

Fresno-Kings-Madera
Regional Health Authority

**CalViva Health
Commission**
Meeting Minutes
September 18, 2025

Meeting Location:
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

Commission Members			
✓	Sara Bosse, Director, Madera Co. Dept. of Public Health		Lisa Lewis, Ph.D., Kings County At-large Appointee
✓	Garry Bredefeld, Fresno County Board of Supervisors	✓	Aftab Naz, M.D., Madera County At-large Appointee
✓	David Cardona, M.D., Fresno County At-large Appointee	✓	Joe Neves, Vice Chair, Kings County Board of Supervisors
✓	Aldo De La Torre, Community Medical Center Representative	✓	Joe Prado, Interim Director, Fresno County Dept. of Public Health
✓*	Joyce Fields-Keene, Fresno County At-large Appointee	✓	Rose Mary Rahn, Director, Kings County Dept. of Public Health
	John Frye, Commission At-large Appointee, Fresno		David Rogers, Madera County Board of Supervisors
	Soyla Griffin, Fresno County At-large Appointee	✓	Jennifer Armendariz, Valley Children's Hospital Appointee
✓	David Hodge, M.D., Chair, Fresno County At-large Appointee	✓	Paulo Soares, Commission At-large Appointee, Madera County
✓*	Kerry Hydash, Commission At-large Appointee, Kings County		
Commission Staff			
✓	Jeff Nkansah, Chief Executive Officer (CEO)	✓	Amy Schneider, R.N., Senior Director of Medical Management
✓	Daniel Maychen, Chief Financial Officer (CFO)	✓	Cheryl Hurley, Commission Clerk, Director Office/HR
✓	Patrick Marabella, M.D., Chief Medical Officer (CMO)	✓	Sia Xiong-Lopez, Equity Officer
✓	Mary Lourdes Leone, Chief Compliance Officer		
General Counsel and Consultants			
✓*	Jason Epperson, General Counsel		
✓ = Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
● = Attended via Teleconference			

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#1 Call to Order	The meeting was called to order at 1:30 pm. A quorum was present.		
#2 Roll Call	A roll call was taken for the current Commission Members.		A roll call was taken.

Commission Meeting Minutes

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Cheryl Hurley, Clerk to the Commission			
#3 Fresno County Department of Public Health Commissioner Action David Hodge, MD, Chairman	Mr. Joe Prado was introduced as the Interim Director for the Fresno County Department of Public Health and replaces David Luchini as Commissioner on the FKM RHA Commission.		Motion: Commission ratified the appointment of Joe Prado to the FKM RHA Commission as representative for Fresno County Dept. of Public Health 11 – 0 – 1 – 5 (Neves / Frye)
#4 Consent Agenda • Commission Minutes dated 7/17/25. • Finance Committee Minutes dated 5/15/25. • QI/UM Committee Minutes dated 5/15/25. • Public Policy Committee Minutes 6/4/25 Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.		Motion: Consent Agenda was approved. 12 – 0 – 0 – 5 (Neves / Naz)
#5 Closed Session	Jason Epperson reported out of closed session. The Commission met in closed session to discuss item #5.A Conference Report Involving Trade Secret, Discussion of Service Program or Facility, Public Disclosure date January 2028, Government code section 54954.5. The Commission discussed this item and took no other reportable action. Closed session adjourned at 1:42 pm. <i>Joyce Fields-Keene arrived at approximately 1:40 pm; not included in motion/votes for items #2 and #3.</i>		No Motion
#6 State and Federal Impacts	Jeff Nkansah gave a presentation on State and Federal Impacts.		No Motion

