Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
May 21st, 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)**	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	Guests/Speakers		
	None were in attendance.		

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

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D., Chair	The meeting was called to order at 10:02 am. A quorum was present.	
#2 Approve Consent Agenda -Committee Minutes: March 19,	March 19th, 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	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2026 - A&G Inter-Rater Reliability Report (Q1 2026) - A&G Classification Audit Report (Q1 2026) - Quarterly A&G Member Letter Monitoring Report (Q1 2026) - CCC DMHC Expedited Grievance Report (Q1 2026) - A&G Validation Audit Summary (Q4 2025) - Concurrent Review IRR Report (Q1 2026) - Quarterly CA Operations Oversight Audit of Call Center Inquiry Calls (Q1 2026) - Medical Policies Provider Updates (Q1 2026) - Provider Office Wait Time Report (Q1 2026) - California Children's Services Report (Q1 2026) - TurningPoint Musculoskeletal Utilization Review (Q4 2025) - Access Workgroup Minutes: January 2026 - Access Workgroup Quarterly Report (Q1 2026) (Attachments A-N) **Action** Patrick Marabella, M.D., Chair	discussion at the request of any committee member. A link for the Medi-Cal Rx Contract Drug List was available for reference.	(Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business/A&G: - A&G Dashboard and Turnaround Time Report (March 2026) - A&G Executive Summary (Q1 2026) - A&G Quarterly Member Report (Q1 2026) (Attachments O - Q) **Action** Patrick Marabella, M.D., Chair	The **Appeals & Grievances Dashboard through March 2026, Appeals & Grievances Executive Summary Q1 2026, and Appeals & Grievances Quarterly Member Report Q1 2026** 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). • Appeals growth is concentrated in Fresno and Madera Counties, not systemwide. • Grievance increases are driven primarily by Fresno and Kings Counties. • A small number of issue types drive the majority of Appeals and Grievances. o 93.1% of Appeals fall into just two categories: Community Supports and Not Medically Necessary o 81.5% of Grievances are driven by five categories: Interpersonal, Transportation, Administrative Issues, Balance Billing, and Access to Care. • Balance Billing, transportation, and interpersonal issues continue as areas of opportunity. o Not Medically Necessary appeals o Quarter Over Quarter (QoQ) grievance increases: Balance Billing, transportation, and interpersonal issues o QoQ grievance decreases: Administrative Issues, Access to Care • Specific Appeal subcategories that present the strongest opportunities for intervention: o Under not medically necessary: ▪ Year Over Year (YoY) Appeal increases (top drivers): DME – Other, Diagnostic – MRI ▪ QoQ Appeals increases: DME – Other, Diagnostic – MRI o Under Community Supports: ▪ YoY Appeals increases (top drivers): Meals/Medically Tailored Meals, Housing Deposits ▪ QoQ Appeals increases: Meals/Medically Tailored Meals, Housing Deposits • Targeted actions can reduce Appeals and Grievances to improve the Member Experience: Provider education and vendor accountability offer the fastest relief. o Appeals/Not medically necessary – DME/Other/Diagnostic MRI ▪ Educate providers on the criteria for medical procedure coverage.	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (March 2026) - A&G Executive Summary (Q1 2026) - A&G Quarterly Member Report (Q1 2026) (Pascual/Ramirez) 4-0-0-4

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	▪ Ensure providers are submitting all needed information prior to medically necessary procedures. o Appeals/Community Supports – Medically tailored meals (14% overturned/86% upheld) ▪ Educate providers on qualification criteria. o Appeals/Community Supports – Housing Deposits (20% overturned/30% upheld/50% Partial) ▪ Educate providers/CBOs on the qualification and submission requirements. o Grievances/Prior Authorization Delay ▪ The provider should keep the member informed of the prior authorization timeline for approval. ▪ Continue providing routine live and recorded provider training webinars to address prior authorizations. o Grievances/Inappropriate Payment Demand (In-network providers) ▪ Coordinate with participating providers to reinforce billing guidelines and ensure members are not receiving inappropriate payment demands. ▪ Increase provider education on balance billing regulations and escalate repeat offenders through the vendor accountability process. o Grievances/General Complaint Vendor ▪ Implement a structured vendor performance review to identify recurring complaint patterns and establish corrective action plans. ▪ Enhance vendor CSR training on grievance resolution protocols and member communication standards. o Grievances/Transportation Missed Appointment ▪ Request feedback from the vendor on how they will address complaints related to no-show transportation. o Grievances/Provider ▪ Expand provider education on patient communication, empathy, and caring standards to address the increase in provider-related grievances. ▪ Develop targeted interventions for provider staff interactions, including office practice standards and member experience training.	
#3 **QI Business**	The **Potential Quality Issues (PQI) Report Q1 2026** provides a summary of Potential Quality Issues	**Motion:** *Approve*

