Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
July 16th, 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,** Senior 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
		✓	***Courtney Shapiro,** Director, Community Relations & Marketing, CVH
	Guests/Speakers		
	None.		

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

ATTENDANT/PRESENTER	MOTIONS/MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D., Chair	The meeting was called to order at 10:02 a.m. A quorum was present. Dr. Marabella introduced Courtney Shapiro, CVH Director of Community Relations and Marketing, to the QI/UM Committee. Ms. Shapiro presented Attachment R.	

AGENDA ITEM/PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTION TAKEN
#2 Approve Consent Agenda Committee Minutes: May 21, 2026 - Initial Health Appointment (IHA) Quarterly Report (Q4 2025) - Provider Preventable Conditions (Q1 2026) - County Relations Quarterly Report (Q1 2026) - Specialty Referrals Report (Q1 2026) - Standing Referrals Report (Q1 2026) - Evolent (Q1 2026) - SPD HRA Outreach (Q1 2026) - TurningPoint Musculoskeletal Utilization Review (Q1 2026) - Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2025) - Access Work Group Minutes from 3/19/26 - Accessibility of Service Report (Primary, BH, & Specialty Care) - Assessment of Network Adequacy (BH & Non-BH) (Attachments A-M) **Action** Patrick Marabella, M.D., Chair	The May 21st, 2026, QI/UM Committee minutes were reviewed, and highlights from the 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 to the Medi-Cal Rx Contract Drug List was available for reference.	**Motion:** *Approve* Consent Agenda (Quezada/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business/A&G: - A&G Dashboard (May 2026) (Attachment N) **Action** Patrick Marabella, M.D., Chair	**The Appeals & Grievances Dashboard Report through May 2026** was 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 May Appeals & Grievances dashboard was reviewed; activity remained generally consistent with prior months, with 212 grievances received and 234 resolved. • Access to care remained the highest grievance category, largely related to prior authorization and PCP scheduling issues. • Balance billing decreased and may reflect a baseline trend; education will continue as the primary intervention. • Community Supports complaints and appeals remained elevated, primarily related to meals, housing-related services, and quality-of-service concerns. • Transportation, interpersonal clinic issues, and provider no-show grievances continue to be monitored; quality-of-care grievances remained low. • Appeals remained higher at 87 in May, all pre-service. • DME appeals mainly involved wheelchairs, CPAP, oxygen, and braces; imaging appeals mainly involved CTs, and PET scans. • A new "Other" appeals trend was noted involving providers using the member appeal process instead of the provider dispute or appeal process; this will be monitored and addressed through education if needed. • The uphold/overturn rate was approximately 40/40.	**Motion:** *Approve* - A&G Dashboard (May 2026) (Ramirez/Waugh) 4-0-0-4
#3 QI Business/A&G: - Behavioral Health Performance Indicator Report (Q1 2026) (Attachment O) **Action** Patrick Marabella, M.D., Chair	**The Behavioral Health Performance Indicator Report Q1 2026** The committee reviewed a substantially revised Behavioral Health report developed by CVH Medical Management leadership, HN's new BH leadership, and the BH operational team to improve visibility for CVH, the QI/UM Committee, and the Board. The consolidated report covers behavioral health activities, performance data, county coordination, care management, access, grievances, satisfaction, MOU-related information, membership and utilization trends, turnaround time compliance, approval and denial rates, mental health parity, care coordination referrals, case management activity, access standards, transportation utilization, county behavioral health updates, and member/provider education efforts. • QI 2026 data indicated that: o Overall CVH membership declined from approximately 425,000 to 410,000; unique behavioral health patients decreased from about 35,000 to 32,000; and service	**Motion:** *Approve* - Behavioral Health Performance Indicator Report (Q1 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM/PRESENTER	MOTIONS/MAJOR DISCUSSION	ACTION TAKEN
	intensity declined from 780 to 650 units per thousand. o Turnaround time compliance was 100%, with average turnaround time increasing from 4.1 days in 2025 to 5.4 days in 2026. o Case management volume declined by 782 cases, or 52%, while engagement remained approximately 70% and case complexity increased. o Care coordination included 922 screenings; Fresno County had the highest volume, adults represented about 78% of activity, and youth volume remained stable at 65. o Access availability standards were 100% compliant. o Transportation totaled approximately 12,000 behavioral health-related trips; SUD trips accounted for about 8,500 trips, or 67%, and Fresno County represented 92% of utilization. Transportation and access to behavioral health services were noted as important areas to monitor, particularly for SUD-related services and rural access limitations. o Behavioral health grievances remained low at eleven (11) total; satisfaction results are pending, with ECHO survey results expected in November. • Behavioral Health Tip Sheets for members and providers were shared for feedback and are nearing deployment to support education on available services and levels of care. *Discussion:* *Dr. Marabella asked the Committee members to provide feedback on the format of the revised report.* *Committee members provided feedback that the narrative summary was helpful and that graphics should continue to be available for reference and trend review.*	
#3 QI Business/A&G: - Lead Screening Quarterly Report (Q4 2025) (Attachment P) Action Patrick Marabella, M.D., Chair	The **Blood Lead Screening Quarterly Report (Q4 2025)** was presented to monitor blood lead screening in children, assess CVH's quarterly performance, and review anticipatory guidance monitoring. Screening compliance reflects clinical guidelines and reporting requirements and helps ensure CVH members receive anticipatory guidance related to lead poisoning prevention, blood lead level testing, and follow-up services from providers. Overall results have not changed significantly, and documentation of anticipatory guidance remains inconsistent. • Facility site review data showed anticipatory guidance documentation increased only slightly, from approximately 2% to 2.5%. • Medical record audits showed higher screening rates at 12 months, lower screening rates at 24 months, and inconsistent documentation of anticipatory guidance.	**Motion:** *Approve* - Lead Screening Quarterly Report (Q4 2025) (Ramirez/Quezada) 4-0-0-4