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Information J. Nkansah, CEO	Publicly Available Information includes: • June 30th 2025 – Governor Newsom signed into law SB 101: Budget Act of 2025, inclusive of AB 116: Health Omnibus Trailer Bill. • July 1, 2025 – Understanding the different immigration status. • July 21, 2025 – California Health and Human Services – Navigating Federal Cuts to Health and Human Services in California: A presentation with CalHHS. • August 20, 2025 – Legislative Analyst’s Office Overview of Major Impacts of H.R.1 – One Big Beautiful Bill Act. • September 2, 2025 – CMS’ Rural Health Transformation (RHT) Program Website has gone live. • September 3, 2025 – Committee on Oversight and Government Reform sends letter to California on its intent to investigate whether federal money is being used to pay for health care and other services for illegal aliens. • September 4, 2025 – Reports on the actions administrative agencies plan to issue in the near and long term. • September 5, 2025 – HCAI has sent a survey seeking input from stakeholders across California on rural health care to inform the rural healthcare transformation program. Survey open from 9/5/25 to 9/12/25 (Extended to 9/16/25). • September 15, 2025 – CMS unveils details on how states can apply to receive funding from the \$50 billion Rural Health Transformation Program. The Immigration Status Categories of Medi-Cal members that the Plan is currently serving are described as Satisfactory Immigration Status (“SIS”) and Unsatisfactory Immigration Status (“UIS”). The Plan has reviewed the health plan membership by the Immigration Status Categories and estimates 86% of the Plan Members fall in one category. The remaining 14% fall in the other category. The Plan anticipates enrollment will decline overall due to State and Federal activity, however, there will likely be a material drop in one category. State Impacts – SB 101: Budget Act of 2025 – Key Dates from State Activities: • January 1, 2026 – Enrollment freeze for Unsatisfactory Immigration Status (“UIS”) individuals 19 years or older.	<i>Dr. Naz asked what the impact will be on FQHCs?</i> <i>Jeff responded that the forecast will be that if individuals are moving from satisfactory status to unsatisfactory immigrant status and if they are not able to keep their Medi-Cal enrollment or eligibility then there will be uncompensated care due to no insurance. At this point in time it does not state that an individual is going to lose Medi-Cal, there is still the expansion and State dollars under the “unsatisfactory” category.</i>	

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	- January 1, 2026 – Sets a \$130,000 asset cap for individuals and adds \$65,000 for each additional household member, capping at 10 members. - January 1, 2026 – Elimination of Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP). - July 1, 2026 – Prior authorization requirements will be implemented for Medi-Cal hospice services. - July 1, 2026 – Limited Scope Medi-Cal is being introduced for all UIS individuals. - July 1, 2026 – Eliminates state-only dental coverage for Unsatisfactory Immigration Status individuals and cuts PPS rates for state-only funded services for Health Centers and Rural Health Clinics. - July 1, 2027 - Requires a monthly \$30 premium per individual for Unsatisfactory Immigration Status ("UIS") individuals ages 19-59. DHCS recently confirmed the enrollment freeze will only apply to those individuals who have no status. AB 144 is aimed at exempting foster youth and former foster youth with UIS status from limitations such as enrollment freezes and monthly premiums (Not Finalized). Understanding the Scopes of Medi-Cal Coverage - Full-Scope Medi-Cal - Benefits generally provides medical, dental, mental health, vision (eye) care, drugs your doctor orders, and more. Eligible for Managed Care Plan enrollment. - Restricted Scope Medi-Cal – Benefits generally provides limited health care coverage such as emergency services and pregnancy-related services. Not Eligible for Managed Care Plan enrollment (NEW)Limited Scope Medi-Cal – Benefits will cover the same services as full-scope Medi-Cal with the exception of dental care services effective July 1, 2026. Eligible for Managed Care Plan enrollment Members subject to the enrollment freeze will only be eligible for restricted scope Medi-Cal as of 1/1/26. Members subject to the enrollment freeze and enrolled in Medi-Cal as of 1/1/26 will retain full scope Medi-Cal. If the member is disenrolled, they have a 3-month grace period to re-enroll in full-scope Medi-Cal coverage. If	<i>Aldo De La Torre asked if the FPL will be considered?*</i> <i>*Question flagged for follow-up.</i>	