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- Potential Quality Issues (Q1 2026) (Attachment R) **Action** Patrick Marabella, M.D., Chair	(PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, a non-member, or a 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 Q1 2026 was reviewed for all case types, including the follow-up actions taken when indicated. • There were two (2) non-member-generated Physical Health (PH) PQIs in Q1 in Fresno County, one (1) scoring level zero (0) and the other scoring level two (2). • Member-generated PQIs decreased compared to previous quarters, inclusive of both physical and behavioral health cases. Outcome scores were reported as 18 at level zero (0), two (2) at level one (1), and nine (9) cases scored at level II; one (1) case at level IV.	- Potential Quality Issues (Q1 2026) (Pascual/Ramirez) 4-0-0-4
#4 Key Presentations - Health Equity Work Plan End of Year Evaluation & Executive Summary 2025 - Health Equity Program Description & Change Summary 2026 - Health Equity Work Plan & Executive Summary 2026 (Attachment S - U) **Action** Patrick Marabella, M.D., Chair	The **Health Equity 2025 Executive Summary and Annual Work Plan Evaluation, 2026 Program Description with Change Summary, and 2026 Executive Summary and Work Plan** were presented. 1. **2025 Health Equity Work Plan Annual Evaluation.** Summary of activities accomplished and improvements made over the last calendar year, and all 2025 work plan activities completed. Highlighted activities completed by category include: • Language Assistance Services o A member newsletter article on how to access language services was completed and disseminated. o One hundred and twenty-five (125) staff completed their bilingual assessment/re-assessment. o MY2024 Geo Access report completed in November. o Twenty-six (26) translation reviews were completed in 2025. o Attended quarterly CAHPS Action Plan meetings and provided feedback for health equity interventions. o Ten (10) health education materials were field-tested. • Compliance Monitoring o HEQ reviewed eight (8) interpreter complaints and 29 grievance cases (27 medical/physical and two (2) behavioral health) with three (3) interventions identified. o The 2024 grievance trending report was completed in Q2 2025. o Launched FindHelp and Cozeva integration in 2025. o Two (2) FindHelp trainings were completed for staff, with 245 attendees and two (2)	**Motion:** *Approve* - Heath Equity Work Plan End of Year Evaluation & Executive Summary 2025 - Health Equity Program Description & Change Summary 2026 - Health Equity Work Plan & Executive Summary 2026 (Waugh/Pascual) 4-0-0-4

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	provider trainings with 86 attendees. New programs (288) were added to the platform. • Communication, Training, and Education o One (1) A&G training was completed on coding and resolution of grievances. o Two (2) Call Center trainings were conducted for 47 new staff. o Providers were updated on cultural practices, Language Assistance Program (LAP) services, health literacy, and online cultural competency/Office of Minority Health (OMH) training. o Language identification posters for provider offices were remediated and posted in the provider library. • Health Literacy, Cultural Competency, and Health Equity o English material review completed for a total of 58 materials. o Conducted Plain Language training for nine (9) staff. o Implemented Diversity, Equity, and Inclusion (DEI) and Transgender, Gender-Diverse, and Intersex (TGI) trainings for providers to meet All Plan Letter (APL) 24-017 and APL 24-018. Cultural competency training has been extended to be completed by providers by 12/31/2026. o Completed cultural competency education through Culturally and Linguistically Appropriate Services (CLAS) Month. o Supported the completion of quality projects for Well Child Visits (W30-6+) for 0-15 months and Substance Use Disorder (SUD)/Metal Health (MH) follow-up after ED Visit. o Completed three (3) focus groups on perimenopause/menopause. Perimenopause and Menopause Awareness Campaign was completed in October 2025. 2. **2026 Health Equity Program Description**. Roadmap for structure, resources, and monitoring. Updated annually with changes noted below: o Pages 4 & 8. Updated NCQA Accreditation name. o Page 10. Due to DHCS APL 25-005, update the tagline term to Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (NOA). o Page 12. Removed list of topics from Cultural Competency Training and provided reference to the CVH Policy (CA.CLAS.10). o Page 14. Included information on training completed by providers, which can be found in the provider directory. o Page 15. Update the health literacy process to include "Content and Layout Review	

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	checklist to streamline EMRs". Updated the title of the section. o Page 16. Changed the checklist name from Cultural Competency and Plan Language checklist to Content and Layout Review checklist. o Page 17. Update Health Equity Interventions to new intervention strategies. o Page 22. Remove PNA from the Health Equity Program Description, as responsibility has moved to the Population Health Management team. o Page 26. Removed Director of Program and added VP of Quality Management. 3. **2026 Health Equity Work Plan.** The plan for Health Equity activities throughout the year. Updated annually with a mid-year evaluation of progress. The 2026 Work Plan is consistent with the 2025 Work Plan while incorporating enhancements into four (4) categories: • Language Assistance Services • Compliance Monitoring • Communication, Training, and Education • Health Literacy, Cultural Competency, and Health Equity o Key updates include: ▪ Removed Population Needs Assessment (PNA) from the workplan as the Health Equity Department now contributes to Population Health and the Community Health Assessment, which is developed in collaboration with each county. ▪ Added: attendance at community events and meetings to sustain local relationships and partnerships. ▪ Expanded activities associated with Oversight of Provider Training in collaboration with other departments. ▪ Updated the project goal for Phase 2 of the IHI/DHCS Child Equity Sprint Collaborative, focusing on improving Well Child Visits for non-Spanish-speaking Hispanic children 0-15 months at three (3) targeted clinic sites from Clinica Sierra Vista in Fresno County. o Adding three (3) new activities: ▪ Partner with Kings County Public Health to advance their Community Health Improvement Plan (CHIP) priorities to improve preventive care, access and outcomes. ▪ Participate in the Fresno CHIP to develop and administer a provider-facing survey to identify gaps in Developmental Services and convene a Community Advisory	