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	• Q4 2025 lead screening compliance was approximately 33.38% overall, with the older age group continuing to show lower performance. • A special audit was conducted with high-volume providers to better understand the barriers associated with documentation of the provision of anticipatory guidance. Audit findings showed significant variation by provider and based upon EMR use; clinics using available anticipatory guidance prompts had much higher documentation rates (over 90%), while clinics not using prompts showed very low rates (0-10%). • Provider education and technical support were identified as key interventions, including encouraging clinics to activate EMR prompts, improve documentation workflows, and use point-of-care lead testing equipment when available. • Fresno County was noted as a high-risk area for childhood lead exposure, reinforcing the importance of improving screening, parent education, and documentation. *Discussion:* *The committee discussed the need to support providers through multiple approaches, including member outreach, provider lists, EMR enhancements, potential pilot support, and continuing education.* *Dr. Quezada asked why rates are low for FHCN providers if they are prompted in EMR systems.* *Dr. Marabella indicated that providers may not be responding to prompts. FHCN accounts for approximately 36% of CVH pediatric membership in Kings County. Kings County is performing below the 25th percentile. Further investigation is needed into the root cause of the lack of documentation for this metric in Kings County.* *Dr. Ramirez stated that providers are doing the blood test, but it is difficult to correctly code the anticipatory guidance as there is no specific code for it. Would a global texting campaign suffice? This would only meet the standard if there was evidence in the child's record indicating that parents were educated.* *Amy Schneider stated that CVH is using multiple methods to communicate with families, such as sending education letters to parents, but they would need to be included in the child's record to meet DHCS standards. CVH Providers are also receiving lists of members to target to meet the MPL.*	
#3 QI Business/A&G: - Enhanced Care Management	**Enhanced Care Management and Community Supports Performance Report (Q1 2026)** summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the	**Motion:** *Approve* - Enhanced Care

