

Fresno-Kings-Madera  
Regional Health Authority

**CalViva Health  
QI/UM Committee  
Meeting Minutes**  
March 19<sup>th</sup>, 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 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 Senior Nurse Analyst
		✓	Norell Naoe, Medical Management Administrative Coordinator
	<b>Guests/Speakers</b>		
	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 10:10 am. A quorum was not present. *Dr. Ramirez arrived at 10:11 am, and a quorum was present.	
#2 Approve Consent Agenda Committee Minutes: February 19,	February 19 <sup>th</sup> , 2026, 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	<b>Motion: Approve Consent Agenda</b>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p>2026</p> <ul style="list-style-type: none"> <li>- Appeals &amp; Grievances Validation Audit Summary (Q3)</li> <li>- Behavioral Health Performance Indicator Report (Q4)</li> <li>- Pharmacy Provider Updates (Q4 2025, Q1 2026)</li> <li>- Performance Improvement Project Updates – Clinical &amp; Non-Clinical</li> <li>- Specialty Referrals Report (Q4)</li> <li>- Standing Referrals Report (Q4)</li> <li>- Evolent (NIA) (Q4)</li> <li>- SPD HRA Outreach (Q4)</li> <li>- Access Committee Update (December 2025, January 2026)</li> <li>- Enhanced Care Management (ECM) &amp; Community Supports (CS) Performance Report (Q4)</li> </ul> <p>(Attachments A-K)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>discussion at the request of any committee member.</p> <p>A link for the Medi-Cal Rx Contract Drug List was available for reference.</p>	<p>(Cardona/Waugh) 4-0-0-4</p>
<p><b>#3 QI Business</b></p> <ul style="list-style-type: none"> <li>- A&amp;G Dashboard and Turnaround Time Report (January 2026)</li> </ul> <p>(Attachments L)</p>	<p>The <b>Appeals &amp; Grievances Dashboard and Turnaround Time Report</b> through January 2026 were presented. The Dashboard (or log) identifies each member who submitted a grievance during the reporting period (monthly) with a narrative description of the grievance and the resolution. A total of 209 grievances were received during January 2026.</p> <ul style="list-style-type: none"> <li>• This month, 158 grievances were categorized as Quality of Service (QOS), most commonly for prior authorization, access other/DMHC, Administrative issues, Balance Billing, and other.</li> </ul>	<p><b>Motion: Approve</b> - A&amp;G Dashboard and Turnaround Time Report (January 2026)</p> <p>(Ramirez/Waugh) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<ul style="list-style-type: none"> <li>• Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes were consistent with prior months at 171 in January 2026. Balance Billing continues to be one of the higher volume categories, but Transportation Access – Provider no-show has dropped to zero (0) for January.</li> <li>• The total number of Appeals received has increased (55) in January 2026, with 54 resolved. Patterns are consistent with Community Supports/meals and housing, and DME (Durable Medical Equipment), having the highest volumes of cases for the month.               <ul style="list-style-type: none"> <li>○ Advanced imaging cases have decreased to nine (9) this month.</li> <li>○ Surgery category had eight (8) cases this month with four (4) venous ablations for varicose veins from the same provider noted. Education follow-up will be provided.</li> <li>○ The Upholds (44.4%) and Overturn (33.3%) rates have improved. The Partial Overturns (22%) were mentioned due to the member requesting an out-of-network service or DME, which were approved as medically necessary however, an in-network provider/vendor needed to be used.</li> <li>○ One (1) Appeal resolution letter was out of compliance with the turnaround time. The translation vendor was experiencing Outlook system issues and was unable to respond to translation requests on 1/22/26. The issues have since been resolved.</li> </ul> </li> </ul>	
<p><b>#3 QI Business</b> -CVH QIUM Committee Charter 2026  (Attachment M)  <b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The CVH QI/UM Committee Charter 2026 was presented and reviewed. The Long-Term Care Quality Assurance Performance Improvement Annual Plan has been added to the list of Program Documents that require the QI/UM Committee’s approval to recommend to the RHA Commission. No other edits were made to the charter.</p>	<p><b>Motion: Approve</b> - CVH QIUM Committee Charter 2026  (Cardona/Ramirez) 4-0-0-4</p>
<p><b>#3 QI Business</b> - Lead Screening Quarterly Report (Q3 2025)  (Attachment N)</p>	<p>The Lead Screening Quarterly Report (Q3 2025) was presented to provide results of practitioner adherence to lead screening guidelines and their compliance rates for providing anticipatory guidance to parents/caregivers to prevent lead exposure. Lead screening compliance reflects adherence to clinical guidelines. The Q3 2025 report provides CVH’s performance for Q1 2025 to Q3 2025 for data captured through Facility Site Medical Record Review and Claims and Encounters.</p>	<p><b>Motion: Approve</b> - Lead Screening Quarterly Report (Q3 2025)</p>

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<p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<ul style="list-style-type: none"> <li>The Facility Site Reviews (sample) show in Q3 2025, 76% of member records were compliant for both lead screening and anticipatory guidance, with 50% of the PCP sites in compliance.</li> <li>CVH has issued a Corrective Action Plan (CAP) to HN for the continued poor performance with documentation of anticipatory guidance.</li> </ul> <p><i>Discussion:</i> Dr. Cardona asked what the positive Lead exposure rate was for the County. Dr. Marabella indicated that it is lower than in urban areas with older homes and lead paint exposure. Exposure in this region is primarily environmental and airborne. Amy Schneider indicated that the state gave us a rate a few years ago, but that information isn't consistently communicated to the plans. Dr. Marabella indicated that Lead poisoning is generally more prevalent in the socioeconomic group that doesn't have access to healthcare, so it is difficult to track.</p>	<p>(Cardona/Waugh) 4-0-0-4</p>
<p><b>#3 QI Business</b> - Initial Health Appointment (IHA) Quarterly Report (Q3 2025)  (Attachment O)  <b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an <b>Initial Health Appointment (IHA)</b> completed within the first 120 days of enrollment. The Q3 2025 IHA Quarterly Report demonstrates CVH's performance on IHA compliance monitoring from Q4 2024 through Q3 2025.</p> <p>The current approach to monitoring has three components:</p> <ul style="list-style-type: none"> <li>Primary Care Physician Facility Site (FSR) and Medical Record Review (MRR) via onsite (or virtual) provider audits. <ul style="list-style-type: none"> <li>Facility Site Review/Medical Records Review results show that 68% of pediatric patients and 55% of adult patients completed their IHAs for the providers audited during Q3 2025. For providers who were found non-compliant during the review period, follow-up occurs via provider notification of IHA requirements and corrective action when indicated.</li> </ul> </li> <li>Monitoring includes claims and encounters data. <ul style="list-style-type: none"> <li>IHA completed visits within 120 days of enrollment at a rate of 46.44 %, decreased by 2.46 % compared to Q4 2024. IHA completed outside the 120-day window rate of 4.32 % declined by 7.10% compared to Q4 2024.</li> </ul> </li> <li>Member outreach utilizes a three-step methodology. Outreach Compliant [three (3) attempts completed, two (2) + phone and one (1) + mail]. <ul style="list-style-type: none"> <li>The Q3 2025 outreach automated call completion rate 82.66% demonstrates a 2.29 percentage point decrease from Q2 2025. The Q3 2025 outreach attempt completion rate, 48.22%, represents a 7.56 percentage-point decline compared to Q2 2025. Q3 2025</li> </ul> </li> </ul>	<p><b>Motion: Approve</b> - Initial Health Appointment (IHA) Quarterly Report (Q3 2025)  (Cardona/Waugh) 4-0-0-4</p>