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	Council by Q3 2026. ▪ Co-lead the Diabetes and Heart Health Workgroup within Madera County Public Health Live Well Madera initiative to improve prevention, early detection, and management of chronic conditions among priority populations. *There were no additional questions or concerns from the Committee.*	
#4 Key Presentations - Health Equity Language Assistance Program Report 2025 (Attachment V) Action Patrick Marabella, M.D., Chair	The **Health Equity Language Assistance Program End-of-Year Report for 2025** was presented and reviewed for an annual comparative analysis of language service utilization. CVH Race/Ethnicity as of 12/31/25 is as follows: (n=427,003) • Latino/Hispanic 72%: 305,935 • White/Caucasian 9%: 39,946 • Asian/Pacific Islander 9%: 36,480 • Unknown/Blank 3%: 13,951 • African American/Black 4%: 18,673 • Other 2%: 10,268 • American Indian/Alaska Native 1%: 1,750 Spanish and Hmong are CVH's Threshold Languages. Spanish 99%: 59,592 consistently has the highest volume, and Hmong was .09%: 827 calls. Interpretation utilization was performed via the following: • 76% (2,935) telephonic interpreters down from 80% in 2024 • 21% (791) face-to-face – up from 18% in 2024 • 3% (130) Sign language – up from 2% in 2024 • 0.1% (2) Video Remote Interpretation – consistent with 2024 Behavioral Health interpretation was performed via the following: • 6% telephonic interpreters • 33% face-to-face • 40% Sign language • 20% Video Remote Interpretation Limited English (LEP) and non-English membership remain high for the CVH population, and therefore, interpreter services are integral to maintaining safe, high-quality care.	**Motion:** *Approve* - Health Equity Language Assistance Program Report 2025 (Waugh/Pascual) 4-0-0-4

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	Discussion: *Dr. Ramirez asked how much utilization there is of the interpretation services overall, not by modality?* *Dr. Marabella indicated that certified interpreters are supposed to be present in a clinic setting or hospital. However, it is not uncommon for a family member to interpret, which increases risk due to members not consenting to treatment or clearly understanding the situation. The risk increases outside of the threshold languages, as fewer people speak Russian, Arabic, or specific dialects, etc. Interpretation services are not being utilized as much as they should be. All members can call certified interpreter services available 24-7.* *Sia Xiong-Lopez added that Community Health Workers in the CalAIM program for enhanced case management routinely request interpreter services.* *Dr. Ramirez wondered how often providers are taking it upon themselves to offer interpretation services versus using CVH interpreters.* *Dr. Marabella indicated that there was no way to know, but utilizing certified interpreters would be the best option. It is probably easier for clinics to use their own staff, but that also brings up access issues if the in-house interpreter is busy or out of the office.* *Dr. Ramirez asked if CVH measures how many calls were performed by CVH interpreters.* *Dr. Marabella quoted the report stating that, "Member Services Department representatives handled a total of 161,035 calls across all languages. Of these, 60,419 (38%) were handled in Spanish and Hmong. A total of 3,858 interpreter requests (specific request for interpretation with a provider) were fulfilled for CVH members; 2,935 (76%) of these requests were fulfilled utilizing telephonic interpreter services, with 791 (21%) for in-person."* *There were no additional questions or concerns from the Committee.* *Maria McDivitt left the meeting at 10:52 am and returned at 10:53 am.* *Morgan Simpson left the meeting at 10:55 am and returned at 10:58 am.*	
#4 Key Presentations - PHM Strategy Description 2026 (Attachment W) Action Patrick Marabella, M.D., Chair	The **PHM Strategy Description & Change Summary 2026** was presented. The Population Health Management (PHM) Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Changes to the **2026 Strategy Description** include: • Population Needs Assessment (PNA) (pgs. 2, 3): Added reference to the renaming of Population Needs Assessment to "Local Planning". Added Local Planning requirements,	**Motion:** *Approve* - PHM Strategy Description 2026 (Waugh/Ramirez) 4-0-0-4