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and Community Supports Performance Report (Q1 2026) (Attachment Q) Action Patrick Marabella, M.D., Chair	quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system with program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) are responsible for administering both ECM and CS services. This report now includes DHCS audit findings and corrective action plan (CAP) updates. • Of the 22,782 members who were assigned to the three (3) CVH counties, 4,330 were successfully enrolled in ECM, representing a 19% enrollment rate below the 30% goal; Madera was closest at 25.8%, followed by Fresno at 19.6% and Kings County at 10.8%. Children and youth, including child welfare and CCS populations, remain key growth opportunities. • CS activity remained high, with approximately 64,000 authorizations and 700,000 claims; top paid claims were concentrated in Housing Transition/Housing Sustaining/Housing Deposits Services (36%), Assisted Living Facility Transition (25%), Personal Care and Homemaker Services (12%), and Medically Tailored Meals/Medically Supported Foods (11%). • CS referrals through Findhelp totaled 348 across 24 providers, while claims activity was concentrated in Fresno, with lower reported rates in recent months. • ECM in-person engagement averaged 44%, and focused provider audits showed progress, though audit completion rates remain an area for improvement. • The DHCS CAP addressed three (3) areas: documentation of the seven (7) ECM core components, timely written notices for discontinued ECM services, and standardization of ECM member-facing materials. • Discontinuation notice requirements were reported as fully compliant for February and March, while documentation of the seven (7) ECM core components remains a work in progress. • The committee reviewed ongoing barriers, provider engagement efforts, incentives, audit follow-up, and corrective action tracking to support improvement.	Management and Community Supports Performance Report (Q1 2026) (Waugh/Quezada) 4-0-0-4
#4 Key Presentations - DHCS Community Reinvestment (Attachment R)	DHCS All Plan Letter 25-004 established Community Reinvestment requirements for Medi-Cal Managed Care Plans. As part of these requirements, health plans must invest a portion of net income in activities that address community needs and improve health outcomes. Courtney Shapiro presented the **DHCS Community Reinvestment Plan** to review CVH's investments and goals, evaluate the potential impact on health outcomes, and provide the QI/UM Committee with an opportunity to provide feedback before submission to DHCS. • Community Reinvestment funds are divided into Base Community Reinvestment and Quality	**Motion:** *Approve* - DHCS Community Reinvestment (Quezada/Waugh) 4-0-0-4

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Action Patrick Marabella, M.D., Chair	Community Reinvestment categories. Quality Community Reinvestment investments must measurably advance health outcomes, address a documented community need, support Community Health Improvement Plans (e.g., improving prevention, screening, care access), and reduce health disparities, all while demonstrating measurable success. • **CVH Quality Community Reinvestment Obligation** (Net income calculated on 2024 Medical Loss Ratio (MLR)): **Fresno County $1,306,583; Kings County $144,904; Madera County $183,702; Total $1,634,379.** o Planning Process 2025-2026 (including County engagement and DHCS review) o Implementation Period 2027-2029. • Quality investments were selected based on each county's Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), Behavioral Health priorities, stakeholder engagement, and CVH quality performance opportunities. Focus by CVH County: **Fresno's Behavioral Health Early Identification and Navigation Initiative** focuses on behavioral health screening, suicide prevention, warm handoffs, referral coordination, and post-crisis follow-up, with potential partners including county behavioral health and public health departments, community-based organizations, healthcare providers, and hospitals. **Kings County's Community Health Workers/Promotores Initiative** focuses on care navigation, PCP linkage, health literacy, behavioral health referrals, and workforce development, with expected outcomes including improved access to care, increased preventive care, and reduced health disparities. **Madera's Women's Preventive Health Initiative** focuses on breast and cervical cancer screening, mobile mammography, community outreach, navigation, and follow-up support, with potential partners including county public health and behavioral health departments and community-based organizations. • Success measures across the Reinvestment Plan include individuals screened and referred, connections to care, referral completion, follow-up after crisis, CHWs trained or certified, navigation encounters, PCP connections, behavioral health referrals, childhood vaccinations, FUA/FUM performance, screening completion, early detection, navigation assistance, appointments scheduled, and improvement in relevant preventive-care quality measures. • The proposed portfolio is intended to improve preventive care and behavioral health outcomes, reduce disparities, and advance county Community Health Improvement Plans with	