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	<p>successful attempts to mail members a welcome packet rate of 90.83%, increased by 11.17 percentage points compared to Q2 2025.</p> <p><i>Discussion:</i>  <i>Dr. Cardona asked if there are additional barriers to compliance other than providers not looking at their list of new members, therefore not conducting an IHA.</i>  <i>Dr. Marabella indicated that if there were a standardized format and code for the IHA, it would be easier to implement across the state, as when the SHA was implemented years ago. When a physical assessment plus the SHA was completed, we could count it as IHA. Right now, there is too much variation to capture if the IHA was completed and all the criteria were met. An additional barrier is that it is a cumbersome, manual process to capture new member outreach attempts before an appointment is scheduled and the member's information is uploaded to a provider's EMR system.</i></p>	
<p><b>#4 Key Presentations</b>                      - QI/HE Program Description and Change Summary 2026                       (Attachment P)   <b>Action</b>                      Patrick Marabella, M.D., Chair</p>	<p>The <b>2026 Quality Improvement/Health Education Program Description</b> was presented to the committee for approval. Updates include:</p> <ul style="list-style-type: none"> <li>• Information Systems and Analysis (p. 5). Removed section since it is redundant to the additional resources - Information Systems section.</li> <li>• Quality Improvement Goals (p. 7). Added bullet item: Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.</li> <li>• Scope: Services Covered by CVH (p. 10). Removed Health Homes Program (HHP), added Community Supports to meet social needs of all members.</li> <li>• Health Education Programs (p. 13) Added description on Complex Health Needs/Care Management.</li> <li>• Care Management (CM) Program (p. 15). Removed section and added Complex Health Needs/Care Management to the Health Management Programs section.</li> <li>• Operations and Service (p. 16). Provider Performance &amp; Analytics team name updated to Data Strategy &amp; Insights. Removed "Sales" from collaboration efforts.</li> <li>• Health Plan Performance (pgs. 16-17)</li> <li>• The Health Equity Accreditation survey name was updated to Health Outcomes Accreditation (HOA), and Health Equity Accreditation Plus was updated to Community-Focused Care Accreditation (CFCA).</li> <li>• Added MCAS and DMHC Health Equity and Quality measure performance to CVH's monitoring</li> </ul>	<p><b>Motion: Approve</b>                      - QI/HE Program Description and Change Summary 2026                       (Waugh/Ramirez)                      4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>activities. Specified that member outreach activities are conducted to close care gaps to improve outcomes and performance metrics.</p> <ul style="list-style-type: none"> <li>• Delegation (p. 19). Removed language, “The delegates may review for medical necessity and appropriateness of care following the triage exam when there is no emergency condition or following stabilization of an emergency condition.”</li> <li>• Health Equity and Cultural and Linguistic Needs (p. 20). Replaced Diversity, Equity, and Inclusion training with Cultural Competency Training.</li> <li>• Access and Availability (pgs. 23-24) Shortened first paragraph. Added, “Standards are communicated through the online Provider Operations Manual and Provider Updates.” Added information on monitoring and reporting activities in the last two paragraphs.</li> <li>• Satisfaction (p. 24). Revised and rephrased Satisfaction description. Added ECHO/OPMH surveys and description of Program Manager responsibilities.</li> <li>• Health Education Programs (p. 25). Removed the Health Education phone number. Rephrased the “Kick It California” description.</li> <li>• Telehealth Services (pgs. 26-27) Added ConferMed of CA as vendor. Removed and replaced the goals for the Telehealth Program.</li> <li>• Staff Resources and Accountability (p. 35-39).</li> <li>• Added Case/Care Management department description; Updated Management Information Systems (MIS) summary description, and updated the titles of several departments or functional areas.</li> <li>• Revised Enterprise Data Warehouse (EDW) and Statistical Analysis Software (SAS) descriptions and added other new software descriptions.</li> <li>• QI Program Activities: Projects, Surveys and Audits, Incentive Programs (pgs. 41-42). Added ECHO and OPMH, Revised Member and Provider Incentive Programs.</li> <li>• QI Process (p. 48) Added DMHC Health Equity and Quality measure performance as areas for focused performance improvement.</li> <li>• Other minor edits.</li> </ul> <p><i>Dr. Marabella left the meeting at 10:38 a.m. and returned at 10:38 a.m.</i></p>	
<p><b>#4 Key Presentations</b> - QI/HE &amp; W Work Plan 2026</p>	<p>The <b>2026 Quality Improvement/Health Education and Wellness Work Plan</b> was presented for approval. The Work Plan is divided into two (2) sections:</p>	<p><b>Motion: Approve</b> - QI/HE Work Plan</p>

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<p>(Attachment Q)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p><i>I. Work Plan Initiatives: Implement activities to improve performance measures in eight (8) key areas for QI &amp; Health Education Work. Includes program objectives, monitoring, and evaluation for the year. Each section has specific initiatives for a total of fourteen (14).</i></p> <p>1. <b>Behavioral Health:</b> Improving Behavioral Health (Mental Health and Substance Use) Outcomes <u>MY2024 Results:</u> FUA-30: (100%, 3/3 objectives met) FUM-30: (100%, 3/3 objectives met)</p> <p>New Measure for 2026: (DSF-E) Depression Screening and Follow-up for Adolescents and Adults (must meet MPL in MY26)</p> <ul style="list-style-type: none"> <li>• MPL met for both measures (FUM &amp; FUA) in Kings County for MY2024.</li> <li>• Statistically significant directional improvement noted in Fresno and Madera Counties, but MPL was not met for either measure in MY2024.</li> <li>• Continue efforts on both FUM/FUA measures in 2026.</li> <li>• Ensure broad and consistent implementation of depression screening by all providers in all 3 counties (DSF-E).</li> <li>• Work with providers to capture depression screening data.