

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
September 17th, 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	✓	Morgan Simpson, 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	✓	Maria McDivitt, Director of Compliance	
	Carolina Quezada, M.D., Internal Medicine/Pediatrics, Family Health Care Network	✓	Patricia Gomez, Senior Compliance Manager	
	Joel Ramirez, M.D., Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	Norell Naoe, Medical Management Administrative Coordinator	
✓	DeAnna Waugh, Psy.D., Psychology, Adventist Health, Fresno County			
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA (Alternate)			
	Guests/Speakers			
	None were in attendance.			

✓ = in attendance

* = Arrived late/left early

** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D., Chair	The meeting was called to order at 10:03 AM. A quorum was present. Dr. Marabella let the Committee know that Amy Schneider has been out on medical leave but is joining the meeting remotely today. He reminded the QI/UM Committee that Mary Lourdes Leone	

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	retired and introduced Morgan Simpson as the new Chief Compliance Officer for CVH.	
#2 Approve Consent Agenda Committee Minutes: July 16, 2026 - A&G Inter-Rater Reliability Report (Q2 2026) - A&G Classification Audit Report (Q2 2026) - Quarterly A&G Member Letter Monitoring Report (Q2 2026) - CCC DMHC Expedited Grievance Report (Q2 2026) - Lead Screening Quarterly Report (Q1 2026) - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement (QAPI) Dashboard (Q1 2026) - Member Incentive Programs – Semi-Annual Report (Q1&Q2 2026) - Call Center Inquiry Calls Audit (Q2 2026) - Initial Health Appointment (IHA) Quarterly Audit (Q1 2026) - Medical Policies Updates (July, June) - Pharmacy Provider Updates (Q3, Q2) -ECM & Community Supports Performance Report (Q2 2026)	The July 16th, 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 discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	Motion: Approve Consent Agenda (Cardona/Pascual) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Provider Office Wait Time Report (Q2 2026) - County Relations Quarterly Update (Q2 2026) - Performance Improvement Project Updates – PIPs - California Children’s Services Report (Q2 2026) - Utilization Management Program Description 2026 - Evolent Report (Q2 2026) - PA Member Letter Monitoring Report (Q2 2026) - Disparities Analysis and Actions Report (2026) - Health Equity Social Risks and Social Needs Analysis and Prioritization Report 2026 - Health Equity Social Risks and Social Needs Resource Assessment Analysis Report 2026 - Health Equity 2026 Annual Referral Tracking Disparity Report - Access Workgroup Committee Minutes 5/26/26 (Attachments A-Y) Action Patrick Marabella, M.D., Chair		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business - A&G Dashboard and Turnaround Time Report (July 2026) - A&G Executive Summary (Q2 2026) - A&G Quarterly Member Report (Q2 2026) (Attachments Z-BB) Action Patrick Marabella, M.D., Chair	The Appeal & Grievance Dashboard and Turnaround Time Report (Q2 2026), the Appeal & Grievance Executive Summary (Q2 2026), and the Appeal & Grievance Quarterly Member Report (Q2 2026) were presented and reviewed. Monthly Excel files include the logs identifying each member who submitted a grievance during the reporting period (monthly), with a narrative description of the grievance and the resolution. • The Mid-Year Appeals & Grievances dashboard was reviewed; activity remained generally consistent with 2025 trends, with 1300 grievances received and 1200 resolved. • Quality of Service Grievances (QOS), particularly Access to Care/DMHC, remained the highest grievance category, largely related to prior authorization. ○ Balance billing is consistent; education will continue as the primary intervention with new providers joining the network. ○ Community Supports' complaints and appeals remained elevated, primarily housing-related services and quality-of-service concerns. ○ Behavioral Health (BH) became its own category this year, noting the increase from one in 2025 to 26 at the mid-year. ○ Transportation missed appointments remains an issue, and monitoring continues. • Exempt grievances have generally improved compared with last year, especially assignment and ID card issues, due to increased automation and digital card access. ○ Transportation no-shows increased slightly in the second quarter, primarily related to a vendor issue. ○ Balance billing trends have remained relatively stable. • Appeals volume is increasing, with 430 resolved mid-year compared with 600 total for 2025. ○ Community Supports appeals are a key driver, reaching 103 mid-year compared with 95 last year, largely due to confusion around housing-related benefits and changing program rules. ○ Provider education is ongoing through the ECM Community Supports teams. ○ Durable Medical Equipment (DME) appeals remain a significant category, with 96 mid-year compared with 111 last year, driven by autism-related DME requests such as speech-generating devices, protective beds, and specialized wheelchairs. ○ New DME vendors and higher-cost products are creating medical-necessity challenges, often resulting in partial approvals for basic medically necessary equipment rather than more expensive options.	Motion: Approve - A&G Dashboard and Turnaround Time Report (July 2026) - A&G Executive Summary (Q2 2026) - A&G Quarterly Member Report (Q2 2026) (Faulkenberry/ Cardona) 5-0-0-2