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	including participation in each LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process and data sharing. • Stakeholder Engagement (pg. 4): Removed the requirement for the PNA report to be available on the health plan's website. • Population Stratification (pgs. 4-7): Updated definitions and descriptions, including Population Stratification and PHM Risk Stratification, Segmentation and Tiering (RSST) methodology. Updated the PHM model. Added Adverse Childhood Experiences (ACEs) screening to how SDoH needs are identified. • Basic Population Health Management (BPHM) (pg. 13): Added information on the First Year of Life program. Added statement on Care Management availability to members at any time and at any age to support with physical health, behavioral health, or SDoH needs. • Transitional Care Services (pg. 14) Changed "Conducting an initial outreach call within 72 hours of inpatient referral" to "... successfully connecting with the member within seven (7) days of discharge to complete an inpatient discharge risk assessment". Removed "A minimum of two (2) follow-up calls are made to the Member within fifteen (15) days of discharge". • PHM Programs and Services (pgs. 15-25) o Updated age eligibility criteria and program goals. Added program services and updated verbiage. Added program eligibility criteria. o Updated eligibility criteria for Pregnant Members at risk for adverse maternal and neonatal outcomes using the new Pregnancy Prioritization logic. Updated Program services to include Trimester-Based Assessment, Edinburgh Postnatal Depression Scale, and Patient Health Questionnaire-9. o Added Enhanced Care Management (ECM) to supplemental support for Members. o Updated details of the Diabetes Management Program goal to explain that a lower rate indicates better performance for Glycemic Status Assessment for Diabetes (GSD). Removed the value of directional improvement of 1-5% from the program goal. o Updated age eligibility criteria and program goals. Added program services and updated verbiage. Added program eligibility criteria. o Updated eligibility criteria for Pregnant Members at risk for adverse maternal and neonatal outcomes using the new Pregnancy Prioritization logic. Updated Program services to include Trimester-Based Assessment, Edinburgh Postnatal Depression Scale, and Patient Health Questionnaire-9.	

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	○ Added Enhanced Care Management (ECM) to supplemental support for Members. ○ Updated details of the Diabetes Management Program goal to explain that a lower rate indicates better performance for GSD. Removed the value of directional improvement of 1-5% from the program goal. External Partnerships (pg. 28): Within Local Health Departments, COVID-19 information was removed, and community-based vaccination events were held. ○ Updated program name and eligibility criteria throughout. ○ Updated Program goal for Tobacco Cessation. ○ Updated eligibility criteria for Breast Cancer Screening (BCS) to 40-74 years. Added high-risk breast cancer screening e-project for appropriate member outreach, scheduling, and follow-up to program services. ○ Added phobia, anxiety, and additional self-harm diagnoses to the denominator in the event/diagnoses for Severe and Persistent Mental Illness and Follow-Up Care after Mental Health Emergency Department Visits (SPMI & FUM). • External Partnerships (pg. 28): Within Local Health Departments, removed COVID-19 information and added community-based vaccination events. • Data and information sharing with Practitioners (pg. 30): As the Behavioral Health Quality Improvement Program (BHQIP) ended, additional information was added on developing new partnerships and data exchange options to facilitate this type of bidirectional data exchange with organizations across California through the MOU process. *There were no additional questions or concerns from the Committee.*	
#4 Key Presentations - Continuity & Coordination of Care Improvement Plan (Attachment X) Action Patrick Marabella, M.D., Chair	The **Continuity & Coordination of Care Improvement Plan 2025** monitors aspects of continuity and effective coordination between medical and behavioral healthcare and CVH leaders and managers with the goal of improving patient safety by reducing miscommunication and addressing issues associated with Care Coordination. The purpose of this presentation is to review and discuss performance results from the activities selected for 2025 and to review and confirm activities selected for 2026. The committee will also discuss specific barriers to improvement, share information, and brainstorm applicable initiatives or potential actions that should be executed. Measures meeting goals and quality metrics: • Eye Exam for Patients with Diabetes (EED), Rating Score 4 • Prenatal and Postpartum Care (PPC) – Prenatal Rate, Rating Score 4 • Prenatal and Postpartum Care (PPC) – Postpartum Rate, Rating Score 3	**Motion:** *Approve* - Continuity & Coordination of Care Improvement Plan (Waugh/Ramirez) 4-0-0-4

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	• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Rating Score 2 • Follow-up After Emergency Department Visit for Mental Illness, seven (7) days Total Rate (FUM), Rating Score 2 • Follow-up After Emergency Department Visit for Substance Use, seven (7) days Total Rate (FUA), Rating Score 2 • Follow-up After Hospitalization for Mental Illness, seven (7) days Total Rate (FUH), N/A for CVH. • Follow-up After High-Intensity Care for Substance Use Disorder, seven (7) days Total Rate (FUI), N/A for CVH. • HEDIS® Diabetes Screening for Members diagnosed with Bipolar Disorder or Schizophrenia Prescribed Antipsychotic Medications (SSD), Rating Score 4 Opportunities for Improvement: HEDIS® HPR Measures • Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment Total Rate (IET). Rating Score 1 did not meet the performance goal, and therefore, an improvement plan is required. **Opportunities Recommended for 2026 with Potential Actions:** <u>#1 Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow-Up (IET).</u> Quantifiable Metric: HEDIS® Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow-Up (IET) Barriers: • The primary barrier is engaging members to continue treatment; members are successfully initiating treatment but are not consistently engaged in treatment following initiation, representing a gap in continuity of behavioral health care. Potential Actions: • Expand network to include alcohol treatment, medication-assisted treatment, and peer support services. • Create a resource directory that can be accessed and utilized by providers and members. • Create both a Provider Tip Sheet and Member Resource Sheet to include descriptions of the	