</li> </ul> <p>2. <b>Chronic Conditions:</b></p> <ul style="list-style-type: none"> <li>• Maintain achievement of MPL for two measures in 2026: Diabetes (CDC GSD/HBD): CDC &gt;9 – HbA1c to below 9; Heart Health: Control Blood Pressure (CBP)</li> <li>• Asthma Medication Ratio measure retired.</li> <li>• “Follow-up After Acute and Urgent Care Visits for Asthma” is a new measure this year. MCPs are not held to MPL for this measure in MY26.</li> </ul> <p>3. <b>A. Hospital Quality/Patient Safety:</b> Monitoring of hospital-acquired conditions (infections &amp; c-section rates). Goals were not met in MY2024.</p> <ul style="list-style-type: none"> <li>• MY2026 focus is to increase the number of reporting hospitals.</li> <li>• Reduce infection rates &amp; c-section rates.</li> </ul> <p><b>B. Hospital Quality/Patient Safety/Maternal Health:</b> In 2026, maintain achievement of MPL with a new priority activity that will focus on the coordination of care.</p> <ul style="list-style-type: none"> <li>• Implement two (2) new Depression Screening Measures consistently in all three (3) counties, ensuring appropriate follow-up and data capture for MY2026: <ul style="list-style-type: none"> <li>○ PND-E: Prenatal Depression Screening and Follow –up Screening (held to MPL)</li> <li>○ PDS-E: Postpartum Depression Screening and Follow-up Screening (held to MPL)</li> </ul> </li> </ul>	<p>2026</p> <p>(Waugh/Ramirez) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>4. <b>Member Engagement and Experience (IHA):</b> New Member completion of Initial Health Appointment (IHA) in under 120 days. IHA does not have a HEDIS benchmark, but it is a DHCS compliance measure. In 2026:</p> <ul style="list-style-type: none"> <li>• Meet or exceed the goal for timely IHA of 59.40%.</li> <li>• Ensure providers are clear on the minimum requirements for a comprehensive IHA.</li> <li>• Connect new members with medical home and support the timely completion of IHA within 120 days.</li> </ul> <p>5. <b>Pediatric/Dental:</b> Improvement noted in Children’s Domain measures in MY2024, but continued focus needed in MY2026 for:</p> <ul style="list-style-type: none"> <li>• Well Child Visits (W30) in Fresno County and (WCV &amp; W30) in Kings County.</li> <li>• Topical Fluoride (TFL-CH), Developmental Screening (DEV), and Immunizations (CIS-10) in Kings County.</li> <li>• Maintain achievement in other Children’s Domain measures in all counties.</li> </ul> <p>6. <b>Preventive Health: For 2026:</b> A. Maintain achievement of MPL for BCS, CCS &amp; COL through special events, mobile events, and member outreach. B. Strive to understand barriers and improve flu vaccine rates (AISE Flu).</p> <p>7. <b>Member Engagement and Experience: For 2026:</b> A. Continue to obtain directional improvement from prior year on CAHPS Access measures, including Getting Needed Care, Getting Care Quickly, and Care Coordination. B. Implement strategies to meet or exceed the CAHPS 25<sup>th</sup> percentile for Rating of Health Plan, Customer Service, and Ease of Filling Out Forms.</p> <p>8. <b>Provider Communications/Engagement:</b></p> <ul style="list-style-type: none"> <li>• After Hours Access met performance goal &gt; 90% on both metrics.</li> <li>• Improvement needed for Appointment Access related to: <ul style="list-style-type: none"> <li>○ Specialist Urgent</li> <li>○ Specialist Non-urgent</li> </ul> </li> <li>• Interventions will focus on improving member access to appointments with Specialists in 2026.</li> </ul> <p>ii. <b>Quality Improvement Tracking System Activities Log.</b> These activities support meeting the program objectives in Section 1. Some of these activities include, but are not limited to, the following:</p>	

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	<ol style="list-style-type: none"> <li>1. <b>Behavioral Health:</b> <ul style="list-style-type: none"> <li>• Monitor results of BH member satisfaction surveys at least annually and Appeal and Grievance Quarterly results and analysis to identify trends and opportunities for improvement.</li> <li>• Conduct Member outreach (Outreach Team or CHW) following ED Visit for substance use or mental health issue post-discharge utilizing the Admit, Transfer, and Discharge (ADT) report (Lanes Report).</li> <li>• Ensure PHQ-9 data from Teledoc appointments can be used to improve HEDIS® Depression Screening rates for Adults and Adolescents (DSF-E).</li> </ul> </li> <li>2. <b>Chronic Conditions:</b> <ul style="list-style-type: none"> <li>• Member outreach campaign (by Sprinter Health) to provide in-home blood pressure devices to self-monitor blood pressure (CBP).</li> <li>• Outreach campaign to support Diabetic Members who may be due for an A1c test to provide "Simple Health Kits", A1c home test kits sent directly to the Member via mail.</li> </ul> </li> <li>3. <b>Hospital Quality/Patient Safety:</b> Outreach to hospital leadership regarding patient safety metrics, standards/expectations, and opportunities to improve. Metrics will focus on hospital-acquired infections, sepsis management, the Patient Safety Honor Roll, and the Opioid Care Honor Roll.           <ul style="list-style-type: none"> <li>• Produce and distribute Hospital Quality Scorecards.</li> </ul> </li> <li>4. <b>Member Experience (IHA):</b> <ul style="list-style-type: none"> <li>• Identify high-volume, low-performing Initial Health Appointment (IHA) providers quarterly and collaborate with Provider Engagement to provide targeted training and support to the identified providers.</li> <li>• Report quarterly IHA results of monitoring and training status to stakeholder committee members.</li> </ul> </li> <li>5. <b>Pediatric:</b> <ul style="list-style-type: none"> <li>• Share Quarterly Blood Lead Screening gap lists with providers for members who have not completed blood lead screening by age 1, age 2, or by age 6.</li> <li>• Send IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1-year checkup.</li> </ul> </li> </ol>	

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	<ul style="list-style-type: none"> <li>• Promote the CDC's Milestone Tracker App in future newsletters, website locations, add to Health Education Provider Resource (QR Codes), promote it to CVH's Pregnancy and First Year of Life programs, etc.</li> </ul> <p>6. <b>Preventive Health:</b></p> <ul style="list-style-type: none"> <li>• Launch a targeted text campaign designed to remind and encourage Members to complete recommended breast, cervical, and/or colorectal cancer screenings.</li> <li>• Partner with Exact Sciences, who will outreach to members and inform them of the importance of colorectal cancer screening via a letter.</li> <li>• Increase access to breast cancer screening services using mobile mammography, especially for individuals who have limited access to traditional healthcare facilities, including those in rural and underserved communities.</li> </ul> <p>7. <b>Member Experience:</b> Revise the CAHPS Provider Playbook Best Practices into one (1) resource for providers to utilize and improve CAHPS measures.</p> <p>8. <b>Member Experience:</b></p> <ul style="list-style-type: none"> <li>• Offer physician-led webinar trainings; topics will focus on improving provider communication and access.</li> <li>• Develop a Behavioral Health (BH) Resource Sheet for PCPs to support member referral to the appropriate BH services.</li> </ul> <p><i>Discussion:</i>  <i>Dr. Cardona commented that the PCP's ability to refer to an MH provider was removed, and now patients need to self-refer. It is ultimately up to the patient, so the Plan should provide them with access numbers.</i>  <i>Amy Schneider indicated that a tool is in development and will be helpful to get the conversations started. Patients are more likely to follow through with seeing a MH provider after a conversation with their PCP.</i>  <i>Dr. Marabella agreed that the tool in development must contain a QR code or a link to the most up-to-date resources and how to get plugged into the system of care, which can be overwhelming and stigmatizing.</i></p>	