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	funding expected to roll out in July of 2027. *Discussion:* *Dr. Ramirez asked if there are enough behavioral health providers in Kings County. Dr. Marabella indicated that Kings County met the MPL for FUA and FUM. Additional promotores can increase the number of referrals made (success metric), which improves access rates. The HEDIS® scores with the greatest opportunity for improvement are in the pediatric domain for Kings County. Courtney Shapiro mentioned that the promotores are there to help members overcome access barriers and navigate getting care.* *For Madera's screening focus, Dr. Ramirez indicated that the hospital's temporary closure impacted breast cancer screening access. They have tried mobile mammography units in the past, but these units do not have historical images available for the radiologists' review, which can affect quality. Dr. Marabella indicated that an ideal solution would be to create a local imaging center that has mammography and ultrasound equipment. Rates should improve now that the hospital has reopened.* *The Committee had no further questions or recommendations.* *Maria McDivitt left the meeting at 11:12 AM and returned at 11:15 AM.* *Morgan Simpson left the meeting at 11:17 AM and returned at 11:20 AM.* *Nicole Foss left the meeting at 11:18 AM and returned at 11:20 AM.* *Courtney Shapiro left the meeting at 11:21 AM.* *Mary Lourdes Leone left the meeting at 11:21 AM and returned at 11:25 AM.*	
II4 Key Presentations - Care Management Program Evaluation & Executive Summary 2025 (Attachment S) **Action** Patrick Marabella, M.D., Chair	The **Care Management Program Evaluation and Executive Summary for 2025** was presented and reviewed. The Care Management (CM) Program encompasses Physical Health (PH), Behavioral Health (BH), Perinatal Wellness, and Transitional Care Services (TCS). The program is designed to support member wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Its goal is to provide quality health care along a continuum, decrease fragmentation of care across settings, enhance the member's quality of life, and support efficient utilization of patient care resources. The Goals for 2025 were both met: • The first goal was to increase the number of cases managed. In 2025, total cases increased to 8,816, compared to 3,649 in 2024, representing 2.03% of the total CVH population managed	**Motion:** *Approve* - Care Management Program Evaluation & Executive Summary 2025 (Quezada/Ramirez) 4-0-0-4

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	through PH, BH, First Year of Life, perinatal case management, or TCS. • Maintain ≥90% compliance with the medical record documentation requirements: Each program achieved an overall file review score of 90% or greater in 2025. * Overall average was 94%. o *Physical Health and Transitional Care Services each fell below goal in one quarter during 2025; however, they were back above goal in the next quarter. CM Quarterly Audit Results of Complex & Non-complex File Reviews by Program in 2025 (Overall Average Scores: PH = 93%, BH = 95%, Perinatal = 98%, and TCS = 91%. For members enrolled in CM, readmissions decreased by 7.7%, ED visits decreased by 17.8% per 1,000 members per year, and inpatient, outpatient, and pharmacy claim volume decreased compared to the 90 days before CM enrollment. Clinical Outcomes for High-Risk OB: • First Prenatal Visit in 1st Trimester - improved 15.5% (Goal ≥8%) • Reduction in Pre-term Deliveries by 5.1% (Goal 2%) • Timely Post-partum Visit – improved 11.9% (Goal ≥10%) Member Satisfaction Survey results for 2025 included 75 respondents, with eleven of the thirteen (11/13) questions answered. • The goal of a 90% positive response (very satisfied – satisfied) was met (92%). • 59% are satisfied with the ability to reach their CM. • 84% reported CM helped them to reach their health goals. • 81% reported CM helped to organize care with their MD and other caregivers. • There were five (5) complaints in 2025. Key Accomplishments for 2025: • Exceeded our goal to reduce readmissions for CM-engaged members in BH, PH, and TCS programs. • Exceeded our goals to reduce ED visits. • Exceeded our Perinatal program goals. • Increased referrals in all programs in 2025 compared to 2024 (PH 31%, BH 50%, PCM and FYoL 55%, and TCS 45% increased) • Continue to enhance the TCS program to meet PHM requirements: o On-site staff at additional Hospitals (opened communication with Valley Children's)	

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	o Launched texting program with members Program Goals for 2026: • Enhancements in TCS program to meet updated PHM requirements. o Increase length of program for postpartum TCS cases. o Increase staffing. o Create a birthing checklist in portal and system. o Expand onsite staff presence at hospitals. • Launch enhanced Pregnancy Program o Utilize trimester-based assessments. o Ensure alignment with PHM policy update for postpartum member requirements. • Manage more members across CM programs. • Increase use of member texting programs. • Utilize texting platform to conduct timely satisfaction surveys. • Increase the ED visit reduction goal for members in CM. *The Committee had no further questions or recommendations.*	
#5 UM/CM Business - Key Indicator Report & Turnaround Time Report (May 2026) (Attachment T) **Action** Patrick Marabella, M.D., Chair	**The Key Indicator Report and Turnaround Time Report for May 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 were slightly down overall, while the Expansion and SPD categories increased. Readmission rates followed a similar pattern. • Bed days increased overall; TANF bed days showed a recent increase after prior decreases, while SPD bed days remained relatively stable. • Average length of stay increased overall; however, Expansion and SPD length of stay decreased. • Utilization data for Q1 2026 initially appeared to demonstrate reductions in all categories; however, upon further analysis, some data errors were identified and when corrected showed no significant overall changes with trends remaining consistent with prior months; TANF readmissions remained stable, consistent with other categories which continued to demonstrate random variation. • Turnaround time compliance remained relatively stable, although Expedited Pre-service cases were out of compliance in April and May due to routing issues, holiday timing, and a system	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (May 2026) (Ramirez/Waugh) 4-0-0-4