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	disenrolled for more than 3 months, the member will only be eligible for restricted scope. State Budget Act Concepts to Monitor: • There is a 3-month grace and cure period for re-enrollment following the payment of any outstanding premiums. • Pregnant women are exempt from premium payments. So are those under 19 and those over 59. • Change in asset limits will likely reduce the number of eligible members for Medi-Cal. • Change in dental now introduces a bifurcation of benefits for the first time in Medi-Cal for Health Plan members. Premiums will be collected through a third-party vendor; it will not be the responsibility of the plans or the counties. CVH understands and anticipates the State will handle all premium collection and non-payment activities. CVH will need to operationalize Medi-Cal hospice prior authorization requirements. CVH will need to educate health plan staff and potential and current members of the changes to benefit coverages, asset test limits, dental coverage, and premium payment requirement. And CVH anticipates enrollment in one category to grow at a slower pace than previously. Federal Impacts – H.R.1 – One Big Beautiful Bill Act Key Dates from Federal Activities Impacting Enrollment: • October 1, 2026 – Changes to the definition of “qualified alien” to include only lawful permanent residents, certain Cuban and Haitian immigrants, and individuals residing in the US through a Compact of Free Association (Medi-Cal Impact) • January 1, 2027 – Mandatory Work Requirements for Medicaid expansion adults only ages 19 to 64 • January 1, 2027 – Redetermine eligibility for Medicaid Expansion Adults only once every 6 months.	<i>Aldo De La Torre asked where these members/individuals are today?</i> <i>Jeff Nkansah stated currently, they are in the Plan as full scope Medi-Cal.</i> <i>Paulo Soares offered clarification that the dental coverage is for those aged 19-59.</i>	

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	- January 1, 2027 – Identification and disenrollment of deceased members through a quarterly review process. Implementation of a review process to ensure new individuals applying for coverage do not have coverage in another State - January 1, 2027 – Shorten Medicaid retroactive coverage for expansion adults from 3 months to 1 month and 2 months for all other Medicaid applicants - January 1, 2027 – Establishes a 1M cap on home equity for individuals applying for long term care under Medicaid - January 4, 2027 – Limit Medicare coverage for non-citizens to lawful permanent residents certain Cuban and Haitian immigrants, and individuals residing in the US through a Compact of Free Association (Medicare/Medi-Cal Impact Impact). Enrollment Concepts to Monitor: - There is a State option to delay implementation until December 31, 2028, with HHS Secretary approval. - There are exemptions to the work requirements and if one qualifies for an exemption it must be verified every 6 months. - Interim final rule for implementing Work requirements section is anticipated no later than June 1, 2026 (Can be done under an 1115 waiver if want to proceed earlier than December 2026). - Will change to definition of “qualified alien” mean these populations will fall into the DHCS definition of Unsatisfactory Immigration Status (“UIS”). The Plan will need to await to see how the State and County intend to comply with the new federal requirement(s) surrounding work requirements. The Plan anticipates State and County will operationalize these requirements. The Plan currently anticipates enrollment will decline because of the federal and state activities in both categories. A decline in enrollment will impact CalViva Health’s Fiscal Year Net Income, but, presently, CalViva Health does not anticipate impact to its core business operations and model. Key Dates from Federal Activities Impacting the Medi-Cal Health Plan Delivery	<i>Joe Prado asked if the Plan was to put a plan together on the education piece when would that start?</i> <i>Jeff Nkansah stated that currently there is no exact timeline; however, the earlier the better.</i> <i>Aldo De La Torre asked if the premium payments impact the rate the Plan receives from the State?</i> <i>Daniel Maychen stated it should not impact the rate.</i> <i>Dr. Cardona asked on the Medicaid expansion, are there going to be any medical exemptions for work requirements for patients and if so, who do they anticipate sending that to for approval of exemption?</i> <i>Jeff Nkansah responded the Plan is currently waiting for the information to flow from the Federal Government to</i>	

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	- January 1, 2027 – Health Plan must transmit address information to the State and Health Plan address information is now considered a ‘reliable source’. - January 1, 2028 – Identification and exclusion of providers who are on the Social Security Administration Death Master File. - October 1, 2028 – Impose copayments on most services for expansion adults only with incomes above 100% of the federal poverty level (FPL 100-138%). 100% of the FPL in 2025 is \$15,650. - October 1, 2029 – State must establish a system such that individuals who are applying or are already enrolled are reviewed to ensure they do not have Medicaid in another state. On this date, state must submit information monthly and at redetermination to HHS. HHS will have established a national verification system. Health Plan Delivery Concepts to Monitor - The State will need to decide the amount not to exceed \$35 per service and subject to an aggregate limit of 5% of family income. - The State will need to ensure cost sharing does not apply to exemptions under current law or to primary care services, behavioral health services, federally qualified health center services, rural health clinic services, and certified community behavioral health clinic services. - The State will need to determine and coordinate the ultimate source of truth between the various reliable sources monthly. - Additional reporting may be required of the Health Plan to send address information to the State. The Plan will need to await to see how the State intends to comply with the new federal requirement(s). The Plan’s understanding is the State of California is already currently monitoring the Social Security Administration Death File and removing members and providers when and where applicable. The Plan has started a process to check its own internal systems to identify member irregularities and is reporting those activities to DHCS monthly. The Plan will need to educate health plan staff and potential and current members of the potential addition of copayments and understand whom will be responsible for the copayment communication and collection.	<i>the State, and the State down to the Plan.</i> <i>Aldo De La Torre asked if the Plan has a projection on how many members CVH will lose?</i> <i>Daniel Maychen responded that for CVH the loss related to Medicaid work requirements would be approximately 40,000. In relation to the premiums, according to the California Dept of Finance, they projected approximately 20% subject to the premiums would not pay the premiums. That equates to</i>	