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	○ Advanced imaging appeal activity remains relatively steady, with continued PET scan and CT-related requests. ○ The “Other” appeals category has increased, partly because some hospitals and providers are submitting member appeals to seek payment for already completed services that were denied for lack of medical necessity. ○ Providers are being reminded to use the appropriate provider dispute process rather than routing payment disputes through member appeals. • Uphold and overturn rates are out of the desired ratio due to need for continued education related to new benefits and changes to existing benefits. • The July A&G Dashboard was reviewed: July grievances exceeded 300, with patterns generally consistent with prior months. ○ The “Other” grievance category included a significant number of prior authorization-related items. ○ Community Supports grievances included housing, meals, and personal care concerns, with housing remaining the largest category. ○ BH QOS grievances increased slightly into double digits, while missed appointments remained relatively stable. • July appeals reached 88, the highest monthly total of the year; trends will continue to be monitored to determine whether this is a one-month increase. ○ Community Supports appeals were high, with most related to housing, followed by personal care attendants and meals. ○ DME appeals continued, including prosthetics, wheelchair support, and other equipment requests; only one (1) speech-generating device appeal was noted. ○ Advanced imaging appeal volume remained favorable, while pharmacy biologics showed a temporary increase.	
#3 QI Business - Potential Quality Issues (Q2 2026) (Attachment CC)	The Potential Quality Issues (PQI) Report provides a summary of PQIs identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or Peer Review activity. Peer Review activities include cases with a severity code level of III or IV, or any case that the CVH CMO requests to be forwarded to Peer Review. Data for Q2 2026 was reviewed for all case types, including the follow-up actions taken when indicated. • There were two (2) non-member-generated Fresno County Physical Health (PH) PQI in Q2.	Motion: Approve - Potential Quality Issues (Q2 2026) (Faulkenberry/ Cardona)

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Action Patrick Marabella, M.D., Chair	• Member-generated PQIs increased based on previous quarters, with a total of 57 PH cases and two (2) Behavioral Health (BH) cases. All cases were scored level zero (0) to two (2). • Thirteen (13) Peer Review cases were generated (one was BH). Five (5) cases are closed, and eight (8) cases are open. • Five (5) Peer Review cases reviewed from April through June needed Further Action. All cases scored level zero to two (0-2).	5-0-0-2
#4 Key Presentations - RY2026 HEDIS® Results & Quality Improvement Update (Attachment DD) Action Patrick Marabella, M.D., Chair	The RY2026 HEDIS® Results & Quality Improvement Update was presented and reviewed. HEDIS® Measures: The Managed Care Accountability Set (MCAS) is a set of performance measures that DHCS selects for annual reporting by Medi-Cal Managed Care health plans (MCPs). These are generally HEDIS® measures. • High-Performance levels (HPLs) are used as performance goals and to recognize MCPs for outstanding performance at the national Medicaid 90th percentile. • Minimum Performance Levels (MPLs) are set at the national Medicaid 50th percentile. MCPs are contractually required to perform at or above MPLs. DHCS will impose sanctions on MCPs that fail to meet the MPLs. • For RY2025/26 (MY2024/25), MCPs were required to meet the MPL on 18 measures in each county in four (4) Domains. • Fresno County did not meet the Minimum Performance Level (MPL) for MY25 in three (3) Domains (BH (2/2 same as last year), Children’s Health (1/8 improvement), and Reproductive Health/Cancer Prevention (1/5 decline). • Kings County did not meet the MPL for MY25 in the Children’s Domain (4/8 improvement). • Madera County did not meet the MPL for MY25 in the BH Domain (2/2 same as last year) and Reproductive Health/Cancer Prevention (1/5 decline). • Performance Improvement Projects (PIPs) ○ <u>PIP #1</u>: Improve Well Child Visits (WCV) for African American/Black (AA/B) children from zero to fifteen (0 to 15) months in Fresno County with two (2) interventions: 1. Refer all caregivers/mothers of B/AA children to Black Infant Health to encourage and facilitate WCV. 2. Promote use of the CDC Milestone Tracker App to engage parents in WCV and encourage appointment attendance. ▪ Statistically significant improvement noted for B/AA Children. Completion of six (6)	Motion: Approve - RY2026 HEDIS® Results & Quality Improvement Update (Pascual/Waugh) 5-0-0-2

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	Well Child Visits by 15 months for remeasurement period 1 (MY24) and remeasurement period two (2) (MY25). ▪ Successful rollout of CDC Milestone Tracker App to provide caregiver education on developmental milestones & promote timely WCVs. ▪ Continue referral of all B/AA pregnant members to Black Infant Health. ○ <u>PIP #2:</u> Improve Follow-up with Provider after ED Visit for Behavioral Health/Substance Use in Fresno and Madera Counties with three (3) interventions: 1. Educational Intervention for Hospital staff on Use of Smart Phrases in EMR to document services & referrals provided for BH/SUD in the ED (SUNs, CHWs, LCSWs, etc.) to represent codes that meet FUM/FUA measures. 2. Cultural Training to Improve behavioral health/substance use Treatment Compliance for the Hispanic population in the Central Valley. 3. Expand Resources by engaging with local providers - Resiliency Center. 4. Final Report submitted to HSAG & DHCS on 8/6/26. ▪ Statistically significant improvement in the percentage of timely SUD/MH ED visit provider notifications in Fresno and Madera Counties for remeasurement period 1 (MY24) and remeasurement period 2 (MY25). ▪ Although the MPL has not yet been met for FUM/FUA measures in Fresno or Madera counties, compliance rates have more than doubled for both measures in both counties since the project was initiated. • Institute for Healthcare Improvement (IHI) Collaborative Project to Improve Well Child Visit Rates for Hispanic Children zero to fifteen (0 to 15) months in Fresno County. Successful collaboration with Clinica Sierra Vista to implement all four (4) interventions at three (3) high-volume pediatric clinic sites. This project demonstrated our ability to spread interventions within an FQHC and sustain these improvements over time. ○ Phase 2 began Sept 2025 to Sept 2026: 1. Expanding Appointment Access – Designated Outreach Staff 2. Optimizing Scheduling Workflow – Newborn Gateway 3. Connect Birthing Parents to Resources – Community Baby Showers 4. New WIC Referral Process There were no questions or comments from committee members.	