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	breakdown. A formal corrective action plan will be requested if these trends continue in June. • Case management trends remained positive overall, with perinatal engagement staying strong, physical health engagement high, transitional care cases stabilizing around 600 per month, and behavioral health engagement also remaining strong. • First Year of Life engagement remains near 100%, although volume decreased again after the high volumes noted in March.	
#5 UM/CM Business - UM Report – Top 10 Inpatient Diagnoses MY2025 (Attachment U) **Action** Patrick Marabella, M.D., Chair	**The UM Top 10 Diagnoses Report 2025** provides an annual evaluation of the hospital admissions per one thousand (Adm/k), bed days per one thousand members (Days/k), and average length of stay (ALOS) for the top ten (10) diagnoses among the Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), and Medicaid Covered Expansion (MCE) populations. Identifying utilization trends helps establish opportunities for collaboration and outcome improvement. • Sepsis: Remained a leading diagnosis with a 4.23% increase in admissions, a 6.57% increase in bed days per thousand members, and a 2.25% increase in the average length of stay (ALOS) from 2024 to 2025. • Diabetes (Type 1 and Type 2 diabetes mellitus): Utilization decreased overall in 2025; admissions -5.7%, bed days -15.3%, and average length of stay - 10.2%. Type 2 diabetes ranked as the highest diagnosis in 2025. • Cardiac Diagnoses (Hypertensive heart and chronic kidney disease and Hypertensive heart disease): Showed a 17.3% reduction in admissions per thousand members and a 15.2% reduction in bed days per thousand members from 2024 to 2025. • Respiratory Diagnoses (Respiratory failure, not elsewhere classified, and Pneumonia, unspecified organism): Showed a 13.7% increase in admissions per thousand members and a 17.6% reduction in bed days per thousand members year over year. • Each population (SPD, TANF, MCE) exhibited minor variations in its top diagnoses for 2025.	Motion: *Approve* - UM Report – Top 10 Inpatient Diagnoses MY2025 (Ramirez/Waugh) 4-0-0-4
#5 UM/CM Business - Care Management & CCM Report (Q1 2026) (Attachment V) **Action**	**The Care Management and CCM Report Q1 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 (FYOL) activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness. • From Q4 2025 to Q1 2026, the referral volume for PH CM increased by 67%, while TCS referrals increased by 5%, and BH CM referral volume remained about the same. Referrals also	Motion: *Approve* - Care Management & CCM Report (Q1 2026) (Ramirez/Waugh) 4-0-0-4

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Patrick Marabella, M.D., Chair	Increased for PCM and FYOL programs in Q1. The volume of managed cases decreased across all programs in Q1, except Perinatal. • TCS has shown an increase in the volume of members referred in Q1 2026, and the engagement rate has increased this quarter to 90%, up from 82%. • Q3 to Q4 2025, referral volume decreased, which matched the IP trend in Q4. The percentage of PCP visits within 30 days increased from 38.1% in Q3 to 47.2% in Q4. • BH CM referrals have remained consistent in Q1 2026, and the engagement rate increased from 66% to 73%. • PCM's total referrals increased compared to the previous quarter, while the engagement rate varied from 71% to 68%. • The Pregnancy and Post-Delivery Mailings will no longer be sent as the Maternity Program has fully transitioned to the Enhanced Pregnancy Program. Members will be directed to the materials that are online. Materials can be mailed to members upon request. • FYOL referrals have increased in Q1 2026, but the engagement rate decreased slightly (95%). • The Readmission rate was 7.7% lower 90 days following CM enrollment compared to 90 days prior to CM. • ED claims per 1,000 members per year decreased by 651 (21.8% for Q4) after CM enrollment. • Survey participation in Q1 was low, limiting the ability to draw meaningful conclusions from satisfaction results this quarter. Survey content and methodology modifications are in progress to improve these results in the near future.	
#5 UM/CM Business - Clinical Practice Guidelines (Attachment W) **Action** Patrick Marabella, M.D., Chair	The **Clinical Practice Guidelines** were presented and reviewed by the Committee. HN adopts guidelines from Centene's National organization, and then CVH reviews, provides feedback, and asks questions as indicated about any new guidelines or changes to existing guidelines. The links to each guideline are listed in the attachment and are also available on the provider portal. After review, no concerns or questions were raised by committee members, and the clinical practice guidelines were adopted for CVH. *Maria McDivitt left the meeting at 11:41 AM.*	Motion: *Approve* - Clinical Practice Guidelines (Ramirez/Quezada) 4-0-0-4
#5 UM/CM Business - Medical Policies Provider Updates (Q2 2026)	The **Medical Policies (Q2 2026)** were presented to the committee. Dr. Marabella requested that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback. Medical	Motion: *Approve* - Medical Policies Provider Updates (Q2

