twice monthly). • All new admits are assessed by PT within 48 hours. Barrier Analysis: • Staffing Challenges in the Central Valley: Facilities report challenges with recruiting and retaining qualified Certified Nursing Assistants. • Unreported Falls: "Nursing Homes Failed to Report 43% of Falls." MDS 3.0 assessments are used to capture patient changes in conditions. Quarterly monitoring and analysis of trends will continue, and new opportunities for improvement identified with facilities and interventions reprioritized and modified as more data is gathered. The impact of these initial interventions will also be evaluated and modified as indicated by the data.	
#4 QI/UM/CM Business - NCQA Non-Behavioral Health Member Experience Report MY 2024 - NCQA Behavioral Health Member Experience Report MY 2024 (Attachments Z-AA) **Action** Patrick Marabella, MD, Chair	**NCQA Non-Behavioral Health Member Experience Report MY 2024** was presented and reviewed. CVH oversees and monitors member experience and identifies areas of opportunity by conducting required activities to meet the standards and guidelines of accreditation (NCQA ME.7): • Annual satisfaction surveys (CAHPS (Non-Behavioral Health) and ECHO (Behavioral Health)) • Ongoing analysis of grievances and appeals. All appeals and grievances are included, no sampling. NCQA requires Health Plans: 1. Evaluate member satisfaction for physical health at least annually. o Quantitative and qualitative analysis of CAHPS Survey results. Compared to the Medicaid CAHPS National Averages. 2. Evaluate member satisfaction for behavioral health at least annually. o Experience of Care and Health Outcomes ECHO® Survey results. CVH CAHPS Member Survey: • All measures, except Rating of the Health Plan, fell below the 2024 QC 25th percentile goal, and no year-over-year improvement was observed. o Although the rating of the Health Plan declined compared to the previous year, it did reach and exceed the 25th QC percentile in MY24, meeting the goal. • CVH's MY2024 CAHPS® survey results showed declines in overall rating measures and mixed performance across composite measures, highlighting opportunities for targeted	Motion: *Approve* - NCQA Non-Behavioral Health Member Experience Report MY 2024 - NCQA Behavioral Health Member Experience Report MY 2024 (Waugh/Quezada) 5-0-0-3

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	improvement. o Enhancing focus on appeals and grievances related to attitude, service, and billing concerns may help improve the overall member experience. Formal Grievance Issues MY2024 vs. MY 2023 (Formal Grievances can either be Quality of Care (QOC) or Quality of Service (QOS) in nature): • Overall volume increased year-over-year in three out of the five grievance classifications. o MY2024 formal grievances increased above MY2023 volume and PTMPY rate. o Internal goals were not met. • In MY2024: o Access Issues saw a 5.6% decrease in volume o Attitude and Service saw a 102.9% increase year over year. Exempt Grievance Issues MY2024 vs. MY2023 (Exempt grievances are grievances received by the Member Services Call Center that are not coverage disputes or regarding investigational treatment, and that are resolved by the close of the next business day.): • In MY2024, Exempt Grievance volume increased by 21.1%. • Internal goals were not met • The Access grievance category had an increase in volume of 124.7% from the previous year. • The largest Exempt category was Attitude & Service (76%). Appeal Issues MY2024 vs. MY2023: • Total number of appeals increased in volume, PTMPY rate, and Overturn rate in MY2024. • Internal goals were not met. • The Billing and Financial Issues category continues to be the most common classification category in CVH, with a 45.4% increase from the prior year. Some of the Planned Actions that CVH will act on beginning Q2 2026 include, but are not limited to: • Member Dissatisfaction with Staff Attitude and Service Quality: o Deliver ongoing training to providers/staff focused on enhancing member experience, highlighting its impact on CAHPS Survey results, and equipping teams with best practice tools to improve patient interactions. • Grievances Related to Billing and Financial Issues:	