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#4 Key Presentations - Quality Improvement and Health Education Work Plan Mid-Year Evaluation and Executive Summary 2026 (Attachment EE) Action Patrick Marabella, M.D., Chair	The Quality Improvement and Health Education Work Plan Mid-Year Evaluation 2026 and Executive Summary were presented and reviewed by the Committee. Planned Initiatives and Nine (9) Areas of QI Focus for 2026 include: • Access and Availability, Behavioral Health, Care Coordination/Member Engagement, Chronic Conditions, Maternal Health/Hospital Quality and Patient Safety, Member Experience, Pediatric/Perinatal/Dental, Pharmacy and Related Measures, and Preventive Health. Objectives: There are a total of 95 measurable objectives for the QI and Health Education 2026 Work Plan. Ongoing activities continue. • 79 objectives completed at mid-year. • 70/79 objectives were met. • 9/79 objectives were not met. • 16 additional objectives scheduled for Q3-Q4 2025 and on track at mid-year. The programs that did not meet their objectives were Access and Availability, Member Experience, Pediatric/Dental, and Preventive Health. 98 Total Activities planned for the year: • 22/22 mid-year activities completed. • 76 additional activities are planned from July to December. Of those, two (2) activities were cancelled. QIHed Mid-Year Performance Progress (refer to Table 1 in the PowerPoint presentation): • Behavioral Health, Chronic Conditions, Maternal Health/Hospital/Patient Safety, and Pharmacy have one hundred percent (100%) of their objectives met. • Hospital Quality/Patient Safety (N/A at mid-year 11 goals), Care Coordination/Member Engagement (N/A at mid-year 2 goals), Member Experience (N/A at mid-year 3 CAHPS goals) have not yet met their objectives. QIHed Mid-Year Work Plan Activities (refer to Table 2 in the PowerPoint presentation): • Eight (8) categories (excluding Pharmacy) have additional Year-end activities planned. Access, Availability, and Service: Access to Care: ○ Provider Appointment Availability Survey – PAAS ▪ PCP Urgent and Non-Urgent exceeded the 70% threshold. ▪ Specialist Urgent & Non-Urgent improved but did not meet the 70% threshold.	Motion: Approve - Quality Improvement and Health Education Work Plan Mid-Year Evaluation and Executive Summary 2026 (Cardona/Waugh) 5-0-0-2

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	▪ Ancillary non-urgent exceeded the 70% threshold. ○ Provider After Hours Access Survey – PAHAS ▪ Appropriate Emergency Instructions exceeded the 90% threshold. ▪ Ability to Contact On-Call MD did not meet the 90% threshold. Access Actions: ○ All non-compliant providers will receive Corrective Action Plans in September 2026. ○ Eighteen (18) Provider Training Webinars from July to December. Member Satisfaction: Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey was conducted by Press Ganey in May 2026. ○ Report in August. ○ Quarterly Root Cause Analysis of A & G Data. ○ Sullivan Luallin Webinar Trainings are available for Providers. RY2026 HEDIS® Results (Refer to the chart on page nine (9) of the corresponding PowerPoint): • Fresno County did not meet the Minimum Performance Level (MPL) for RY26 in the following measures: FUM, FUA, W30-6+, and BCS-E. • Kings County did not meet the MPL for RY26 in the following measures: CIS-10, LSC, WCV, and W30-2+. • Madera County did not meet the MPL for RY26 in the following measures: BCS-E, FUM, and FUA. Performance Improvement Projects (PIPs) and Other Projects - All On Track Two (2) PIPs: • Clinical: Well Child Visits in First Thirty (30) Months of Life, Fresno County. • Non-Clinical: Improve Provider Notifications after ED Visit for SUD/MH, Fresno and Madera Counties. Other Projects: • IHI Well Child Visit Collaborative • DHCS Lean Project Madera County (BH Domain) Health Education Activities and Actions (July to December 2026): • Continuing Member incentive strategy for all priority MCAS measures. • Member Services to inform Members of programs and materials that are available.	