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(Attachment X) **Action** Patrick Marabella, M.D., Chair	Policies are compiled based on a national review by physicians and sent monthly to providers, featuring new, updated, or retired medical policies for the Plan. Updated policies for Q2 2026 include the following, but are not limited to these examples: CP.MP.185 Skin and Soft Tissue Substitutes CP.MP.244 Liposuction for Lipedema CP.MP.247 Transplant Service Documentation Requirements CP.MP.58 Intestinal and Multivisceral Transplant CP.MP.242 Pulmonary Function Testing CP.BH.500 Behavioral Health Treatment Documentation Requirements HNCA.CP.MP.55 Assisted Reproductive Technology Retired policies for Q2 2026 include the following, but are not limited to these examples: CP.MP.126 Sacroiliac joint fusion CP.MP.14 Cochlear implant replacements HNCA.CP.MP.127 Ambulance, Non-emergent HNCA.CP.MP.134 Voice Therapy HNCA.CP.MP.391 Refractive Surgery	2026) (Ramirez/Quezada) 4-0-0-4
#6 Policy & Procedure Business - Quality Improvement Policy & Procedure Annual Review (Attachment Y) Action Patrick Marabella, M.D., Chair	**The Quality Improvement Policy and Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with no changes: QI-006 Annual HEDIS® Production and Reporting QI-010 Medical Records Documentation Standards QI-011 Medi-Cal PCP Facility Site & Medical Record Review QI-012 Physical Accessibility Review Survey QI-013 Medical Record Confidentiality & Release of Information QI-014 Potential Quality Issues (PQI) Management Process QI-017 Provider Preventable Conditions Program The following policies were presented for annual review and approved with changes: **QI-005** Quality Improvement and Health Equity Transformation Program (QIHETP) Requirements: Revised and updated the organization's commitment to quality and health equity, performance monitoring and reporting, health equity tiers and domains, and quality and health equity initiatives, including the addition of Cancer Prevention. Updated the purpose, general requirements, MCAS performance measure requirements, consumer satisfaction survey requirements, health equity and quality data provisions, the Health Plan Level definition within the	Motion: *Approve* - Quality Improvement Annual Policy & Procedure Review (Quezada/Ramirez) 4-0-0-4

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	Quality Monitoring and Improvement Program, authority references, and attachments. **QI-007** Health Equity Quality Review and Engagement Strategies: Deleted the Population Needs Assessment section in the Engagement Strategy section. Minor edits throughout. **QI-008** Data Collection and Disparity Analysis: Added demographic categories for data segmentation in the Disparity Dashboard and Disparity Analysis, Identification, and Prioritization sections. **QI-018** Initial Health Appointment (IHA): Updated language throughout to align with DHCS APL 26-001 requirements. Updated the authority section. **QI-019** Childhood Blood Lead Screening: Added follow-up with providers who have agreed to contact members who have not been screened for lead in the Monitoring of Childhood Lead Testing Services. *Committee members agreed with the policy changes as stated and voiced no questions or concerns.*	
#7 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q2 2026) (Attachment Z) Action Patrick Marabella, M.D., Chair	The **Credentialing Subcommittee Quarterly Report Q2 2026** was presented. The Credentialing Subcommittee met on May 21, 2026, to review routine credentialing and re-credentialing reports for both Q4 2025 delegated and Q1 2026 non-delegated entities (Health Net (HN) and HN Behavioral Health (BH)). • The **Credentialing Adverse Actions Q1 2026** for CVH from the HN Credentialing Committee was presented, with no (0) cases presented for discussion for Q1 2026 for CVH. • The **Adverse Events Q1 2026** report was presented: o Credentialing submitted zero (0) cases to the Credentialing Committee in Q1 2026. There were no (0) incidents involving appointment availability issues resulting in substantial harm, zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner, and zero (0) cases required reporting for 805 in Q1 2026. • The **Access and Availability Substantial Harm Report Q1 2026** was presented 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) related to identified appointment availability and are ranked by severity level. o After reviewing all Q1 2026 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil	Motion: Approve - Credentialing Subcommittee Report (Q2 2026) (Ramirez/Quezada) 4-0-0-4