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	available resources and how they can be accessed and utilized via the Resource Directory of substance abuse providers and services. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® (Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow Up (IET). <u>#2 Appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care.</u> Quantifiable Metric: • HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM) • HEDIS® Follow-Up After Emergency Department Visit for Substance Use (FUA) Barriers: • Timely provider notification of MH/SUD ED visits. • Lack of provider/member awareness of best practices for follow-up after MH ED visits • Limitations to relying on ADT reports for MH ED visits: too many notifications, difficulties when prioritizing outreach. • Member's resistance to BH or SUD treatment. Potential Actions: • Continue BH live member outreach calls after the MH ED visit. o Leverage internal MoCAT files to improve the member reach rate by offering additional phone numbers for outreach. • Implement Cozeva enhancements to increase and improve prioritized provider notifications about MH ED visits. • Embed staff (CHW, Substance Use Navigators, etc.) in high-volume EDs to conduct MH and SUD assessments and referrals that close HEDIS® gaps. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® Follow-Up After Emergency Department Visits for Mental Illness & Substance Use (FUM & FUA). *Discussion:* *Amy Schneider polled the Committee on whether the tip sheet and resource sheet are reasonable and helpful activities to pursue.*	

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	The Committee agreed. *Amy Schneider will forward a draft of both to the Committee for review before distribution.* *Amy also asked the Committee if there are any potential barriers to these activities.* *Dr. Ramirez said it would be easy to distribute a tip sheet internally for larger FQs.* *There were no questions or recommendations from the Committee.*	
#4 **Key Presentations** - CVH 2026 Long-Term Care Quality Assurance Performance Improvement Plan - Skilled Nursing Facility Quality Assurance and Performance Improvement Report (Q4 2025) (Attachment Y, Z) **Action** Patrick Marabella, M.D., Chair	The **CVH 2026 Long-Term Care Quality Assurance Performance Improvement Plan** was presented and reviewed. As part of CalAIM's benefit standardization and to move to a more seamless system, beginning January 1, 2023, DHCS initiated a transition of responsibility for Long-Term Care services from Fee-for-Service to Medi-Cal Managed Care Plans. • Starting with Skilled Nursing Facilities (SNF) • Followed by Subacute Care Facilities • Finally, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) The transition was completed in 2024. CalViva has a designated Long-Term Support Services (LTSS) Liaison. • With the responsibility for contracting with providers and authorizing members to receive LTC services, health plans are required to establish a system for monitoring and overseeing the quality of services provided to their members. • Goal: Continuous, Data-Driven Improvement across the full long-term-care continuum. • Scope: Fresno, Kings, and Madera Counties in and out of network Skilled Nursing Facilities (SNF) Developed a Plan to Address Required Elements: • Ongoing, comprehensive program covering clinical care, quality of life, and resident autonomy. • Multi-source data integration: o Claims Data o Data from DHCS o CDPH Survey Data (Publicly available) o Critical Incident Data (*Never events*) o Appeal and Grievance Data o Satisfaction Data • Benchmark against Title 22/42, LTC MCAS measures, CMS quality metrics, others as indicated. • Oversight: QI/UM Committee and RHA Commission	**Motion:** *Approve* - CVH 2026 Long Term Care Quality Assurance Performance Improvement Plan - Skilled Nursing Facility Quality Assurance and Performance Improvement Report (Q4 2025) (Pascual/Ramirez) 4-0-0-4

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	Components of the Plan: • The main monitoring tool is a Quarterly QAPI Dashboard, which has been developed. • CalViva LTSS Liaison maintains the dashboard, leads SNF and stakeholder engagement, and ensures transparency. • A cross-functional team (LTSS, UM, Transitional Care, Contracting, Quality/Data Analytics, etc.) updates the dashboard every quarter by gathering and compiling data from the various sources. • QI/UM Committee reviews the Dashboard to identify trends and opportunities. • CVH collaborates with SNFs, the LTC Ombudsman, and CBOs for root-cause analysis and technical assistance. Through the LTC Dashboard, we will monitor: • Integrated monitoring: claims analytics, public survey metrics, MCAS LTC measures per SNF/county. • Track ED visits, preventable admissions/readmissions, HAIs, infection control, staffing, abuse/neglect. • PQI system for reporting and investigating potential quality issues/critical incidents. Tied to Appeal and Grievance Data. • Adverse events: root-cause analysis, corrective action plans for prevention of recurrence (ensure CDPH has completed). • Active feedback loops with staff, residents, and families incorporated into the improvement cycle. Satisfaction/complaints. The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q4 2025)** was presented and reviewed to provide 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), DHCS Supplied WQIP data – scoring system that uses a combination of metrices across workforce, clinical quality and equity domains to determine incentive payments for SNFs, publicly available data (CMS and CDPH data including survey, complaint, critical incident), and MCAS/HEDIS® Long Term Care measures.	