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	o Deliver ongoing customer service training for all member-facing teams, ensuring alignment with the Ops Manual. • Mixed Performance in Composite Measures: o Conduct Quarterly A&G Root Cause Analysis to identify underlying causes, data trends to pinpoint recurring barriers, and share findings with relevant teams to inform process improvements and training needs. o Partner with Provider-facing teams to actively disseminate the CAHPS Provider Playbook and promote adoption of Best Practices through targeted engagement and collaboration. • Decline in Overall Rating Measures: o Launch Provider webinars that cover how to improve empathy and communication with members. o Lead the CVH A&G Workgroup meetings to present transportation-related complaints and facilitate direct resolution by engaging the vendor leadership. o Continue efforts to improve transportation services and address balance billing issues. *Discussion:* *Dr. Quezada asked how will we know if the targeted improvement trainings were actually completed?* *Dr. Marabella stated that the trainings are taught in person by members of our Provider Engagement Team, or if the training is online, those taking the training must attest to completing the training.* *Dr. Quezada stated that it would be challenging to have these providers complete the training online and could result in low compliance rates.* *Dr. Marabella indicated that all Appeals and Grievances are monitored, and PCPs that exceed the threshold for the number of Appeals and Grievances within a certain time period are referred to Peer Review. If their behavior or compliance does not improve, there are consequences.* *Amy Schneider stated that tracking grievances helps to target key providers and monitors them over time for continued improvement.* **NCQA Non-Behavioral Health Member Experience Report MY 2024** was presented and reviewed. CVH oversees and monitors member experience and identifies areas of opportunity through	

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	analysis of grievances, appeals, and Experience of Care and Health Outcomes (ECHO®) survey results. Complete results in the full report.
	• Sample size is smaller in MY24.
	• Four (4) measures had statistically significantly lower results for MY24.
	Formal Grievance Issues MY2024 vs. MY 2023 (Formal Grievances can either be Quality of Care (QOC) or Quality of Service (QOS) in nature):
	• Overall volume of formal grievances decreased in MY2024 compared to MY2023.
	  o MY2024 formal grievances decreased below MY2023 volume, but the PTMPY rate increased when compared to MY2023.
	  o Internal goals were partially met.
	• In MY2024:
	  o Attitude and Service increased from nine (9) in 2023 to sixteen (16) in 2024.
	  o Primary drivers included interpersonal complaints about providers and provider staff.
	Exempt Grievance Issues MY2024 vs. MY2023 (Exempt grievances are grievances received by the Member Services Call Center that are not coverage disputes or regarding investigational treatment, and that are resolved by the close of the next business day.):
	• In MY2024, the volume of Exempt Grievances increased.
	• Internal goal not met.
	• The Access grievance category had an increase in volume from three (3) in 2023 to fourteen (14) in 2024.
	• Attitude and Service grievances increased from two (2) in 2023 to six (6) in 2024.
	Appeal Issues MY2024 vs. MY2023:
	• Total number of appeals and PTMPY rate decreased in MY2024. Overturn rate also decreased.
	• Internal goal was met.
	• There were no Quality of Care, Access, Attitude and Service, or Quality of Practitioner Office Site appeals in 2023 or 2024.
	• Billing and Financial Issues appeals decreased from three (3) in 2023 to one (1) in 2024.
	Behavioral Health Opportunities for Improvement MY2024 VS. MY2023:
	• The BH grievances, appeals, and survey data point to similar opportunities:
	  o Attitude and Service Issues is the biggest category of formal grievances for CVH members. (Interpersonal Issues)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Access is the biggest category of exempt grievances (volume is very small) (Availability Issues) ○ Billing/Financial appeals are the only appeal category • Greatest Opportunity: ○ Getting Treatment Quickly ○ How Well Clinicians Communicate ○ Perceived Improvement ○ Office Wait Times Planned Actions that CVH will act on beginning in Q1 2026: 1. Access to Care: ○ Educate and promote provider and member resources: ▪ A Provider Tip/Resource Sheet will be created to define the different types of services available and identify available resources and how they can be accessed. ▪ A Member sheet will be created to define the services available and how they can be accessed. • Attitude and Service: ○ Educate and improve comfort by addressing mental health issues and referring for services. ▪ A Provider tip sheet on Depression will be created, identifying signs and symptoms, screening tools, and resources that provide treatment. ▪ A Provider Tip Sheet on Anxiety will be created, identifying signs and symptoms, screening tools, and resources that provide treatment. • Our goal is to give providers the necessary resources to connect members to services and improve interactions with members. • In addition, the survey fielding process will return to the previous process utilized in 2023 due to significantly lower response rates for 2024. *Discussion:* *Dr. Marabella asked the Committee whether they felt tip sheets were more helpful than a webinar for this demographic of PCPs, as more BH providers are online.* *Amy Schneider reminded the committee of a previous recommendation to develop resource and*	