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	Code section 3428(b)(1). • The **NCQA Information Integrity Credentialing Oversight Report Q1 2026** was presented and reviewed. This report identifies incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe: 1. What primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. 4. Annual training to ensure incidents of data integrity are reported. 5. The security controls in place to protect the information from unauthorized modification. 6. How the organization monitors its compliance with the policies and procedures. 7. Initiate a Corrective Action Plan (CAP) for findings. 8. Assess CAP findings to ensure validity of corrections/actions. • The county-specific **Credentialing Subcommittee Reports** of significant subcommittee activities for January through March 2026 were presented. There were no (0) new cases identified in Fresno, Kings, or Madera Counties for Q1 2026.	
#7 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q2 2026 (Attachment AA) Action Patrick Marabella, M.D., Chair	The **Peer Review Subcommittee Quarterly Report Q2 2026** was presented. The Peer Review Subcommittee met on May 21, 2026, to review Q1 2026 data provided in the following reports: • The county-specific **Peer Review Subcommittee Summary Reports for Q1 2026** were reviewed for approval. No (0) significant cases to report. • The **Q1 2026 Adverse Events Report** was presented to provide a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o There were eleven (11) Q1 2026 cases that met criteria and were submitted to the Peer Review Committee: ▪ Three (3) cases involved practitioners, and eight (8) cases involved organizational providers (facilities). ▪ Of the eleven (11) cases, three (3) were tabled, one (1) was tabled and placed on a corrective action plan with a letter of concern, one (1) was closed to track and trend with a letter of concern, and six (6) were closed to track and trend. ▪ Eight (8) cases were quality of care grievances, three (3) were potential quality issues,	Motion: Approve - Peer Review Subcommittee Report Q2 2026 (Ramirez/Quezada) 4-0-0-4

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	and zero (0) were track and trend. ▪ Two (2) cases involved seniors and persons with disabilities. ▪ Zero (0) cases involved behavioral health. o The Investigations Team submitted six previously presented, remaining open cases to the Peer Review Committee in the first quarter of 2026. ▪ Four (4) cases were regarding practitioners, and two (2) cases involved organizational providers (facilities). ▪ Of the six (6) cases, one (1) was placed on a corrective action plan with monitoring, one (1) was closed to track and trend with a letter of concern, and four (4) were closed to track and trend. ▪ Five (5) cases were quality of care grievances, one (1) was a potential quality issue, and zero (0) were track and trend. ▪ One (1) case involved seniors and persons with disabilities. ▪ Zero (0) cases involved behavioral health. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026. o Grievance data reviews (NCQA CR 5.A.3-4) completed in December, January, and February did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. o Two (2) cases were placed on corrective action in Q1 2026. o Grievance data reviews for health equity, site review, chaperone, or medical records, completed in Q1, did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. o There was one (1) new case and two (2) previously reported cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner (NCQA CR.5.A.4) in Q1 2026. o The reviewing Medical Directors determined that further outreach was required for six (6) cases. Outreach can include, but is not limited to, an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. o Ten (10) 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	