<p><b>#4 Key Presentations</b>                      - UM Program Description and Change Summary 2026</p>	<p>The <b>2026 Utilization Management Program Description &amp; Change Summary</b> was presented, and changes for this year include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Page 10. Removed Managed Risk Medical Insurance Board.</li> <li>• Page 11-12. Updated decisions about following the required medical necessity review. Also</li> </ul>	<p><b>Motion: Approve</b>                      - UM Program Description and Change Summary</p>

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<p>(Attachment R)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>added services related to the California Prenatal Screening Program (CPSP).</p> <ul style="list-style-type: none"> <li>• Page 18. Behavioral health utilization management decisions follow Centene Clinical Policy and evidence-based guidelines from recognized professional organizations. To ensure consistent application of these criteria, all BH Utilization Review Clinicians complete annual Inter-Rater Reliability testing.</li> <li>• Page 26. Updated the most recent locations for mental health and substance abuse.</li> <li>• Page 38. Added referral of Members to CalAIM Community Supports.</li> <li>• Page 48. Updated the Vice President of Population Health and Clinical Operations.</li> </ul>	<p>2026</p> <p>(Cardona/Ramirez) 4-0-0-4</p>
<p><b>#4 Key Presentations</b> - UM/CM Work Plan 2026 (Attachment S)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p><b>The 2026 Utilization Management/Care Management Work Plan</b> was presented. UM/CM Work Plan for 2026 includes:</p> <ul style="list-style-type: none"> <li>• Expanding the integration of BH into utilization activities was a key enhancement this year.</li> <li>• The addition of a separate section for Enhanced Care Management (ECM) was also a priority.</li> <li>• Five Areas of focus remain the same for the 2026 Work Plan, with minor changes, including but not limited to:               <ol style="list-style-type: none"> <li><b>1. Compliance with Regulatory &amp; Accreditation Requirements</b> <ul style="list-style-type: none"> <li>○ Annual Review of UM Clinical Criteria (1.7)                   <ul style="list-style-type: none"> <li>▪ Added Behavioral Health (BH) to Physical Health (PH) to ensure annual review and approval of UM criteria by Medical Advisory Committee and QI/UM Committee.</li> </ul> </li> </ul> </li> <li><b>2. Monitoring the UM Process</b> <ul style="list-style-type: none"> <li>○ The number of authorizations for services requested (2.1)                   <ul style="list-style-type: none"> <li>▪ Clarified objectives to track both PH and BH authorizations monthly.</li> </ul> </li> <li>○ Timeliness of processing authorization requests (2.2)                   <ul style="list-style-type: none"> <li>▪ Monitor turnaround times for both PH and BH authorizations.</li> </ul> </li> <li>○ Annual Interrater Reliability (IRR) testing of healthcare professionals (2.3)                   <ul style="list-style-type: none"> <li>▪ Clarified IRR testing applies to both PH and BH.</li> <li>▪ Clarified two (2) remediation opportunities offered for scores below 90%.</li> </ul> </li> <li>○ Number of Appeals of UM Decisions Received (2.4)                   <ul style="list-style-type: none"> <li>▪ Clarified tracking for PH and BH.</li> <li>▪ Expanded planned interventions when TATs aren't met.</li> </ul> </li> </ul> </li> <li><b>3. Monitoring Utilization Metrics</b> <ul style="list-style-type: none"> <li>○ Improve Shared Risk &amp; Fee for Service UM Acute Inpatient Performance (3.1)</li> </ul> </li> </ol> </li> </ul>	<p><b>Motion: Approve</b> - UM/CM Work Plan 2026 (Cardona/Ramirez) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> <li>▪ Updated Planned Interventions to emphasize support of discharge to various Post-Acute care destinations.</li> <li>▪ Goals for Key Metrics (admits, ALOS, Bed Days, etc.) under review, to be established by the end of Q1.</li> </ul> <p><b>4. Monitoring Coordination with Other Programs and Vendor Oversight</b></p> <ul style="list-style-type: none"> <li>○ Care Management (4.1) <ul style="list-style-type: none"> <li>▪ Removed ECM enrollment and graduation rates.</li> </ul> </li> <li>○ Disease/Chronic Condition Management (4.4) <ul style="list-style-type: none"> <li>▪ New program implemented last year.</li> <li>▪ Added new annual report to monitor Member outcomes.</li> </ul> </li> <li>○ Behavioral Health Care Coordination (4.6) <ul style="list-style-type: none"> <li>▪ Added measures related to screening for referral to county programs, other referral data, referrals to CM, and appointment access data.</li> <li>▪ Added demonstrate 12-month growth in % of members receiving ECM.</li> <li>▪ Added Members not meeting criteria are referred to alternative programs or CM.</li> </ul> </li> <li>○ Added new section for <b>Enhanced Care Management (ECM)</b> to monitor: (4.8) <ul style="list-style-type: none"> <li>▪ Demonstrate 12-month growth in percentage of members receiving ECM</li> <li>▪ Members not meeting ECM criteria will be referred to alternative programs or care management</li> <li>▪ Notice of Action Letters (NOA) are distributed to members being disenrolled from ECM</li> </ul> </li> </ul> <p><b>5. Monitoring Activities for Special Populations</b></p> <ul style="list-style-type: none"> <li>○ <i>No changes.</i></li> </ul> <p><i>There were no questions or recommendations from the Committee.</i></p>	