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	referral sheets to assist PCPs in the moment with the member explaining the differences between services and how to access them. Our goal is to follow through on the recommendation by Dr. Waugh and this committee. *Dr. Waugh felt that tip sheets used as a tool are more permanent than webinars.* *Dr. Quezada felt that looking through printed tip sheets can be cumbersome and that QR codes that link to the most current information would be beneficial.* *Amy Schneider agreed that we would want to provide electronic access to all documents as well as offer a handout for patients.* *Mary Lourdes Leone arrived at the meeting at 11:19 AM.*	
#5 UM/CM Business - Key Indicator Report (December) - UM Concurrent Review Report (Q4 2025) (Attachments BB, CC) **Action** Patrick Marabella, MD, Chair	The **Key Indicator Report December 2025 and the Utilization Management Concurrent Review (CCR) Report Q4 2025** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Admissions: o MCE (Medicaid Expansion): Acute admissions and utilization remained consistent throughout Q4, with figures closely aligning with 2024 averages and showing no significant variance. o TANF (Temporary Assistance for Needy Families): Stability persisted with only minimal decreases in admissions and utilization in Q4 compared to 2024 levels. o SPD (Seniors and Persons with Disabilities): Q4 reflected continued downward trends across all acute care metrics. • Average Length of Stay (ALOS): o MCE patients had shorter hospital stays in Q4 2025, with an ALOS of 5.0 days, a 12.3% reduction compared to the annual goal of 5.7 days. This trend again suggests improved discharge planning, more efficient inpatient care, or a shift toward outpatient and short-stay interventions. o TANF patients maintained an ALOS of 3.8 days, exactly in line with the annual goal. This stability suggests consistent hospital utilization patterns with no major changes in inpatient management for this group. o SPD patients had an ALOS of 5.8 days in Q4 2025, a 10.8% reduction from the 6.5-day annual goal. This decrease may indicate enhanced efficiencies in hospital care,	Motion: *Approve* - Key Indicator Report (December) - UM Concurrent Review Report (Q4 2025) (Quezada/ Faulkenberry) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	improved care transitions, or an increasing reliance on alternative care settings such as outpatient or home-based care. • Readmissions: o MCE 30-day readmission rates dropped to 13.1%, a 2.9% reduction from the 2024 average of 13.5%. o TANF readmissions decreased to 3.0%, a 37.5% reduction from the 2024 average of 4.8%. o SPD readmissions improved significantly, moving from a 20.2% 2024 average to 16.3% in Q4 2025. • Turnaround Time Compliance Goal 100%: o Routine Pre-Service Authorization w/Extension/Deferral TAT (non-BH) missed the goal of 100% in Q1 – Q3 2025 but had returned to 100% compliance in Q4 2025. o Expedited Pre-Service Authorization TAT (non-BH) missed the goal of 100% in Q3 2025 but has returned to 100% compliance in October and November. o Expedited Pre-Service Authorization w/Extension/Deferral TAT (non-BH) in March and April. ▪ TAT Non-Compliance issues were due to a change in the staffing model from LVNs to RNs as the RNs were being onboarded and have since been resolved. o The CCS rate remains stable. • Physical Health Care Management: o The total number of referrals, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed remained steady. • Behavioral Health Care Management: o The total number of referrals, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed declined. • Perinatal Care Management: o The total number of referrals, outreached, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed declined. • Transitional Care Services: o The total number of referrals, numbers engaged, engagement rate and cases managed increased significantly in 2025. • First Year of Life:	