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	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, averaging 1,080 patients monthly, with the majority in Fresno County. The Dashboard monitors eight (8) different issues/events, including preventable ED visits/hospital admissions/readmissions, healthcare-acquired infections, facility staffing issues, abuse/neglect, potential quality issues, adverse events, and member satisfaction/complaints. A weighted five (5) -point scale is used to evaluate each facility for quality of care and outcomes by assigning an overall score for quarterly comparisons and ranking over time. The Dashboard monitors the following Quality Categories: • Use of Anti-Psychotic Medications • Rate of Falls with Injury • Pneumococcal Vaccine Rate • Pressure Ulcers • UTI Rates • Staffing • Number of State Enforcement Actions • Infection Control Deficiencies • Quality of Care Deficiencies • Freedom from Abuse Deficiencies • Overall CMS Star Rating • Preventable Emergency Department Utilization • Preventable Inpatient Admission to Acute Care Charts presented provided the Q4 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: • Top Ten (10) SNFs in CVH Service Region by Unique Member Utilization. • Overall Top and Bottom Performing SNFs in CVH Region. • Lowest and Highest Five (5) Performing SNFs serving CVH members. • Lowest and highest rates of preventable ED visits. • Lowest and highest rates of preventable acute inpatient admissions. Based upon these results, the following three (3) SNFs were selected as having the greatest	

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	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 continue daily, all shifts. ▪ Pharmacy Education – Anti-Psychotic utilization education held in Q4 2025. In-service was conducted on 11/4/25 with all shifts. ▪ Management of BH: Psychiatrist-led in-service for all staff held in Q1 2026. 2. Kingsburg Center (managed by NewGen): Analysis of publicly available data shows a higher-than-state-average use of Falls, development of new wounds/ulcers, and UTIs. Member-level details are shared for additional investigation and targeted training. This facility is implementing the following to improve its quality outcomes: ▪ Hydration Rounds – Daily starting 3/1/26, dedicated staff will monitor availability and consumption of water – hydration rounds continue daily with all shifts. ▪ Repositioning Training and In-Services – Hosted during various shifts in March 2026, the Director of Staff Development and the Wound Care nurse provided training and education on repositioning, wound care, and techniques to relieve pressure. Arrangements will be made in Q2 2026 for a Wound Care Specialist physician to provide wound care and pressure sore in-service to the licensed and clinical staff at Kingsburg. ▪ Physical Therapy (PT) Team is making rounds to ensure all walkers are properly measured, starting 3/1/26. Rounds are conducted twice a month, and all new admits are assessed by PT within 48 hours of admission. 3. Community Subacute and Transitional: Analysis of publicly available data shows a better-than-average Fall rate and Antipsychotic Medication use. Rates of UTI and Pressure Ulcers are higher than the state averages, resulting in higher-than-expected ED utilization and inpatient admissions. This facility is implementing the following to improve its quality outcomes: ▪ Hydration Rounds - Daily, started on 9/1/25, dedicated staff will monitor availability and consumption of water. Hydration rounds to continue daily on all shifts. ▪ Physical Therapy Team Rounds to provide staff caregiver training on safe patient	

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	repositioning skills, starting 9/1/25 and conducted twice a month. ▪ 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. Immigration enforcement in the community caused fear. Immigrant CNAs stopped showing up for work. Additionally, Fresno Adult School and Pacific Health Education have reported a drop in enrollment in their CNA programs. Nursing Homes and their associations are working to develop strategies to train staff for certified nursing assistant positions. • Acute hospital psychiatric evaluations - Patients showing behavioral health needs/episodes in acute care are not assessed or evaluated by the acute psychiatric physicians. *Discussion:* *Dr. Ramirez asked when we would see results if changes were implemented in the fall of 2025.* *Dr. Marabella stated that we monitor trends quarterly to see if SNFs move out of the bottom five. There is a data lag.* *Dr. Ramirez asked if there was any sort of correlation made between the implementation of the activity and improvements in care.* *Dr. Marabella stated that the correlation is indirect. If the staff is doing physical therapy and wound care, then pressure ulcers should decrease. Hydrated members will have fewer UTIs.* *There were no additional questions or concerns from the Committee.* *Nicole Foss left the meeting at 11:00 am and returned at 11:02 am.*	
#5 UM/CM Business - Key Indicator Report & Turnaround Time Report (March 2026) - UM Concurrent Review (Q1 2026) (Attachments AA-BB) **Action**	The **Key Indicator Report & Turnaround Time Report March 2026 and the Utilization Management Concurrent Review (CCR) Report Q1 2026** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Acute Admissions: o MCE (Medicaid Expansion): Acute admissions and utilization remained consistent throughout Q1 2026, with figures closely aligned with 2025 averages. o TANF (Temporary Assistance for Needy Families): There was a minimal increase in admissions and utilization in Q1 2026 compared to 2025 levels. o SPD (Seniors and Persons with Disabilities): Q1 2026 utilization remained consistent.	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (March 2026) - UM Concurrent Review (Q1 2026) (Ramirez/Waugh) 4-0-0-4