<p><b>#4 Key Presentations</b>  - Population Segmentation Report 2026  (Attachment T)</p> <p><b>Action</b>  Patrick Marabella, M.D., Chair</p>	<p>The <b>Population Segmentation Report 2026</b> was presented and reviewed to understand the portions of the population targeted by each Population Health Management program in accordance with NCQA Accreditation standards.</p> <p>The following programs were reviewed along with their eligible population, and the number of eligible members ranged from 231 to 423,525/0.05%-100%:</p> <ul style="list-style-type: none"> <li>• Improve Preventive Health: Flu Vaccinations 92.46%, Breast Cancer Screening 14.37%</li> <li>• Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care</li> </ul>	<p><b>Motion: Approve</b>  - Population Segmentation Report 2026</p> <p>(Waugh/Ramirez)  4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>after Mental Health Emergency Department Visits – Data unavailable until mid-2026;                      Depression Screening and Follow-Up Care 59.81%</p> <ul style="list-style-type: none"> <li>• CVH Pregnancy Program 0.05% (per month)</li> <li>• Care Management 8.45%</li> <li>• Transitional Care Services 0.56% (per month)</li> <li>• Chronic Condition Disease Management (Asthma, COPD, Diabetes, Cardiovascular Conditions, and Sickle Cell Disease) 28.82%</li> <li>• Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program 3.33%</li> <li>• Tobacco Cessation – Kick It California 71.64%</li> <li>• Diabetes Prevention Program 5.77%</li> <li>• Diabetes Management Program 6.54%</li> <li>• Cardiac + Diabetes 21.14%</li> <li>• Health Information Form 100%</li> <li>• Initial Health Appointment 100%</li> <li>• Teladoc Mental Health Digital Platform 71.64%</li> <li>• Behavioral Health Care Management 100%</li> <li>• Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma) 6.28%</li> <li>• Emergency Room Diversion Program 0.05%</li> <li>• Chronic Condition: Oncology 1.69%</li> <li>• Telemedicine 100%</li> </ul> <p><i>There were no questions or recommendations from the Committee.</i></p> <p><i>Morgan Simpson left the meeting at 11:05 a.m. and returned at 11:09 a.m.</i></p>	
<p><b>#5 UM/CM Business</b>                      - Key Indicator Report &amp; Turnaround Time Report (January 2026)                       (Attachments U)</p>	<p>The <b>Key Indicator Report &amp; Turnaround Time Report</b> through January 2026 were presented.</p> <ul style="list-style-type: none"> <li>• Numbers remain similar from the Year-end report presented in February.</li> <li>• Membership has decreased slightly.</li> <li>• Utilization for Acute Admits, Acute Length of Stay, and ER visits (adjusted PTMPY) have remained roughly the same.</li> <li>• Utilization for Bed Days and for Readmissions (all adjusted PTMPY) for TANF, MCE, and SPDs</li> </ul>	<p>Motion: <i>Approve</i>                      - Key Indicator Report &amp; Turnaround Time Report (January 2026)</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>shows a decline in January. The Readmission rates remain low as well.</p> <ul style="list-style-type: none"> <li>Behavioral Health, Perinatal, Physical Health, Transitional Care Services (TCS), and First Year of Life Care Management referrals and member engagement rates have demonstrated random and seasonal variation throughout calendar year 2025 and demonstrate positive trends in January 2026. Timely Pre-service Urgent letters requiring language translation were delayed due to a technological issue that has since been resolved. In another instance, increased urgent inventory volumes contributed to assignment delays, alongside manual process-driven routing to the transplant review team.</li> </ul>	<p>(Cardona/Ramirez) 4-0-0-4</p>
<p><b>#5 UM/CM Business</b> - Care Management &amp; CCM Report (Q4 2025)  (Attachment V)  <b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The <b>Care Management and CCM Report Q4 2025</b> was presented to provide an overview of Physical Health Care Management (PH CM), Transitional Care Services (TCS), Behavioral Health Care Management (BH CM), Perinatal (PCM), and First Year of Life (FYoL) activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness.</p> <ul style="list-style-type: none"> <li>From Q3 to Q4 2025, the referral volume for PH CM decreased by 16%, TCS referrals decreased by 3%, and BH CM referral volume increased by 22%. Referrals decreased for PCM 9% and for FYoL programs 3% in Q4. Managed cases decreased across all programs in Q4, except for BH, which had an increase. Year to date (YTD) 2025 compared to YTD 2024, all programs had significant increases in referrals.</li> <li>PH CM referral numbers decreased 16% in Q4 and demonstrated a seasonal trend.</li> <li>TCS referrals, engagement, and cases managed decreased from Q3 to Q4, however total volumes for 2025 are significantly higher compared to 2024.</li> <li>PCP Visits within 7, 14, and 30 days of referral remained consistent.</li> <li>BH CM referrals increased in Q4, but the engagement rate and total cases managed decreased.</li> <li>PCM's total numbers are up compared to last year, with a notable increase in engagement. Key metrics show improved post-enrollment outcomes, such as reduced readmissions, fewer emergency department visits, improved timeliness of prenatal visits, fewer preterm births, and an increase in postpartum visit rates.</li> <li>Seventy-five (75) members completed a Member Satisfaction Survey, with 92% being satisfied with the CM program, though respondents were less satisfied with their specific Care Manager. Going forward, the team will review satisfaction survey results with staff to identify opportunities to improve results.</li> </ul>	<p>Motion: <i>Approve</i> - Care Management &amp; CCM Report (Q4 2025)  (Ramirez/Cardona) 4-0-0-4</p>
<p><b>#5 UM/CM Business</b></p>	<p><b>InterQual® Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2025</b> were</p>	<p>Motion: <i>Approve</i></p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p>- Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2025</p> <p>(Attachment W)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>presented to demonstrate UM staff consistency in applying InterQual® Clinical Decision Support Criteria, along with other evidence-based medical policies, clinical support guidelines, training, and technical assessment tools approved by the Medical Advisory Council to ensure consistent and standardized medical criteria review across all cases.</p> <p>To reinforce competency in applying InterQual criteria, Physician and Non-Physician clinical staff completed InterQual® IRR preparatory training in Q3 2025. In Q3 &amp; Q4 2025, InterQual® IRR testing was administered, requiring a minimum passing score of 90% to demonstrate proficiency. Average initial test scores for non-physicians and physicians were 93.5% and 92.0%, respectively.</p> <ul style="list-style-type: none"> <li>• Individuals in leadership roles, including supervisors, managers, and directors, demonstrated consistently high performance, with nearly all meeting or exceeding the 90% threshold across their assigned tests.</li> <li>• Concurrent review nurses also demonstrated strong competency overall, with the majority meeting or exceeding 90% across their testing.</li> <li>• Acute Pediatrics was a consistent strength area, with a high proportion of results at or above 90%. <ul style="list-style-type: none"> <li>○ Durable Medical Equipment (DME) was the clearest opportunity area, with the lowest overall average performance and the highest concentration of lower scores compared with other domains.</li> <li>○ Home Care and Subacute and Skilled Nursing showed higher variability than other domains, with a greater share of results below 80%, indicating an opportunity to improve consistency through targeted reinforcement.</li> </ul> </li> <li>• Focused training in DME, Home Care, and Subacute and Skilled Nursing is likely to produce measurable improvement, given the strong pattern of score increases following remediation.</li> </ul>	<p>- Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2025</p> <p>(Ramirez/Cardona) 4-0-0-4</p>