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	Key Dates from Federal Activities Impacting Health Plan Financing - July 4, 2025 – Prohibits implementation of any new Medicaid provider taxes and increasing existing tax rates. - July 4, 2025 – Prohibits any tax that imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to providers with higher Medicaid volumes, or taxes units of service at a higher rate than non-Medicaid units of service. - July 4, 2025 – Caps any future State-Directed Payments at 100% of Medicare Payment Levels. - July 4, 2025 – Bars for one year Medicaid participation by certain providers of abortion services. - October 1, 2026 – Ends the availability of federal Medicaid and CHIP funding for refugees, asylees, and certain other noncitizens. Prohibits states from receiving 90% enhanced matching rate for emergency Medicaid services to noncitizens. - January 1, 2027 – Impact on 1115 Waiver design. State must now design waivers to achieve budget neutrality (i.e., does not result in more costs prior to the demonstration) – This does not apply to 1915 Waiver Designs. - October 1, 2027 – Ramp-down of provider tax cap begins, with the 6% tax threshold reduced by half a percentage point until the threshold hits 3.5% in 2032. - January 1, 2028 – Requires states with existing State Directed Payments above Medicare rates to reduce payments by 10 percentage points per year until they are no greater than 100% of Medicare. - October 1, 2029 - Eliminates CMS authority to waive states' disallowance of federal funds associated with "excess" improper payments. Financing Concepts Conditions to Monitor: - CMS may allow for a transition period of up to 3 years for any existing tax which is non-compliant (California's MCO tax structure is non-compliant due to the uniformity provision and is also currently at 5.98% which is higher than the 3.5% safe harbor cap).	<i>approximately 20,000 CalViva members; however, this loss does not appear to hit all at once</i> <i>Joe Prado asked with regards to a lot of the unknowns, there's going to be delays when operationalized in some way, and does the Plan see having to restructure contracts to not have CVH/HH on the hook if those requirements are not met but the member hasn't been notified and they are still receiving care; any thoughts on how that will be operationalized in the contract (i.e. eligibility)?</i> <i>Jeff Nkansah stated he does not see an issue as at the time the member receives services, the eligibility should reflect at that time.</i> <i>Aldo De La Torre added for example the premiums, there is a 90-day grace period, if that's not paid is their coverage terminated back 90-days or terminated on the 91st day?</i> <i>Mary Lourdes Leone stated the guidelines have yet to be published.</i>	

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	- Other major provider taxes including the Hospital Quality Assurance Fee could be at risk. - One provider impacted by the ban has filed a lawsuit. There is currently a Temporary Restraining Order (TRO) blocking implementation of law. On 9/11/2025, injunction was overturned, and the law was allowed to remain in effect. - Some CA 1115 Waivers of interest: BH-Connect, CalAIM (Recuperative Care, Short-Term Post-Hospitalization Housing, In-reach services for Justice Involved population). The Plan is aware California has filed a request for a transition period. The Plan awaits a response from State to determine if they were approved for a transition period on the MCO tax. The Plan is continuing to operate in a business-as-usual posture until more guidance is obtained through the State and/or legal processes. In summary, the Plan anticipates material changes to the Medi-Cal program which will start impacting the Health Plan in this current Fiscal Year 2025-2026 and continuing onward to subsequent Fiscal Years. A significant and material education and outreach campaign would be needed. The Plan anticipates community pressures because of State and Federal activities which will impact all Fresno, Kings, Madera Counties entities (City officials, County officials, Community health care providers, and community non-profit organizations). The Plan does not anticipate any changes presently to Health Plan operations and structural model of conducting business, however, the Health Plan does anticipate a need to be responsive to community pressures and align resources when and where appropriate. The Plan anticipates net income will be lower in future Fiscal Years if State and Federal activities as currently represented remain in place.	<i>Aldo De La Torre asked if the co-payments would include deductibles or out-of-pocket maximums, etc.?</i> <i>Jeff Nkansah stated flat co-pays but has not heard anything of deductibles.</i> <i>Sara Bosse asked for the 5%, are they saying the \$35 would be 5% of the income? Or is there an aggregate and if the Plan would have to monitor and let the member know if they do not have co-pays anymore.</i> <i>Jeff Nkansah replied, that yes, monitoring would have to be done.</i> <i>Aldo De La Torre asked for the folks that lose coverage, will they fall back into the County MISP program?</i> <i>Joe Prado responded to Aldo, stating that is a conversation the County is having local public health departments that the older county indigent programs will have to be resurrected and the State would have to provide those dollars so when AB 85 was restructured it took the dollars away from the County</i>	