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	FindHelp had a total of 184 referrals at the mid-year. There were no questions or comments from committee members.	
#4 Key Presentations - Utilization Management/Care Management Work Plan Mid-Year Evaluation & Executive Summary 2026 (Attachment FF) Action Patrick Marabella, M.D., Chair	The Utilization Management/Care Management Work Plan Mid-Year Evaluation 2026 & Executive Summary were presented and reviewed by the Committee. Utilization Management (UM) processes have remained consistent. Case Management (CM) & Disease Management continue to monitor program effectiveness to better serve our members. Activities in 2026 Focus on Five Areas: 1. Compliance with Regulatory & Accreditation Requirements All Compliance Activities are on target at Mid-Year. 2. Monitoring the UM Process All Monitoring activities are on target at the mid-year, except element 2.2 Timeliness of Processing the Authorization Request. <u>Barriers identified:</u> - Two (2) Urgent Pre-service cases exceeded the turnaround time in Quarter 1. Rate declined below 95% in Q2 2026. - Causes include incorrect priority validation, incorrect routing, inconsistent adherence to established processes, failure to escalate, and, in June, a capacity gap caused by high authorization volume and limited staffing. <u>Actions Taken:</u> - Daily turnaround-time huddles - Hourly urgent queue reviews - Proactive staffing and workload adjustments - Staff are reminded of timely escalation of identified compliance risks. 3. Monitoring Utilization Metrics All Monitoring activities are on target at the mid-year except elements 3.1 Acute Inpatient Utilization Performance and 3.3 PPG Profile. 3.1: Utilization Goals (See table on page 20 of the PowerPoint Presentation for KIR metrics through June 2026 – all rates are too soon to tell): 2% reduction in acute bed days over prior year - Average length of stay <5 days 30-day readmission rate maintain 11% or below	Motion: Approve - Utilization Management/Care Management Work Plan Mid-Year Evaluation & Executive Summary 2026 (Faulkenberry/Waugh) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	3.3: PPG Profile and Vendor List – Too soon to tell <u>Barriers identified:</u> - o PPG B: Routine Decision & Member Notification TAT was non-compliant due to staffing and workflow issues. Workflow is being evaluated to determine root cause and appropriate remediation activities. - o PPG C: Routine Decision & Member Notification TAT was non-compliant. Delegate has changed MSO relationship. Monitoring and working with the new MSO to oversee performance trends. <u>Actions Taken:</u> Continue monitoring open PPG CAPs. 4. Monitoring Coordination with Other Programs All Monitoring activities are on target at the mid-year. 5. Monitoring Activities for Special Populations All Monitoring activities are on target at the mid-year. There were no questions or comments from committee members.	
#4 Key Presentations - Population Health Management Program Effectiveness Report 2026 (Attachment GG) Action Patrick Marabella, M.D., Chair	The Population Health Management Program Effectiveness Report 2026 was presented and reviewed. This report provides an annual summary of the CVH Population Health Management program successes and opportunities. It focuses on assessing the impact of key interventions related to: Care process or outcome, Cost/utilization, and Overall member experience. Thirteen (13) measures were included in the PHM analysis, and whether each measure met the goal for 2025 or not. The following programs are not yet meeting the established goals to improve care process or outcome, cost/utilization, and/or member experience. • Breast Cancer Screening (BCS) (54.77%/25th MY 2025 percentile HEDIS rate compared to 60.21%/75th MY 2024 percentile.) Analysis has identified the following barriers negatively impacting our ability to meet our goals: - o Provider and radiology facility awareness of updated Breast Cancer Screening guidelines, which expanded the age range, increasing the denominator for the BCS measure. Members also had difficulty scheduling mammograms. Actions Implemented to improve BCS effectiveness: - o Education for providers and radiology facilities on new guidelines. - o HEDIS® live call outreach campaign. - o Mobile mammography events.	Motion: Approve - Population Health Management Program Effectiveness Report 2026 (Cardona/ Faulkenberry) 5-0-0-2

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	○ Engaged providers/radiology facilities to identify high-risk members for targeted outreach. • Care Management ER Visits (22% higher ER Visits in 2025) Analysis has identified the following barriers negatively impacting our ability to meet our goals: ○ Members often seek Primary Care services in the ED due to lack of access and information regarding their PCP and barriers to scheduling PCP appointments. ○ Members often don't fully understand their discharge instructions or when to seek follow-up care for symptoms. Actions Implemented to improve the ER Visits measure: ○ Expand availability of telemedicine solutions. ○ Member outreach to educate members and connect members to care. ○ Enroll inpatients in the Transitional Care Services (TCS) program to coordinate all discharge services. • Use text messages to offer TCS program to all recently discharged members. Follow-up care after Mental Health Emergency Department Visits (FUM-30) (49.63% MY 2025 rate) • Follow-up care after Substance Use Disorder Emergency Department Visit (FUA-30) (38.18% MY 2025 rate) Analysis has identified the following barriers negatively impacting our ability to meet our goals: ○ Accurate reporting/identification/contact and timely outreach of members for FUM and FUA. ○ Care Coordination to improve the continuity of care for FUM and FUA. Actions taken to address the identified barriers and improve behavioral health measures: ○ Member outreach calls using daily ADT reports to close care gaps. ○ Supplemental member contact info is being fed directly into BH ADT reports. ○ Educated SUNs, CHWs, and Social Workers on "Smart Phrases" to document care and services. ○ Provided culturally appropriate education and outreach strategies to SUNs. CHWs and Social Workers for MH/SUD to increase acceptance of follow-up care. ○ Create an educational flyer on substance abuse services and resources available for Fresno, Kings, and Madera Counties. ○ Create educational flyers on depression and anxiety to identify resources. Take this annual summary into consideration as we prepare our next Population Health Management Strategy Program Description to assist us in establishing priorities, setting new goals, and	