<p><b>#5 UM/CM Business</b></p> <p>- NCQA UM Information Integrity Appeals &amp; Denials Oversight Report</p> <p>(Attachment X)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The <b>NCQA UM Information Integrity Appeals &amp; Denials Oversight Report</b> was presented to demonstrate CVH's oversight of utilization management information and security standard compliance by HN. Per NCQA standards, the report describes how UM Appeals &amp; Denials information is received, stored, reviewed, tracked, and dated.</p> <p>CVH monitors compliance with its UM denial and appeal controls by tracking:</p> <ol style="list-style-type: none"> <li>1. What primary source verification information is received, dated, and stored.</li> <li>2. How modified information is tracked and dated from its initial verification.</li> <li>3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.</li> </ol>	<p>Motion: <i>Approve</i></p> <p>- NCQA UM Information Integrity Appeals &amp; Denials Oversight Report</p> <p>(Cardona/Ramirez) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>4. Annual training, to ensure incidents of data integrity are reported.</p> <p>5. The security controls in place to protect the information from unauthorized modification.</p> <p>6. How the organization monitors its compliance with the policies and procedures.</p> <p>7. Initiate a Corrective Action Plan (CAP) for findings.</p> <p>8. Assess CAP findings to ensure validity of corrections/actions.</p> <p>Audit results regarding monitoring for compliance with established UM System Controls were provided. Results were provided for <i>Appeals</i> (January to December 2025) and for <i>Denials &amp; Partial Approvals</i> (January to December 2025).</p> <p>The UM Data Integrity Reports for calendar year 2025 included only CVH members. Appropriate samples per NCQA requirements of 31 appeals and 50 denials were reviewed.</p> <p>Total Universe Volumes:</p> <ul style="list-style-type: none"> <li>• Appeals – January 1 to December 31, 2025 - total CVH Appeals = 605 (modified &amp; non-modified)</li> <li>• Denials – January 1 to December 31, 2025 - total CVH Denials &amp; Partial Approvals = 15,882 (modified &amp; non-modified)</li> <li>• All 81 cases were audited for compliance with system controls. No (0) incidents of non-compliance were identified; therefore, no (0) corrective actions are indicated at this time.</li> </ul> <p>Zaman Jennaty left the meeting at 11:25 a.m. and returned at 11:31 a.m.</p>	
<p><b>#5 UM/CM Business</b> - PA Member Letter Monitoring Report (Q4 2025)</p> <p>(Attachment Y)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The <b>PA Member Letter Monitoring Report Q4 2025</b> provides a summary of the daily audits of acknowledgment and resolution letters to ensure:</p> <ul style="list-style-type: none"> <li>• Use clear and concise denial language in decision letters.</li> <li>• Use clinical criteria or guidelines for decision letters.</li> <li>• To provide correct anticipated decision date for deferral letters.</li> <li>• Use clear and concise language in deferral letters.</li> <li>• Appropriate member letter translation for deferral letters.</li> </ul> <p>These metrics show improvement, with a few minor issues that are being corrected. All errors identified by the A &amp; G team in Table 1 were corrected prior to mailing.</p> <p>Future versions of this report will include monitoring of compliance with EPSDT criteria for members under 21 as a result of the CAP issued by DHCS.</p> <p>The clinical team will continue to monitor and track acknowledgment and resolution letters.</p>	<p>Motion: <i>Approve</i> - PA Member Letter Monitoring Report (Q4 2025)</p> <p>(Waugh/Ramirez) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p><b>#6 Pharmacy Business</b></p> <ul style="list-style-type: none"> <li>- Pharmacy Executive Summary (Q4 2025)</li> <li>- Pharmacy Operations Metrics (Q4 2025)</li> <li>- Pharmacy Top 25 Prior Authorizations (Q4 2025)</li> <li>- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2025)</li> <li>- Pharmacy Quality Assurance Results 2025</li> </ul> <p>(Attachments Z-DD)</p> <p><b>Action</b> Patrick Marabella, M.D., Chair</p>	<p>The <b>Pharmacy Executive Summary Q4 2025</b> 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.</p> <ul style="list-style-type: none"> <li>• Pharmacy Operations Metrics               <ul style="list-style-type: none"> <li>○ Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q4 2025.</li> <li>○ Overall, TAT for Q4 2025 was 99.8%.</li> <li>○ PA volume was lower in Q4 2025 compared to Q3 2025 and there were some drug-specific differences. October had a higher volume compared to all other months in Q4 2025.</li> </ul> </li> </ul> <p>The <b>Pharmacy Operations Metrics Q4 2025</b> provides key indicators measuring the performance of the PA Department in service to CVH members. The turnaround time (TAT) expectation is 100%, with a threshold for action of 95%.</p> <ul style="list-style-type: none"> <li>• The average turnaround time met the standard with 99.8%.</li> </ul> <p>The <b>Pharmacy Top 25 Prior Authorizations Q4 2025</b> 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 25 PA requests in Q4 2025 were mostly consistent with the top 25 drugs reviewed in Q3 2025, with a few placement variations. Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products.</p> <p>The <b>Quality Assurance Reliability Results (IRR) for Pharmacy Q4 2025</b> evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten (10) prior authorizations [four (4) approvals and six (6) denials] from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas, with a threshold for action of 90%.</p> <ul style="list-style-type: none"> <li>• The 90% threshold was met. The 95% goal was not met. The overall score was 95%.</li> <li>• Three sample cases had potential criteria application or documentation issues after plan review.</li> </ul> <p>The <b>Quality Assurance Reliability Results for Pharmacy 2025</b> reviews the prior authorizations performed on the medical benefit drugs to evaluate the consistency and accuracy with which the MedPharm Pharmacy staff involved in utilization management (UM) review and apply prior</p>	<p>Motion: <i>Approve</i></p> <ul style="list-style-type: none"> <li>- Pharmacy Executive Summary (Q4 2025)</li> <li>- Pharmacy Operations Metrics (Q4 2025)</li> <li>- Pharmacy Top 25 Prior Authorizations (Q4 2025)</li> <li>- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2025)</li> <li>- Pharmacy Quality Assurance Results 2025</li> </ul> <p>(Cardona/Ramirez) 4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>authorization criteria in decision-making, and communicate the decisions made to providers and patients.</p> <ul style="list-style-type: none"> <li>The Quality Assurance (QA) results for all quarters in 2025 show that the Overall (cumulative) threshold was met for the random request reviews in each quarter of 2025 with an average score of 94%. However, the 95% goal was not met. Criteria Application and Clarity of Response seemed to be the largest contributing factors to the overall score meeting the threshold but not meeting the goal. After each quarterly review, QA results are provided to the Pharmacy Services MedPharm Management for review to discuss opportunities for improvement based on deficiencies in the individual categories and specific cases. The Plan provides ongoing feedback and guidance on all cases reviewed.</li> </ul>	