<table>
<tr><th>AGENDA ITEM / PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>The total number of referrals, numbers engaged, and cases managed increased significantly in 2025. The engagement rate remained steady.</td><td></td></tr>
<tr><td>#5 UM/CM Business
- Medical Policies (Q4 2025)

(Attachment DD)

Action
Patrick Marabella, MD, Chair</td><td>The Medical Policies (Q4 2025) 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 Q4 2024 include, but are not limited to:
CP.MP.100 - Allergy Testing & Therapy
CP.MP.168 - Biofeedback
CP.MP.105 - Digital EEG Spike Analysis
CP.MP.106 - Endometrial Ablation
CP.MP.62 - Hyperhidrosis Treatments
CP.MP.180 - Implantable Hypoglossal Nerve Stimulation
CP.MP.91 - Obstetrical Home Care Programs
CP.MP.202 - Orthognathic Surgery
CP.MP.190 - Outpatient Oxygen Use
CP.MP.70 - Proton and Neutron Beam Therapy
CP.MP.174 – Selective Dorsal Rhizotomy for Spasticity in Cerebral Palsy
CP.MP.185 – Skin and Soft Tissue Substitutes for Diabetic Foot Ulcers and Venous Leg Ulcers
CP.MP.117 – Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Stimulation
HNCA.CP.MP.542 – Testing for Drugs of Abuse
CP.MP.55 – Ultrasound in Pregnancy
CP.MP.99 - Wheelchair Seating
CP.MP.145 – Electric Tumor Treatment Fields
CP.MP.248 – Facility-Based Sleep Studies for Obstructive Sleep Apnea
CP.MP.144 – Mechanical Stretching Devices for Joint Stiffness and Contracture
CP.MP.188 - Pediatric Oral Function Therapy
CP.MP.185 - Skin and Soft Tissue Substitutes for Chronic Wounds
CP.MP.247 - Transplant Service Documentation Requirements</td><td>Motion: Approve
- Medical Policies (Q4 2025)

(Waugh/Faulkenberry)
5-0-0-3</td></tr>
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AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The following new policies include, but are not limited to: • HNCACP.MP – Testing for Drugs of Abuse	
#6 Oversight Audit Business - Continuity of Care - Pharmacy (Attachments EE-FF) **Action** Patrick Marabella, MD, Chair	The **2025 Continuity of Care Oversight (COC) Audit** was presented and reviewed. HN provided evidence demonstrating compliance with policies and procedures for COC and Transition of Care (TOC), including call logs and monitoring and tracking reports for TOC, COC, and Out-of-network services provided. Additionally, we reviewed a sample of COC and TOC cases from the audit period of January – December 2024, with 100% compliance noted with audit criteria. The **2025 Pharmacy Services Oversight Audit** was presented and reviewed. CVH conducted an oversight audit of HN Pharmacy Services' (HNPS) pharmacy function, including review of requested policies and procedures, reports, logs, minutes, and other documentation, for compliance with established standards for the audit period covering January through December 2024. • Ten (10) Prior Authorization Denial files were randomly selected that included non-formulary requests, urgent, and routine cases from all three (3) CVH counties. The first ten (10) cases were **100% compliant.** Denial files must meet all required elements (100%) to pass the audit.	Motion: *Approve* - Continuity of Care - Pharmacy (Quezada/ Faulkenberry) 5-0-0-3
#7 Compliance Update - Compliance Regulatory Report (Attachments GG)	Mary Lourdes Leone presented the **Compliance Report** of CVH Oversight Activities of HN in the areas of financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits:** The 2025 UM/CM annual audit is in progress. The following annual audits have been completed since the last Commission report with No CAP: Access & Availability, Call Center, Claims/PDR, Internal Compliance, Continuity of Care, FWA, Marketing, Pharmacy, and Provider Network. Privacy and Security, and Transportation both had a CAP issued to HN. **Fraud, Waste, and Abuse:** There have been fourteen (14) new MC609 filings since the 10/16/2025 Compliance Regulatory Report to the Commission. See the report for case types. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** DHCS advised CVH on 1/30/26 that additional time is needed to review the CAP due to pending Department policy updates, including the forthcoming Transportation APL. DHCS will issue forward-looking guidance on future CAP closure and allow 90 days to implement any required changes. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit** was conducted on	- Compliance Regulatory Report