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	identifying future opportunities for improvement. There were no questions or comments from committee members.	
#5 UM/CM/PHM Business - Key Indicator Report and Turnaround Time Report (July 2026) - UM Concurrent Review Report (Q2 2026) - Care Management & CCM Report (Q2 2026) (Attachments HH-JJ) Action Patrick Marabella, M.D., Chair	The Key Indicator Report, Turnaround Time Report, and the Utilization Management Concurrent Review Report present inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness during Q2 2026. July Key Indicator Report • Membership continued to decline and is expected to decrease further with upcoming Unfavorable Immigration Status (UIS)-related changes. • Utilization remained variable, with no clear year-to-date trend. • Adult bed days increased sharply from 66 to 71 to 77, then to 98; the figures will be validated. • Adult and Temporary Assistance for Needy Families (TANF) Average Length of Stay (ALOS) increased. • Readmission rates fluctuated; possibly in connection with longer inpatient stays, while Seniors/Persons with Disabilities (SPD) performance leveled off. • Turnaround-time issues noted previously appear corrected in July, with performance returning to target. • Care management referrals generally rebounded: Perinatal (PCM), Transitional Care Services (TCS), Behavioral Health (BH), and First-Year-of-Life (FYOL) activity remained high; Physical Health (PH) referrals declined but stabilized. Mid-Year Key Indicator Report (PowerPoint Presentation) • Acute admissions were generally stable, with modest variation across Medi-Cal Expansion (MCE), TANF, and SPD populations. • On a per-1,000-members-per-year basis (PTMPY), acute admissions increased for MCE (8.9%) and SPD (5.5%) and remained about the same for TANF compared to 2025. • Bed-day utilization rose for MCE (20.9% increase compared to 2025) and remained comparatively stable for TANF and SPD. • ALOS increased for MCE and slightly for TANF, while SPD remained about the same and below the annual goal; MCE remains below the annual goal but requires continued monitoring. • Readmission performance was mixed. • Overall trends in ALOS, bed days, and readmissions fluctuated during the first half of the year;	Motion: <i>Approve</i> - Key Indicator Report and Turnaround Time Report (July 2026) - UM Concurrent Review Report (Q2 2026) - Care Management & CCM Report (Q2 2026) - Concurrent Review IRR Report (Q2 2026) (Waugh/Pascual) 5-0-0-2

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	MCE and SPD were identified as priority populations for monitoring. • Key Takeaways: The Q2 2026 readmissions data show mixed performance across populations. TANF improved compared to the 2025 average, while MCE and SPD increased above the 2025 average. Continued focus on discharge planning, care coordination, and post-discharge support remains important to help reduce avoidable readmissions, especially for populations trending above prior-year performance. • Next steps include strengthening hospital-partner onsite presence, coordinating transitions to lower levels of care, reviewing stays longer than 30 days during Discharge Planning (DC) Rounds, identifying barriers, escalating opportunities, facilitating timely transitions, and implementing a mandatory referral to CM for all members readmitted within 30 days of discharge to support care coordination, post-discharge follow-up, and reduction of avoidable readmissions. The Care Management and CCM Report for Q2 2026 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 activities (FYOL). This includes referral volume, member engagement, and an evaluation of Program effectiveness. • PH CM: Referrals increased year to date, engagement improved, and the program managed more total and complex cases than last year. • TCS: Referrals decreased, but engagement remained strong at approximately 90%; year-to-date activity remained sustainable and total cases managed were favorable. • BH CM: Referrals were consistent across the first two quarters, engagement remained near 68%–70%, and total cases managed compared favorably with last year. • PCM: Referrals remained steady at approximately 800 per quarter, engagement stayed in the 60% range, and total cases managed decreased slightly in Q2 2026. • FYOL: Volume dipped slightly in Q2 2026, but engagement remained strong; continued attention is needed to ensure effective handoffs from perinatal services. The effectiveness of the PH & BH CM programs is evaluated based on the following measures: • Readmission rates, ED utilization, overall health care costs, and member satisfaction • PH and BH outcomes: Readmissions and emergency department (ED) utilization declined after care management; BH and PH readmissions decreased by 12%, and ED claims by 845, above our new 20% goal.	

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	• TCS outcomes: Readmissions improved by 8%, exceeding the goal; the reduction in ED visits was just below the new 20% goal. • PCM outcomes: Timely prenatal visits improved by 14%, preterm births decreased by 6%, and postpartum visits improved by 12%; each measure met or exceeded its goal. • Member survey participation remained below target. The team plans to conduct a shorter survey delivered by text to improve response rates. Morgan Simpson left the meeting at 10:50 AM and returned to the meeting at 10:53 AM.	
#5 UM/CM/PHM Business - Concurrent Review IRR Report (Q2 2026) (Attachments KK) Action Patrick Marabella, M.D., Chair	The Concurrent Review Inter-Rater Reliability (IRR) Report Q2 2026 ensures effective, evidence-based medical management decisions are made in a timely and consistent manner. Key components of the CCR medical management process include: Authorization of Inpatient Admissions; Proactive Acute Hospital Discharge Planning; and Medical Appropriateness Review. • Turnaround times and collaboration documentation were strong, but the Q2 2026 report identified concerns with InterQual application and documentation. InterQual compliance scores showed opportunities for improvement. ○ Misses included improper criteria selection and insufficient clinical documentation to support selected InterQual criteria. ○ Planned corrective actions include staff education, audit-team calibration, expanded certification training, strengthened review criteria, and continued trend monitoring.	Motion: Approve - Concurrent Review IRR Report (Q2 2026) (Cardona/ Faulkenberry) 5-0-0-2
#6 Pharmacy Business - Pharmacy Executive Summary (Q2 2026) - Pharmacy Operations Metrics (Q2 2026) - Pharmacy Top 25 Prior Authorizations (Q2 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q2 2026) (Attachments LL-OO)	The Pharmacy Executive Summary Q2 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 ○ Pharmacy Prior Authorization (PA) metrics were within five percent (5%) of the standard for Q2 2026. ○ Overall, TAT for Q2 2026 was 99.6%. ○ PA volume in Q2 2026 was similar to Q1 2026, with some drug-specific differences. Volume was consistent in all months of Q2 2026. • Pharmacy Top 25 Prior Authorizations Q2 2026	Motion: Approve - Pharmacy Executive Summary (Q2 2026) - Pharmacy Operations Metrics (Q2 2026) - Pharmacy Top 25 Prior Authorizations (Q2 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	○ 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 Q2 2026 had high denial rates based on the non-preferred status of the requests. ○ The approval rate was similar in Q2 2026 compared to Q1 2026. ○ The top requests in Q2 2026 were similar compared to Q1 2026. • Quality Assurance Reliability Results (IRR) for Pharmacy Q2 2026 ○ The 95% goal was met; the overall score was 95%. ○ Three (3) sample cases were determined to have a questionable denial or approval after Plan review: it was determined that the decisions were not consistent with criteria or documentation and led to one (1) questionable denial and two (2) questionable approvals. A more detailed review and QA of cases in Q2 2026 has been performed, and results will be shared with PA management to address concerns.	(Q2 2026) {Pascual/ Faulkenberry} 5-0-0-2
#7 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q3 2026) (Attachments PP) Action Patrick Marabella, M.D., Chair	The Credentialing Sub-Committee Quarterly Report was presented. The Credentialing Sub-Committee met on 7/16/26. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q1 2026 were reviewed for delegated entities, and for Q2 2026 for Health Net (HN) and HN Behavioral Health (BH). A summary of the Q1 2026 data was presented. • The Credentialing Adverse Actions report for Q2 2026 for CVH from the HN Credentialing Committee was presented. There was one (1) CVH case presented for discussion in Q2 2026. The Credentialing Committee reviewed a case involving a request for administrative termination of the practitioner's participation in Fresno County due to failure to satisfy required Facility Site Review (FSR) and Medical Record Review (MRR) corrective action requirements. Following the review, the practitioner was required to submit a Corrective Action Plan (CAP) with supporting evidence showing that the cited deficiencies had been resolved. Because the deficiencies remained unresolved after the regulatory correction period and extension, the Credentialing Committee administratively terminated the practitioner's participation, effective 6/25/2026, for the impacted practice site only. This action is regulatory and administrative in nature. Network terminations resulting from failed or noncompliant FSR/MRR findings remain in effect for three (3) years, after which the practitioner may reapply for participation. There are no appeal rights for this	Motion: <i>Approve</i> - Credentialing Subcommittee Report (Q3 2026) (Cardona/Waugh) 5-0-0-2