<p><b>#7 Policy &amp; Procedure Business</b>                      - Annual Pharmacy Policy &amp; Procedure Review 2026                       (Attachment EE)                       Action                      Patrick Marabella, M.D., Chair</p>	<p>The <b>Annual Pharmacy Policy &amp; Procedure Review 2026</b> was presented to the committee. The following policies were presented for annual review with <b>no changes made</b>:</p> <p>RX-002 Program Metrics Review                      RX-003 Pharmacy Program                      RX-006 Specialty Pharmacy Program                      RX-008 Mental Health Parity                      RX-120 Drug Utilization Review</p> <p>The following policies were presented for annual review and were approved with the following changes:</p> <p>RX-001 Medication Prior Authorization: Minor clarifications made regarding Pharmacy oversight of prior authorization processes.                      RX-005 Pharmacy Prior Authorization and Medical Necessity Criteria: Policy updated to clarify PAC oversight of prior authorization criteria development and approval. Updated to align with DHCS APL 25-013 regarding Medi-Cal Rx pharmacy benefit administration and MCP responsibilities. Minor edit to update Continuity of Care (COC) language to be consistent with APL 14-021. Full policy attached.                      RX-007 Injectable Medication Review: Policy updated to align with DHCS APL 25-013 requirements regarding Medi-Cal Rx pharmacy benefit oversight, including coverage distinctions between pharmacy-dispensed medications and provider-administered drugs.</p>	<p>Motion: <i>Approve</i>                      - Annual Pharmacy Policy &amp; Procedure Review 2026                       (Cardona/Waugh)                      4-0-0-4</p>
<p><b>#7 Policy &amp; Procedure Business</b>                      - UM Policy Review and New ABA Clinical Policy Review</p>	<p>The <b>UM Policy Review and New ABA Clinical Policy Review</b> were presented to the committee. The following policies were presented for annual review and were approved with the following changes:</p>	<p>Motion: <i>Approve</i>                      - UM Policy Review and New ABA</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p>(Attachment FF)</p> <p>Action Patrick Marabella, M.D., Chair</p>	<p>UM-040 UM Information Integrity and System Control: Updated annual training requirement and other edits to align with NCQA. Full policy attached.</p> <p>ABA Criteria Clinical Policy: Applied Behavior Analysis: New clinical criteria for approval. Full clinical policy attached.</p>	<p>Clinical Policy Review</p> <p>(Cardona/Waugh) 4-0-0-4</p>
<p><b>#8 Credentialing &amp; Peer Review Subcommittee Business</b></p> <p>- Credentialing Subcommittee Report (Q1 2026)</p> <p>(Attachment GG)</p> <p>Action Patrick Marabella, M.D., Chair</p>	<p>The <b>Credentialing Sub-Committee Quarterly Report Q1 2026</b> was presented. The Credentialing Sub-Committee met on February 19, 2026. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q3 2025 were reviewed for delegated entities, and Q4 2025 for HN and HN Behavioral Health (BH). A summary of Q3 2025 data was presented.</p> <ul style="list-style-type: none"> <li>• The <b>Adverse Events Q4 2025</b> report was presented. <ul style="list-style-type: none"> <li>○ There was one (1) case identified in Q4 2025 that met the criteria for reporting, in which an adverse outcome was associated with a contracted practitioner.</li> <li>○ Zero (0) cases involved behavioral health</li> <li>○ There were no (0) reconsiderations or fair hearings during Q4 2025.</li> <li>○ October, November, and December credentialing, recredentialing, denial, and termination rosters were submitted and approved via live or electronic Credentialing Committee meetings to meet business needs.</li> <li>○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2025.</li> <li>○ There were zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q4 2025.</li> <li>○ Reviews completed in September, October, November, and December did not identify any practitioners requiring removal from the Plan’s network.</li> <li>○ Zero (0) cases required reporting for 805 in Q4 2025.</li> </ul> </li> <li>• The <b>Access &amp; Availability Substantial Harm Report Q4 2025</b> was presented and reviewed. This report identifies incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked by severity level. <ul style="list-style-type: none"> <li>○ After a thorough review of all Q4 2025 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as</li> </ul> </li> </ul>	<p>Motion: <i>Approve</i></p> <p>- Credentialing Subcommittee Report (Q1 2026)</p> <p>(Ramirez/Cardona) 4-0-0-4</p>

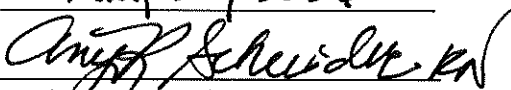
AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>defined in Civil Code section 3428(b)(1).</p> <ul style="list-style-type: none"> <li>• The <b>Credentialing Adverse Actions</b> report for Q4 2025 for CVH from the HN Credentialing Committee was presented.               <ul style="list-style-type: none"> <li>◦ There was one (1) case presented for discussion for Q4 2025 for CVH. The Medical Board of California issued a Cease Practice Order against a practitioner’s medical license. The Credentialing Department administratively terminated the practitioner from the provider network. This administrative termination requires no state or federal reporting by the Plan, and there are no appeal rights. The case was closed with no further action.</li> </ul> </li> <li>• The <b>Credentialing Sub-Committee 2026 Charter</b> was presented and approved with no changes made to the Charter this year.</li> <li>• The <b>Credentialing Policies &amp; Procedures Annual Review</b> was presented to the committee. Most policies were presented with minor or no changes made. Two (2) credentialing policies and their attachments were updated regarding primary source verification (PSV) timeframes, with a change from 180 days to 120 days throughout, to align with revised NCQA standards. All policies were approved.</li> <li>• The county-specific <b>Credentialing Subcommittee Reports</b> of significant sub-committee activities for October through December 2025 were presented. There were no (0) new cases identified in Fresno, Kings, or Madera Counties for Q4 2025.</li> </ul>	