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	escalation for presentation at the Peer Review Committee. o Zero (0) cases required reporting for 805.01 in Q1 2026. • The **Access & Availability Substantial Harm Report for Q1 2026** was also presented 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. o Seventeen* (17) new cases were submitted to the Peer Review Committee in Q1 2026. Of the seventeen (17) cases, four (4) cases were related to appointment availability issues without significant harm, and two (2) were related to significant harm without appointment availability issues. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026. • The **Q1 2026 Peer Count Report** was presented with a total of seventeen (17) cases reviewed with the committee. Twelve (12) cases were closed and cleared. Zero (0) cases were closed and terminated. Zero (0) cases were deferred. Three (3) cases were tabled for further information. Two (2) cases were closed with CAP outstanding/continued monitoring, and zero (0) cases were pending closure for CAP compliance.	
#8 Compliance Update - Compliance Regulatory Report (Attachment BB)	Mary Lourdes Leone presented the **Compliance Report.** **CalViva Health Oversight Activities: Health Net:** Since the last Committee report, CVH's oversight and audit activities included continued monthly and quarterly review of HN clinical and administrative performance indicators and joint work group meetings covering PPG-level financial viability, claims, provider disputes, access and availability, specialty referrals, UM data, grievances, and appeals. **Oversight Audits:** Annual audits in progress include: 2026 Health Education, 2026 Marketing, Call Center, Q4 2025 Claims/PDR, and 2026 Health Equity; the Provider Network (CAP) has been completed. **Fraud, Waste, and Abuse:** Since the last Committee report, there have been six (6) new MC609 filings: Inappropriate Billing: 2 cases; Phantom Provider & Possible Services Not Rendered: 3 cases; Impossible Days: 1 case. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** DHCS will issue forward-looking guidance for the 2023 Focused Audit for	-Compliance Regulatory Report

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	Behavioral Health and Transportation after the final Transportation APL, after which DHCS will close the CAP and allow 90 days for implementation. **MY 2024 Health Equity and Quality Performance:** On 7/1/26, DMHC issued its Health Equity and Quality Performance Findings Report for Measurement Year 2024. CVH exceeded benchmarks for most quality measures and had no administrative deficiencies; however, four (4) aggregate measures and several health equity disparities require a CAP due to DMHC by 9/29/26. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** CVH has completed and submitted all 2025 Medical Audit CAP responses and is awaiting DHCS review, feedback, and final closure. **2026 DMHC/DHCS Joint Medical Survey Audit:** The DMHC/DHCS Joint Medical Survey Audit was conducted on-site from 6/16/26 to 6/18/26, with additional DHCS interviews held virtually from 6/22/26 to 6/25/26; CVH is awaiting the preliminary audit report. **2026 Network Adequacy Validation (NAV) Audit:** CVH received the HSAG Audit Document Request Packet on 5/11/26, submitted the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents on 6/18/26, and is scheduled for a virtual audit on 8/25/26. **Memorandum of Understanding (MOU): Annual Network Certifications:** Since the last QI/UM Committee Meeting, CVH has executed and submitted to DMHC & DHCS the following MOUs: • Correctional Facilities Fresno County **Revised ASA and CPSA with Health Net:** On 6/25/26, CVH received final DMHC/DHCS approval for the executed ASA and CPSA. The agreements are effectively retroactive to 7/1/25. **DMHC APL 25-019 & J-19 Compliance Grid:** To demonstrate full compliance with the DMHC updated network adequacy regulations under APL 25-019, CVH completed its required policy updates and successfully submitted all required policies and J-19 Compliance Grid by 7/1/26. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026. **2026 Updated EOC Errata 2:** DHCS has postponed the elimination of dental benefits for the UIS population until 7/1/2027. **Funding for Abortion Clinics Resumes:** The federal ban on funding Planned Parenthood and other abortion clinics expired on 7/5/2026 when Congress failed to pass an extension. Plans can resume making payments to these clinics. **Public Policy Committee (PPC):** The PPC met on 6/3/26, with the following reports presented: • Health Ed 2025 Summary Work Plan Evaluation	

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	• Health Ed 2026 Work Plan • Health Equity 2025 Summary and Work Plan Evaluation • Health Equity 2025 Summary and Language Assistance Program • Health Equity 2026 Summary and Program Description • Health Equity 2026 Summary and Work Plan • Appeal and Grievance Report • Review and Discussion of A&G Dashboard from Dr Marabella The next PPC meeting will be held on 9/2/26, from 11:30 a.m. to 1:30 p.m., in the CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. *Patricia Gomez left the meeting at 11:47 AM.*	
#9 Old Business	None.	
#10 Announcements	Dr. Marabella announced that Mary Lourdes Leone will be retiring at the end of the month and thanked her for eleven (11) years of dedicated service to CVH. Morgan Simpson will assume the role of Chief Compliance Officer beginning August 1, 2026. The next QI/UM meeting is scheduled for September 17, 2026.	
#11 Public Comment	None.	
#12 Adjourn	The meeting adjourned at 11:59 a.m.	

NEXT MEETING: September 17th, 2026

Submitted this Day: 09/17/26

Submitted by: Amy Schneider

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, M.D., Committee Chair