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		<i>and reinvested in State infrastructure, so that discussion would have to be had.</i>	
#7 2025 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation • Executive Summary • Work Plan Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2025 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation. The Planned Initiatives and QI Focus for 2025 consist of: 1. Behavioral Health 2. Chronic Conditions 3. Hospital Quality & Patient Safety 4. Member Engagement & Experience 5. Pediatric/Perinatal/Dental 6. Pharmacy & Related Measures 7. Preventive Health 8. Provider Engagement/Communication Total Objectives: 83 Measurable • 72 objectives completed at mid-year • 62/72 objectives were met • 10/72 objectives were not met • 11 additional objectives scheduled for Q3-Q4 & on track at mid-year Programs that did not meet their objectives were: 1. Pediatric/Perinatal/Dental 2. Preventive Health 3. Provider Engagement/Communication There were 85 total planned activities for the year; of those: • 18/19 Mid-year activities completed. • One (1) activity under Pediatric/ Perinatal/Dental was off track and not completed. • 66 additional activities are planned for July to December. Of those, four (4) activities were cancelled. Performance Progress and objectives met:		<i>Motion: See item #8 for motion</i>

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	- Behavioral Health: six out of six met - Chronic conditions: six out of six met - Hospital Quality/Patient Safety: n/a at mid-year, all due at year end. - Member Engagement and Experience: two out of two met - Pediatric/Perinatal/Dental: 27 out of 30 met - Pharmacy and Related Measures: three out of three met - Preventive Health: nine out of twelve met - Provider Communication/Engagement: nine out of 13 met Planned Activities: - Behavioral Health: five year-end activities planned. - Chronic conditions: eight year-end activities planned. - Hospital Quality/Patient Safety: eight out of 8 mid-year activities completed; two year-end activities planned. - Member Engagement and Experience: two year-end activities planned. - Pediatric/Perinatal/Dental: five out of six mid-year activities completed; 25 year-end activities planned. - Pharmacy and Related Measures: three year-end activities planned. - Preventive Health: one out of one mid-year activity completed; thirteen year-end activities planned, of which four activities were cancelled. - Provider Communication/Engagement: four out of four mid-year activities completed; 4 year-end activities planned. - Health Education/Wellness: four year-end activities planned. Access, Availability & Service Access to Care - Provider Appointment Availability Survey – PAAS - PCP: Urgent & Non-Urgent exceeded 70% threshold. - Specialist: Urgent & Non-Urgent improved but did not meet the 70% threshold. - Ancillary: Non-Urgent exceeded the 70% threshold. - Provider After Hours Access Survey – PAHAS - Appropriate Emergency Instructions and Ability to Contact On-Call MD both exceeded 90%. Access Actions:	<i>Aldo De La Torre asked what the actual scores were?</i> <i>Amy Schneider responded that the score for PCP Urgent Care was 77%, Non-Urgent was 86%. The Specialist score was 53%, for Urgent and Non-Urgent it was 67%. For Ancillary the score was 91% for Non-Urgent compared to</i>	