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Patrick Marabella, M.D., Chair	• Acute Bed Days: Have increased across all populations for Q1 2026. Monitoring will continue. • Average Length of Stay (ALOS): o ALOS remains within acceptable ranges across all populations, with slight increases that align with observed acuity trends. o Maintain current performance level. Length of stay will continue to be monitored through utilization reviews and quarterly reporting. o SPD to be monitored due to the increase in ALOS. • Readmissions: o MCE declined in Q1 2026. o TANF remained stable. o SPD improved. • Next Steps: o Maintain rigorous utilization review practices aligned with discharge planning. o Continue to support and monitor current performance levels. o Maintain robust collaboration between UM and CM teams to promote seamless care transitions and optimal member support. o Sustain and expand outreach with key hospital partners to strengthen onsite presence and foster coordinated transitions for members moving to lower levels of care. • 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 returned to 100% compliance in Q4 2025 and Q1 2026. 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.	
#5 UM/CM Business - PA Member Letter Monitoring Report (Q1 2026) (Attachment CC)	The **PA Member Letter Monitoring Report Q1 2026** provides a summary of the daily audits of acknowledgment and resolution letters to ensure: • Use clear and concise denial language in decision letters. • Use clinical criteria or guidelines for decision letters. • To provide the correct anticipated decision date for deferral letters.	Motion: *Approve* - PA Member Letter Monitoring Report (Q1 2026)

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Action Patrick Marabella, M.D., Chair	• Use clear and concise language in deferral letters. • Appropriate member letter translation for deferral letters. These metrics show improvement, with a few minor issues that are being corrected. All errors identified by the A & G team in Table 1 were corrected before mailing. 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. The clinical team will continue to monitor and track acknowledgment and resolution letters.	(Pascual/Ramirez) 4-0-0-4
#5 UM/CM Business - Over/Under Utilization Report 2026 (Attachment DD) **Action** Patrick Marabella, M.D., Chair	The **Over Under Utilization Report 2026** was presented to review the impact of the UM Programs to detect and correct potential under and over-utilization through comprehensive monitoring efforts. Key Trends (PTMPY analysis was used to adjust for changes in membership): • **Inpatient Count:** The data reflects a steady multi-year decline in adjusted IP count across all three (3) counties. These trends suggest improved ambulatory care management, effective case management, and avoidance of preventable admissions, rather than inappropriate access barriers. • **Emergency Room Utilization:** ER utilization continues to decline across all three (3) counties. • **Outpatient Utilization:** OP utilization remains highest in Fresno, intermediate in Madera, and lowest in Kings. • **Procedure Specific Trends:** • C-section rates are still an issue, but they are improving in Fresno, where the county is participating in DHCS-led Transforming Maternal Health (TMaH) discussion. • Bariatric surgery utilization continues to decline year-over-year across all counties. Obesity management has evolved in recent years with greater availability of medications. As of 1/1/2026, GLP-1 drugs are not a benefit for adult Medi-Cal members for weight loss or weight loss-related indications. Medi-Cal will review on a case-by-case basis requests for medical necessity indications (e.g., cardiovascular disease, sleep apnea, etc.) approved by the U.S. Food and Drug Administration (FDA). Implications for CM: • Strengthen post-discharge planning to reduce readmissions, especially for high-growth surgical and chronic condition cohorts. • Implement targeted complex CM for frequent utilizers.	Motion: *Approve* - Over/Under Utilization Report 2026 (Pascual/Ramirez) 4-0-0-4

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	• Address social determinants impacting ER utilization through stronger community resource partnerships. *Discussion:* *Dr. Ramirez asked if the overall membership remained the same or increased.* *Dr. Marabella indicated that membership is declining. At the peak, it was close to 450,000, but with the changes in eligibility criteria, we may see it decline under 400,000.*	
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q1 2026) - Pharmacy Operations Metrics (Q1 2026) - Pharmacy Top 25 Prior Authorizations (Q1 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q1 2026) (Attachments EE-HH) **Action** Patrick Marabella, M.D., Chair	The **Pharmacy Executive Summary Q1 2026** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q1 2026. o Overall, TAT for Q1 2026 was 100%. o PA volume was lower in Q1 2026 compared to Q4 2025 and there were some drug-specific differences. Volume was consistent in all months in Q1 2026. The **Pharmacy Operations Metrics Q1 2026** 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%. • The average turnaround time met the standard with 100%. The **Pharmacy Top 25 Prior Authorizations Q1 2026** 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 Q1 2026 were mostly consistent with the top 25 drugs reviewed in Q4 2025, with a few placement variations. IVIG appears in the top 25, which had not previously been seen for several quarters. Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products. Several drug requests in Q1 2026 had high denial rates based on the non-preferred status of the requests.	Motion: *Approve* - Pharmacy Executive Summary (Q1 2026) - Pharmacy Operations Metrics (Q1 2026) - Pharmacy Top 25 Prior Authorizations (Q1 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q1 2026) (Ramirez/Pascual) 4-0-0-4