<p><b>#8 Credentialing &amp; Peer Review Subcommittee Business</b>            - Peer Review Subcommittee Report Q1 2026             (Attachment HH)             Action            Patrick Marabella, M.D., Chair</p>	<p>The <b>Peer Review Sub-Committee Quarterly Report Q1 2026</b> was presented. The Peer Review Sub-Committee met on February 19, 2026.</p> <ul style="list-style-type: none"> <li>• The county-specific <b>Peer Review Sub-Committee Summary Reports for Q4 2025</b> were reviewed for approval. No (0) significant cases to report.</li> <li>• The <b>Q4 2025 Adverse Events Report</b> was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period.               <ul style="list-style-type: none"> <li>◦ Seven (7) cases were identified in Q4 2025 that met the criteria for reporting. Three (3) of these cases involved practitioners, and four (4) cases involved organizational providers (facilities).                   <ul style="list-style-type: none"> <li>▪ Of the seven (7) cases, one (1) was tabled, one (1) was closed to track and trend with a letter of concern, and five (5) were closed to track and trend.</li> <li>▪ Six (6) cases were quality of care grievances, one (1) was a potential quality issue, zero (0) were lower-level cases, and zero (0) were identified through track and trend.</li> </ul> </li> </ul> </li> </ul>	<p>Motion: Approve            - Peer Review Subcommittee Report Q1 2026             (Ramirez/Waugh)            4-0-0-4</p>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> <li>▪ Three (3) cases involved Seniors and Persons with Disabilities (SPDs)</li> <li>▪ None (0) involved Behavioral Health.</li> <li>○ There were no (0) incidents involving appointment availability resulting in substantial harm to a member or members in Q4.</li> <li>○ Grievance data reviews completed in August, September, October, and November did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. (NCQA CR 5.A.3-4)</li> <li>○ Zero (0) cases were placed on corrective action in the fourth quarter of 2025.</li> <li>○ Zero (0) cases were identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner (NCQA CR.5.A.4) in Q4 2025.</li> <li>○ Thirteen (13) cases were identified and 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.</li> <li>○ One (1) case was referred to peer review for further review. Further review includes trended grievances and a license and sanction/exclusion review. This case did not require escalation for presentation at the Peer Review Committee.</li> <li>○ Zero (0) cases required reporting for 805.01 in Q4 2025.</li> <li>• The <b>Access &amp; Availability Substantial Harm Report for Q4 2025</b> 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.             <ul style="list-style-type: none"> <li>○ Sixteen (16) cases were submitted to the Peer Review Committee in Q4 2025. There were two (2) incidents found involving appointment availability issues <i>without significant harm</i> to a member. Five (5) cases were determined to be related to significant harm to a member, but <i>without appointment availability issues</i>.</li> <li>○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2025.</li> </ul> </li> <li>• The <b>2026 Peer Review Sub-Committee Charter</b> was presented and approved by the committee with no changes made to the Charter this year.</li> </ul>	

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	<ul style="list-style-type: none"> <li>The <b>2026 Peer Review Policy &amp; Procedure Annual Review</b> was presented. All Peer Review policies were approved with minor or no changes.</li> <li>The <b>Q3 2024 Peer Count Report</b> was presented and discussed with the committee. There was a total of sixteen (16) cases reviewed. Eleven (11) cases were closed and cleared. Two (2) cases were tabled for further information, two (2) were closed with CAP outstanding/continued monitoring, and one (1) case was pending closure for CAP compliance.</li> <li>The <b>Peer Review Sub-Committee</b> reports for Q4 2025 were reviewed for outcomes of Peer Review cases for Fresno, Kings, and Madera Counties. There were zero (0) cases reported in Q4 2025.</li> </ul>	
<p><b>#8 Credentialing &amp; Peer Review Subcommittee Business</b>                      - NCQA Information Integrity Credentialing Oversight Report (Q1 2026)                       (Attachment II)                       Action                      Patrick Marabella, M.D., Chair</p>	<p>The <b>NCQA Information Integrity Credentialing Oversight Report Q1 2026</b> was presented and reviewed.                      This report aims to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe:</p> <ol style="list-style-type: none"> <li>How primary source verification information is received, dated, and stored.</li> <li>How modified information is tracked and dated from its initial verification.</li> <li>Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.</li> <li>Annual training, to ensure incidents of data integrity are reported.</li> <li>The security controls in place to protect the information from unauthorized modification.</li> <li>How the organization monitors its compliance with the policies and procedures.</li> <li>Initiate a Corrective Action Plan (CAP) for findings.</li> <li>Assess CAP findings to ensure validity of corrections/actions.</li> </ol> <p>Quarterly audits were performed of a 5% sampling methodology (50 cases, 25 credentialing, and 25 recredentialing). Three (3) cases met threshold criteria. There was a total of 159 cases completed for CVH provider records in 2025, and all of these were considered. All files with modifications (3) were included in this review. The audit results provided to CVH reflect 100% compliance with audit criteria. There were no incidents of non-compliance with policies in the 3-case universe.</p>	<p>Motion: <i>Approve</i>                      - NCQA Information Integrity Credentialing Oversight Report (Q1 2026)                       (Cardona/Ramirez)                      4-0-0-4</p>
<p><b>#9 Compliance Update</b>                      -Compliance Regulatory Report</p>	<p>Mary Lourdes Leone presented the <b>Compliance Report</b>.  <b>CVH Oversight Activities: HN:</b> CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group</p>	<p>-Compliance Regulatory Report</p>

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(Attachment JJ)	<p>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 and availability, specialty referrals, utilization management data, grievances, and appeals, etc.</p> <p><b>Oversight Audits:</b> The following annual audits are in progress: UM/CM, Call Center, Claims/PDR, and Provider Network. No audits have been completed since the last Commission report.</p> <p><b>Fraud, Waste, and Abuse:</b> Since the 2/19/26 Compliance Report, there have been five (5) new MC609 filings with the DHCS.</p> <p><b>DMHC/DHCA 2026 Joint Medical Audit Survey:</b> The Plan submitted all required DMHC pre-audit documentation on February 20, 2026, and is currently awaiting additional guidance from DHCS regarding their pre-audit requirements.</p> <p><b>Department of Health Care Services ("DHCS") 2025 Medical Audit:</b> DHCS issued its final audit report and Corrective Action Plan (CAP) citing deficiencies related to delegated oversight of Health Net, 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. The Plan submitted its monthly CAP update on 2/27/2026 and will continue to send updates until the CAP is closed.</p> <p><b>Public Policy Committee (PPC):</b> The Public Policy Committee met on March 4, 2026. The next PPC meeting will be held on June 3, 2026, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.</p>	
#10 Old Business	None.	
#11 Announcements	The next meeting is on May 21 <sup>st</sup> , 2026.	
#12 Public Comment	None.	
#13 Adjourn	The meeting adjourned at 11:47 a.m.	

NEXT MEETING: May 21<sup>st</sup>, 2026

Submitted this Day: May 21, 2026  
 Submitted by:   
 Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X   
 Patrick Marabella, MD, Committee Chair