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	- All non-compliant providers will receive Corrective Action Plans in July 2025. - Ten (10) Mandatory Provider Training Webinars will be held in July to December. Member Satisfaction: - Consumer Assessment of Healthcare Providers and Systems – CAHPS Survey was conducted by Press Garney in May 2025. - Report will be available in August. - Quarterly Root Cause Analysis of A & G Data will be reported. - Sullivan Luallin Webinar Trainings are available for Providers. For RY2025 HEDIS® Results not meeting MPL: Fresno County: - Follow Up After ED Visit for Mental Health Illness- 30 Days (FUM) - Follow Up After ED Visit for Substance Abuse – 30 Days (FUA) - Well-Child Visits in the First 15 Months of Life – Six or more Well-Child Visits (W30-15) - Well-Child Visits for age 15 Months to 30 Months – Two or more Well-Child Visits (W30-30) Kings County: - Childhood Immunizations - Combo 10 (CIS-10) - Developmental Screenings in the First Year of Life - Child and Adolescent Well-Care Visits (WCV) - Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visit (W30-15) - Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits (W30-30) Madera County: - Follow-Up After ED Visit for Mental Health Illness-30 Days (FUM) - Follow-Up After ED Visit for Substance Abuse-30 Days (FUA)	89% for Non-Urgent in MY2023. <i>Aldo De La Torre asked that since this is mostly a function of the networks that HN contracts with do we know whether there's any data that says that we're much closer with the network that LaSalle runs vs. that UPN runs with regard to the metrics (Access & Availability)?</i> <i>Dr. Marabella stated there are CAPs for at least four of the networks currently therefore opportunities for improvement are identified and addressed; these issues are discussed and addressed during management oversight meetings.</i> <i>Joe Prado asked, for instance, if someone is in a CAP for ten years, is there a financial consequence for remaining in a CAP.</i> <i>Dr. Marabella stated if an organization is in a CAP, they have one year to correct the issue.</i>	

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	Performance Improvement Projects - Two (2) PIPs - Non-Clinical – Improve Provider Notifications after ED Visit for SUD/MH Fresno & Madera Counties. - Clinical - Well Child Visits in First 30 Months of Life Fresno County. - DHCS Lean Project Madera County (BH Domain) - DHCS Comprehensive Kings County (Child & Chronic Domains) - DHCS Transformational Project Fresno County (BH, Chronic & Child Domains) - IHI Behavioral Health Collaborative - IHI Well Child Visit Collaborative Health Education Activities & Actions July to December 2025 - Continue Member Incentive Strategy for all priority MCAS measures. - Promote Digital Resources including QR Codes & Links. - Member Services to inform Members of programs and materials that are available. - Review & Update materials following DHCS Guidelines. - Continue partnership and promotion of BCS & CCS screenings at <i>Every Woman Counts</i>. - Continue promotion of “Kick It” California. - Diabetes Prevention Program with new vendor was approved by DHCS in January ‘25. - One member & one provider outreach campaign launched to promote program. Enroll members and continue rollout of the program.		
#8 2025 Utilization Management Care Management Work Plan Mid-Year Evaluation - Executive Summary - Work Plan Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2025 UCM Work Plan Mid-Year Evaluation. Activities in 2025 Focus on Five Areas consisting of: - Compliance with Regulatory & Accreditation Requirements - Monitoring the UM Process - Monitoring Utilization Metrics - Monitoring Coordination with Other Programs - Monitoring Activities for Special Populations Utilization Management processes have remained consistent. Case Management & Disease Management continue to monitor the effectiveness of programs to better serve our members.		Motion: The Commission approved the 2025 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation; and the 2025 Utilization Management Care Management Work Plan Mid-Year Evaluation 13 – 0 – 0 – 4

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	Summary of Work Plan Elements not on track at mid-year: • Periodic audits for Compliance with regulatory standards. • Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making. • Timeliness of Processing the Authorization Request. • PPG Profile and Vendor List. • Care Management (CM) Program. • Referrals to Perinatal Care Management. 1. Compliance with Regulatory & Accreditation Requirements All Compliance Activities on target for Mid-Year except for Work Plan Elements: • Periodic audits for Compliance with regulatory standards (element 1.4) ○ Barriers identified: ○ Improper suspension of regulatory processes ○ Missed hospital notifications ○ Incomplete CAP documentation ○ Inadequate application of post-stabilization requirements to both contracted and non-contracted hospitals. ○ Actions Taken: ○ A dedicated team was established to manage post-stabilization cases. ○ Fax-based authorization requests were eliminated and a single telephone number put in place. ○ Providers received targeted education and formal communication about the changes. ○ Internal policies and procedures were updated. ○ Enhanced tracking and reporting tools were implemented. • Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making (element 1.7) ○ Barrier identified: ○ Behavioral Health transitioned to Health Net from MHN causing a shift in committee structure. The BH criteria did not complete annual review in 2024. ○ Actions Taken:		(Neves / Rahn)