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	5/5/25 and issued its Final Report on 12/23/25. The Report confirmed correction of the PQI-related deficiency; however, the post-stabilization deficiency remains uncorrected and may be referred to the Department's Office of Enforcement for further action. **Department of Health Care Services ("DHCS") 2025 Medical Audit** was conducted virtually from 6/2/2025-6/13/2025. DHCS issued its final audit report and CAP on 11/5/25, citing deficiencies related to delegated oversight of HN, including: 1) application of EPSDT criteria for members under age 21; 2) provision of all required ECM core service components; 3) timely notification of ECM benefit discontinuation; and 4) inclusion of required elements in member-facing ECM materials. CVH submitted its initial CAP response on 12/5/25 and will continue to provide monthly updates until the CAP is formally closed. **2025 Network Adequacy Validation (NAV) Audit** was conducted virtually on 8/21/25 and met all requirements. The audit was closed on 11/17/25. **2026 DMHC/DHCS Joint Medical Survey Audit** will commence on-site at CVH the week of 6/15/26. CVH will submit all required DMHC pre-audit documentation by 2/20/26 and is awaiting DHCS pre-audit requirements. **California Advancing and Innovating Medi-Cal (CalAIM):** DHCS approved CVH's Transitional Rent (TR) Model of Care (MOC) on 1/27/26. As several TR provider agreements were pending at the time of approval, DHCS issued a pre-CAP requiring ongoing status reporting through April 2026; all but one agreement have now been executed. CVH submitted updated MOCs on 2/5/26 for TR and Community Supports. The submissions reflect the Plan's final Community Supports elections and updated provider capacity reports; CVH is currently awaiting DHCS approval of both MOCs. **Memoranda of Understanding (MOU)** for the Local Health Department (Madera County) has been executed and submitted to DMHC and DHCS since the last Commission Meeting. **Annual Network Certifications:** • 2024 Subnetwork Certification (SNC) Landscape Analysis: DHCS closed on 1/15/26. • 2024 Annual Network Certification (ANC): DHCS approved on 12/18/25. • 2025 Subnetwork Certification (SNC) Landscape Analysis: DHCS approved on 12/31/25. • 2024 Annual Network Certification (ANC): Submitted on 2/16/26. • 2025 Subnetwork Certification (SNC): Submitted on 2/11/26. **(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR):** DMHC issued a Network Findings report on 4/18/25. CVH submitted a formal response on 7/17/25 that a separate Material Modification would be submitted to the DMHC to request new time and distance	

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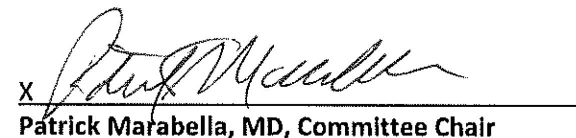
	standards for specific zip codes. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** Submitted to DMHC on 5/1/25, awaiting a response. **(RY) 2026 (MY) 2025 Timely Access and Annual Network Submission (TAR):** Submission due 5/1/26. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY2025. **Public Policy Committee (PPC):** The last PPC meeting was held on 12/3/25, and the next PPC meeting will be held on 3/4/26, from 11:30 AM - 1:30 PM, in the CVH Commission Room. See Public Policy Committee minutes for full details.	
#9 **Old Business**	None.	
#10 **Announcements**	The next meeting is on March 19th, 2026.	
#11 **Public Comment**	None.	
#12 **Adjourn**	The meeting adjourned at 11:38 AM.	

NEXT MEETING: March 19th, 2026

Submitted this Day: March 19, 2026

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

Acknowledgment of Committee Approval:



X
Patrick Marabella, MD, Committee Chair