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	administrative action, consistent with the termination being based on noncompliance with regulatory participation standards rather than on a determination of professional competence or conduct. • The Adverse Events Q2 2026 report was presented. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period. ○ Credentialing submitted no (0) new cases to the Credentialing Committee in Q2 2026 involving an individual practitioner. ▪ Credentialing submitted three previously presented, remaining open cases to the Credentialing Committee in the second quarter of 2026. ○ All cases involved individual practitioners. ○ All cases stemmed from a state licensing board action. ○ One case was placed on annual monitoring, and two cases were closed with no further action. ○ Zero cases involved behavioral health. ▪ There were no reconsiderations or fair hearings during Q2 2026. ○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2026. ○ 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 Q2 2026. ○ Reviews completed in April, May, and June identified one (1) practitioner and one (1) provider requiring removal from the Plan's network. ▪ The provider appeared on both the CMS Preclusion report and the Suspended and Ineligible Provider Listing. ▪ The practitioner appeared on the Suspended and Ineligible Provider Listing. ○ The practitioner and provider were notified, as well as impacted Plan departments such as Claims, Network Management, Delegation Oversight, Special Investigations Team, and Provider Data Management. ○ April, May, and June 90-day monitoring and termination rosters for practitioners whose license status was documented as delinquent on the state licensing board were submitted and approved via live or electronic Credentialing Committee meetings to meet business needs.	

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	○ Zero (0) cases required reporting for 805 in Q2 2026. • The Access & Availability Substantial Harm Report Q2 2026 was presented and reviewed. This report aims to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) cases related to identified appointment availability complaints. Each case is assigned a severity outcome score, and cases requiring follow-up are tracked to conclusion. This report now includes behavioral health cases in addition to physical health. ○ After a thorough review of all Q2 2026 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1). ○ The Investigations Team submitted 13 cases to the Peer Review Committee in the second quarter of 2026: ○ Of the 13 cases, zero (0) cases were related to appointment availability issues without significant harm, and four were related to significant harm without appointment availability issues. ○ There were zero incidents involving appointment availability issues resulting in substantial harm to a member or members in the second quarter of 2026. • The Credentialing Summary Reports for HN and HN Behavioral Health for Q2 2026 were presented and reviewed. ○ The Credentialing Summary Reports were presented for Q1 2026 to reflect Initial Credentialing and Recredentialing activities. These reports also provide information on any Suspensions, Terminations, or Resignations for Quality of Care from the delegated entities. There were no (0) significant issues identified in this reporting period. • The Credentialing Sub-Committee Reports for Q2 2026 were reviewed. The county-specific Credentialing Subcommittee Reports of significant subcommittee activities for April through June 2026 were presented. There was one (1) termination in Fresno County, and three (3) CAPs were issued in Madera County for Q2 2026.	
#7 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q3 2026	Peer Review Sub-Committee Quarterly Report was presented. The Peer Review Sub-Committee met on 7/16/26. • The county-specific Peer Review Sub-Committee Summary Reports for Q2 2026 were reviewed for approval. No (0) significant cases to report.	Motion: Approve - Peer Review Subcommittee Report Q3 2026