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	○ Updated UCMCM workplan rationale and planned interventions to include Behavioral Health criteria. ○ BH utilization review criteria are scheduled to be presented for approval in Q4 2025. 2. Monitoring the Utilization Management Process All Activities related to Monitoring the UM Process are on Target at the Mid-Year except for Work Plan Element: • Timeliness of Processing the Authorization Request (element 2.2) ○ Barrier identified: ○ In Q1 translation of deferral letters missed TAT, causing the below 95% result. ○ In Q2, this continued to be an issue with not ensuring the translation process is completed within the required timeframe. ○ Actions Taken: ○ Targeted staffing initiatives are in progress. ○ Comprehensive training for the Prior Authorization team was conducted to reinforce updated workflows and expectations. ○ Regular performance reviews and compliance tracking are planned to sustain improvements and identify emerging issues proactively. 3. Monitoring Utilization Metrics All Monitoring Utilization Metrics are on target at the Mid-Year except Work Plan Element: • PPG Profile and Vendor List (element 3.3) ○ Barrier identified: ○ Specialty access continues to be a challenge for PPGs. ○ PPG A: Member Notification TAT was non-compliant due to workflow issues with mailroom vendor and inadequate staffing. CAP remains open. ○ PPG B: Increase in authorization requests led to delays. ○ PPG F: Decision TAT was non-compliant due to workflow management, high volume of requests, and inadequate staffing and remained open at the end of Q2. ○ Actions Taken:		

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	○ The Plan continued monitoring of open PPG CAPs. ○ PPG A/B: staffing ratios were reassessed which resulted in hiring additional coordinators, onboarded by 1/1/2025. ○ PPG F: increased staffing and automated workflows to accommodate volume and address TAT. 4. Monitoring Coordination with Other Programs • All Activities related to Monitoring Coordination with other programs are on track except for Work Plan Elements: ○ Care Management (CM) Program (element 4.1) ○ The goal for reducing admissions/readmissions was increased to 5% this year, but at the mid-year this target was not met at 4.5%. ▪ Barrier identified: ▪ Admissions and readmissions experienced a smaller sample in the 1st quarter which skewed results due to one member with multiple re-admissions. ▪ Fewer than expected number of satisfaction surveys completed. ▪ Actions Taken: ▪ CMs to encourage members to take surveys and obtain the preferred contact method by members for survey. • Referrals to Perinatal Care Management (element 4.2) ○ Barrier identified: ▪ Small Q1 sample size makes it difficult to determine if we are on target or not. ▪ Members entering program after first trimester impacts our ability to achieve completion of first pre-natal visit. ○ Actions Taken: ▪ In Q3 we will prioritize members in the first trimester for outreach to improve compliance with completing the first prenatal visit. 5. Monitoring Activities for Special Populations: All Monitoring Activities for Special Populations are on target at Mid-Year.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#9 RY2025 HEDIS Results & Quality Improvement Update Information P. Marabella, MD, CMO	For RY2025 (MY2024), MCP's were required to meet the minimum performance level (MPL) on 18 measures in each county. There are 18 Measures in 4 Domains: 1. Children's Health 2. Reproductive Health & Cancer Prevention 3. Behavioral Health 4. Chronic Disease Management MCAS Measures Not Meeting Minimum Performance Levels by Domain for RY2025: Fresno County: ○ Did not meet Children's Domain ○ Did not meet Behavioral Health Domain Kings County: ○ Did not meet Children's Domain Madera County: ○ Did not meet Behavioral Health Domain Two PIP Projects in Progress 1. Performance Improvement Project (PIP) Improve Well Child Visits (WCV) for AA/Black Children 0 to 15 months in Fresno County. Two Interventions: 1. Referring all caregivers/mothers of Black/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 in WCV rate for B/AA infants after first year. ▪ PIP ends 12/31/2025. Final data submission due to HSAG/DHCS in August 2026. 2. Performance Improvement Project (PIP) Improve Follow up with Provider after ED Visit for Behavioral Health/Substance Use in Fresno and Madera Counties.		<i>No Motion</i>