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	The **Quality Assurance Reliability Results (IRR) for Pharmacy Q1 2026** 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 is reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas, with a threshold for action of 90%. • The 90% threshold was met. The 95% goal was met. The overall score was 96%. • Three (3) sample cases had potential criteria application or documentation issues after plan review.	
#7 **Policy & Procedure Business** - A&G Annual Policy & Procedure Review (Attachment II) Action Patrick Marabella, M.D., Chair	The **A&G Annual Policy & Procedure Review** was presented to the committee. The following policy was presented for annual review with **no changes made:** AG-001 Member Grievance Process AG-002 Member Appeal Process AG-004 Handling DMHC Calls Regarding Urgent Grievances **The following policies were presented for annual review and were approved with the following changes:** AG-005 Managing DMHC Cases: Annual review. Minor grammatical edits. Committee members agreed with the policy changes as stated and voiced no questions or concerns.	Motion: *Approve* - A & G Annual Policy & Procedure Review (Ramirez/Pascual) 4-0-0-4
#8 **Oversight Audit Business** - UM/CM (Attachments JJ) Action Patrick Marabella, MD, Chair	The **2025 UM/CM Oversight Audit** was presented and reviewed. CVH Medical Management staff conducted an oversight audit of HN's Utilization Management (UM) and Case Management (CM) functions. A variety of documents were provided and reviewed, including the UM/CM Program Description, Workplan and Annual Evaluation, a number of policies and procedures, extensive reports and data analyses, logs, and other documentation as evidence of compliance with established standards and regulations. One-hundred and forty-four (144) standards were assessed, with one-hundred and forty (140) in compliance, a 97% overall compliance rating. A corrective action plan has been requested to address three (3) opportunities for improvement mostly related to policy/documentation issues.	Motion: Approve - UM/CM (Waugh/Pascual) 4-0-0-4
#9 **Compliance Update** -Compliance Regulatory Report	Morgan Simpson presented the **Compliance Report**. **CVH Oversight Activities: HN:** CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group	-Compliance Regulatory Report

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(Attachment KK)	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. **Oversight Audits**: Annual audits in progress: Call Center, Q4 2025 Claims/PDR, 2026 Credentialing, 2026 Health Education, 2026 Health Equity, 2026 Marketing, and the 2026 Provider Network. Completed audits since the 3/19/26, report to the Commission: UMCM 2025 (CAP) **Fraud, Waste, and Abuse:** Since the 3/19/2026 Compliance Regulatory Report, there were eight (8) new MC609 filings relating to: Inappropriate Billing: two (2) cases, Phantom Provider: two (2) cases, Insufficient Documentation: two (2) cases, False Representation: one (1) case, and Services not rendered: one (1) case. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** No change in status: DHCS will issue forward-looking guidance at future CAP closure and allow 90 days to implement any required changes. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** CVH submitted its monthly CAP update on 4/15/26 and will continue to send updates until the CAP is closed. **2026 DMHC/DHCS Joint Medical Survey Audit:** CVH submitted all required DMHC pre-audit documentation on 2/20/26 and DHCS pre-audit requirements on 5/1/26. DHCS sent a Verification Study Sample request on 5/7/26, and the Plan will submit files by 5/19/26. DHCS and DMHC will be on-site from 6/16/26 through 6/26/26 to conduct audit interviews. **Memorandum of Understanding (MOU):** Since 3/19/26, the Plan has executed the following MOUs: DMC-ODS Madera County **Revised ASA and CPSA with HN:** The DHCS approved the Plan's revised ASA and CPSA on 4/29/26 and subsequently filed them with the DMHC on 5/5/26. Upon DMHC approval, the ASA and CPSA will be fully executed and retroactively effective 7/1/25. **(RY)2026 (MY)2025 Timely Access and Annual Network Submission (TAR):** CVH submitted its Annual TAR filing to DMHC on 5/1/26 and is awaiting a response. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026. **Public Policy Committee (PPC):** The next PPC meeting will be held on 6/3/26, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.	

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#10 **Old Business** -Lead Levels in Children (Attachment LL)	*At the March 19th QIUM meeting,* Dr. Cardona asked what the positive Lead exposure rate was for the County. Dr. Marabella reported that Fresno County has one of the highest rates of childhood lead poisoning in California, with approximately **1,500 children** affected, particularly in older neighborhoods. Fresno, Alameda, Los Angeles, and Monterey counties have all been identified as having high rates. Approximately **4.09%** of children tested in Fresno County (2022 data) had **elevated blood lead levels ≥ 3.5** (mu/g/dL), which is higher than many other California counties. **Elevated Levels:** In **2023, 5.85%** of children under 6 in Fresno County had blood lead levels (BLL) at or above 3.5 (mu/g/dL). **High-Risk Areas:** Specific ZIP codes, particularly in downtown Fresno (e.g., 93701), show higher incidences due to older housing. **Childcare Facilities:** A 2023 report indicated that 66 out of 73 tested childcare centers in Fresno County had water with lead levels exceeding 5 ppb. There is no "safe level". **Common sources** are paint, soil, dust, ceramics, crystals, imported toys, and stained glass. Other sources of lead can come from remodeling older homes, shooting ranges, or welding. The **Childhood Lead Poisoning Prevention Program** (CLPPP) offers home visitation, education, and inspection. CLPPP participates in the National Lead Poisoning Prevention Week in October and the National Poison Prevention Week in March annually.	
#11 **Announcements**	The next meeting is on July 16th, 2026.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 11:45 a.m.	

NEXT MEETING: July 16th, 2026

Submitted this Day: July 16, 2026

Submitted by: Amy Schneider RN

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, MD, Committee Chair