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(Attachment QQ) Action Patrick Marabella, M.D., Chair	• The Q2 2026 Adverse Events Report was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. ○ There were eight (8) cases identified in Q2 2026 that met the criteria and were submitted to the Peer Review Committee. ▪ Four (4) cases were regarding practitioners, and four (4) cases involved organizational providers (facilities). ▪ Of the eight (8) cases, three (3) were tabled, one (1) was closed to track and trend with a letter of concern, one (1) was closed to track and trend with a letter of education, and three (3) were closed to track and trend. ▪ Eight (8) cases were quality of care grievances, zero (0) were potential quality issues, and zero (0) were track and trend. ▪ One (1) case involved seniors and persons with disabilities. ▪ One (1) case involved behavioral health. ○ The Investigations Team submitted five (5) previously presented, remaining-open cases to the Peer Review Committee in Q2 2026. ▪ Two (2) cases were regarding practitioners, and three (3) cases involved organizational providers (facilities). ▪ Of the five (5) cases, one (1) was tabled, one (1) was placed on monitoring, and three (3) were placed on pending closure. ▪ Two (2) cases were quality-of-care grievances, three (3) were potential quality issues, and zero (0) were track-and-trend. ▪ Two (2) cases involved seniors and persons with disabilities. ▪ Zero (0) cases involved behavioral health. ○ There were zero (0) new or previously reported incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2026. ○ Grievance data reviews (NCQA CR 5.A.3-4) completed in March, April, and May did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. ○ Two (2) cases were placed on or remain on corrective action in Q2 2026. ○ Grievance data reviews for health equity, site review, chaperone, or medical records, completed in April, May, and June, did not identify any providers/practitioners who met	(Cardona/ Faulkenberry) 5-0-0-2

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	the Peer Review trended criteria for escalation. ○ There was one (1) new case and one (1) previously reported case identified outside of the ongoing monitoring process in which an adverse injury occurred during a procedure by a contracted practitioner (NCQA CR.5.A.4) in Q2 2026. ○ The reviewing Medical Directors determined that further outreach was required for ten (10) cases. ○ Zero (0) cases were referred to peer review for further review. Further review includes trended grievances and a license and sanction/exclusion review. Zero (0) cases required escalation for presentation at the Peer Review Committee. ○ Zero (0) cases required reporting for 805.01 in Q2 2026. • The Access & Availability Substantial Harm Report for Q2 2026 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. ○ Thirteen (13) cases were submitted to the Peer Review Committee in Q2 2026. Of the thirteen (13) cases, zero (0) cases were related to appointment availability issues without significant harm, and four (4) were related to significant harm without appointment availability issues. ○ Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q2 2026. • The Q2 2026 Peer Count Report was presented and discussed with the committee. There were thirteen (13) cases reviewed. Five (5) cases were closed and cleared. Zero (0) cases were closed/terminated. Zero (0) cases were deferred. Four (4) cases were tabled for further information. There was one (1) case with CAP outstanding/continued monitoring, and three (3) are pending closure for CAP compliance.	
#8 Access Business - Access Workgroup Quarterly Report (Q3 2026) (Attachment RR)	The Access Work Group Quarterly Report (Q3 2026) was presented by Morgan Simpson and reviewed by the QI/UM Committee. This report provides an update on the CVH Access Workgroup activities since the last report to the QI/UM Committee. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. Access Workgroup meetings were held on 5/26/26 and 7/28/26, with the full list of reports	Motion: Approve - Access Workgroup Quarterly Report (Q3 2026)

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Action Patrick Marabella, M.D., Chair	reviewed by the Access Workgroup in Appendix A. See full report for additional details. 5/26/26 Access Workgroup Meeting: ACCESS 1 MY 2024 Access & After-Hours CAP & Evaluation: Corrective Action Plans (CAPs) were issued to seven (7) PPGs and six (6) direct network providers. All PPG and direct-network corrective action activity was validated and closed. ACCESS 5 Network Adequacy Report Q1 2026: - DMHC PCP alternative access was requested for non-compliant ZIP codes. Mammography fell below standard in Fresno County, and Diagnostic Radiology fell below standard in Kings County. - DHCS PCP Access: Access standards (adult and pediatric populations) were not met in Fresno and Madera Counties. ACCESS 8 Appeals & Grievances Executive Report (Full & Executive Summary) Q1 2026: Top access-related grievance classifications: Prior authorization delays (72 cases), Missed transportation appointments (29), PCP referrals for services (15), Network availability (12), Availability of appointment with PCP (10), Availability of appointment with specialist (9), and Prescription Delay (6) Q1 2026 Transportation Oversight Report: Transportation utilization increased to 12.27% from 11.50% in Q4 2025. 7/28/26 Access Workgroup Meeting: MY 2025 Integrated Accessibility Report: Access metrics fall under two categories: "Rate of Compliance", DMHC Provider Appointment Availability (PAAS) Survey and the DHCS standards, and other metrics CVH uses to monitor access to care that are not part of the Rate of Compliance. Timely Access Metrics: MY 2025 PAAS results show that the 70% DMHC compliance threshold was met for both Urgent Care (70%) and Non-Urgent (77%) appointments across all survey types <u>when combined across all counties</u>, even though individual providers may not have met the compliance threshold. After-Hours Survey: Two metrics were used to measure performance with Access to After-Hours: - Appropriate After-Hours Emergency Instructions: percent of providers who give clear and appropriate instructions for emergency issues. Goal met. 93% overall compliance rate - Ability to contact on-call physician after-hours – percent of providers that can be contacted	(Pascual/ Faulkenberry) 5-0-0-2

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	within thirty (30) minutes for urgent issues. Goal not met. 86.9% overall compliance rate • Provider Satisfaction Survey: Satisfaction rates ranged approximately between 49% and 62%, which was a decrease from the prior year's results, which ranged between 66% and 72%. • Enrollee Experience Survey (EES): Results of the 2025 EES show that 67% of members indicate that they had no problems getting a timely appointment for routine care, an increase in rate in 2025 from 54% in 2024. CAHPS® Survey: In MY2025, CVH participated in the Health Services Advisory Group, Inc. (HSAG) annual CAHPS® survey using standardized NCQA questions to assess member experience with the Plan and Plan providers. Behavioral Health Survey: CVH surveyed members who used behavioral healthcare services between 3/1/24, and 2/28/25. The Experience of Care and Health Outcomes (ECHO) Survey for MY 2025 assessed member satisfaction regarding Urgent and Non-Urgent Appointments. MY2024 results reflect improvement across all measures, with scores ranging from 45% to 95%. Member Grievances: For MY2025, CVH monitored member grievances related to access by analyzing the volume and PTMPY rates of Quality of Service (QOS) and Quality of Care (QOC) grievances. Planned improvement actions include stronger provider and member communications, increased monitoring of providers and PPGs, and a summit with HN and its provider network team to expand specialty and BH networks. MY2025 Integrated Availability Report: Overall, CVH is meeting the ratio standards and the time and distance standards. Exceptions include: Standard drive times were not met for hospitals across Fresno, Kings, and Madera counties due to geographic distance, particularly for rural members in Madera. Ancillary Services (Urgent Care Centers and Laboratory facilities) and Limited Specialists were not met in Kings County. Telehealth Program Report Q1 2026: Telehealth and eConsult utilization demonstrated overall strong performance, highlighting average response times of 14 minutes for general medical visits and 78% of eConsults completed within 24 hours. 2025 Alternative Access Network Adequacy: When the Plan does not meet time or distance standards for a particular specialty in a geographic area (i.e., zip codes), an exemption request is filed with the Department of Managed Health Care (DMHC) and with the Department of Health Care Services (DHCS) through an alternative access standard (AAS). Five (5) PCP and three (3) Hospital AAS were submitted to the DMHC. 240 AAS requests were submitted to the DHCS across both adult and pediatric measurement categories.	

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#9 Compliance Update - Compliance Regulatory Report (Attachment SS)	Morgan Simpson presented the Compliance Report. CVH Oversight Activities: Health Net: CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participates in joint work group meetings, and discusses any issues or questions during the monthly oversight meetings with HN. CVH and HN also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. The reports cover PPG-level data in the following areas: financial viability data, claims, provider disputes, access and availability, specialty referrals, utilization management data, grievances, and appeals, etc. Oversight Audits: Annual audits in progress: Q4 2025 Claims/PDR, 2026 Credentialing, 2026 Health Education, Member Rights, Quality Improvement, ECM, and Behavioral Health. Completed Annual Audits since the last Commission report: Call Center (No CAP), Health Equity (No CAP), and Marketing (No CAP). Fraud, Waste & Abuse Activity: Since the 7/16/2026 Compliance Regulatory Report to the Committee, there were seven (7) new MC609 filings: Inappropriate Billing (5), SNF Excessive Billing (2) Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation: On 8/4/26, DHCS accepted and closed the Focused Audit CAP. Department of Health Care Services ("DHCS") 2025 Medical Audit: All CAP responses were completed and submitted to DHCS. Awaiting DHCS review, feedback, and final closure. MY 2024 Health Equity and Quality Performance: DMHC issued its Health Equity and Quality Performance Findings Report for MY2024 on 7/1/26. The Plan exceeded benchmarks for most quality measures with no administrative deficiencies; however, four (4) aggregate measures and several health equity disparities require a CAP, due to DMHC on 9/29/26. 2026 DMHC/DHCS Joint Medical Survey Audit: The Plan is awaiting the preliminary audit report for the onsite audit conducted from June 16, 2026, through June 18, 2026. 2026 Network Adequacy Validation (NAV) Audit: The Plan is expected to receive audit findings in January 2027 for the virtual audits conducted on 7/14/26 and 8/25/26. Memorandum of Understanding (MOU): Executed MOUs since the last Commission meeting: • Public Health (LDH) Kings County • First Five Fresno County • Child Welfare Fresno County As required by the DHCS contract, these MOUs have also been posted on the CalViva Health website	

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	under Key Documents and Forms: www.calvivahealth.org/meeting-agenda/procedures-forms/ Unsatisfactory Immigration Status (UIS): Effective 1/1/27, Medi-Cal members with Unsatisfactory Immigration Status (UIS) will transition from Medi-Cal managed care to the Fee-for-Service (FFS) delivery system in accordance with federal requirements. DHCS has established implementation requirements and associated deliverables for MCPs to support an orderly transition of affected members, including activities related to member communications, continuity of care, data, and transition readiness. The Plan submitted the first deliverable on 9/1/26. The next deliverable is due on 9/15/26. New DHCS Regulations/Guidance: Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026. Public Policy Committee (PPC): The Public Policy Committee meeting was on 9/2/26. The following standing reports were presented: • Semi-Annual Member Incentive Program Q1, Q2 2026 • Appeals and Grievance Report Q2 2026, including additional perspective on specific issues/trends from Dr. Marabella. There were no recommendations or action items requiring a response from the Commission. The next Public Policy Committee meeting will be held on December 3, 2026, 11:30 am -1:30 pm, located at 7625 N. Palm Ave, Suite 109, Fresno, CA 93711.	
#11 Old Business	None.	
#12 Announcements	The next meeting is on October 15 th , 2026.	
#13 Public Comment	None.	
#14 Adjourn	The meeting adjourned at 11:28 a.m.	

NEXT MEETING: October 15th, 2026

Submitted this Day: October 15th, 2026

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

Acknowledgment of Committee Approval:

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