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Three Interventions: 1. Working with Saint Agnes Medical Center in Fresno County on Educational Intervention for staff (SMART Phrases to capture services provided). 2. Hispanic focused Cultural Competency. 3. Increase referral resources with Resiliency Center. ▪ Statistically significant improvement after first year. ▪ PIP ends 12/31/2025. Final data submission due to HSAG/DHCS in August 2026. Three (3) DHCS County Projects in Progress Lean Project for Madera County 1. Lean Health Equity Quality Improvement Project in Madera County based on RY24/MY23 MCAS results. ▪ Madera County (Behavioral Health Domain) Focusing on the Hispanic population to improve follow up care after ED Visit for BH/SUD. ▪ Support use of Community Health Workers (CHWs) at FQHCs in collaboration with Camarena Health to link patients to BH services after ED visit. ▪ Utilize Lanes ADT data to facilitate timely follow up (7 days/30 days) after ED visit. Comprehensive Project for Kings County 2. Comprehensive Health Equity Quality Improvement Projects in Kings County (RY24/MY23 results) ▪ Kings County Improve Children's & Chronic Disease Domains. ▪ Children: Focused on increasing provider/member access to pediatric digital health education resources and data reconciliation for well child visits (W30) and Developmental Screening (DEV) measures. ▪ Chronic: Improve Asthma Medication Ratio (AMR) HEDIS® rates through best practices including prescribing Formoterol/ICS combo. Transformational Project for Fresno County 3. Transformational Health Equity Quality Improvement Projects in Fresno County (RY24/MY23 results)		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	▪ Fresno County Improve Children's, Chronic and Behavioral Health Domains. ▪ Implement strategies in Fresno County as outlined for Children's and Chronic Domains in Kings County and participate in a Transformational Project. ▪ Transformational Project in collaboration with Anthem Blue Cross and United Health Centers to improve access to pediatric services at two (2) targeted UHC clinics to improve all eight (8) Children's Domain measures. DHCS coaching. Two (2) IHI Collaborative Projects Improving Well Child Visit Rates and Improving F/U After ED Visit for SUD/MH Phase 1 of these Institute for Healthcare Improvement (IHI) lead Collaboratives was from April 2024 to March 2025: 1. IHI WCV Collaborative focused on testing of five (5) Interventions with a provider–Clinica Sierra Vista-Elm St Clinics- to improve WCV rates for Hispanic Children 0-15 months. ▪ Ending with an emphasis on Community Partnerships and collaboration with Community Based Organizations including Centro La Familia and WIC. 2. IHI BH Collaborative focused on improving referrals to outpatient BH providers after an ED Visit for SUD/MH issue by working in collaboration with Anthem Blue Cross, Community Regional Medical Center and Fresno County Department of Behavioral Health. Phase 2 is scheduled to begin September 25th. ▪ CalViva will continue the Well Child Visit Collaborative with Clinica Sierra Vista to build upon progress made in Phase 1. ▪ Status of the Behavioral Health Collaborative is unclear at this time. CalViva may continue efforts in Fresno County or move to Madera County. Overall: ▪ RY2025 MCAS results showed improvement in all counties.		

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	▪ MY25 (RY26) results are on track to maintain positive results with ongoing improvements. ▪ Medical Management Team is starting to schedule Annual Clinic Visits at CalViva's larger FQHCs in each county to share RY25 results and discuss opportunities for improvement and collaboration.		
#10 Standing Reports • Finance Reports Daniel Maychen, CFO	Finance <u>Fiscal Year End Financials as of June 30, 2025</u> The FY 2025 financials are currently in the final stages of the audit process by Baker Tilly, formerly known as Moss Adams, and no audit adjustments or findings have been identified. A full presentation of the audited financials by Baker Tilly will be conducted at the October meeting. As of June 30, 2025, total current assets were approximately \$520M; total current liabilities were approximately \$345.4M. Current ratio is approximately 1.51. Amount due to DHCS relates to MCO tax gains that the Plan has recorded related to calendar year 2024 and 2025. The Plan believes it is more likely than not that DHCS will recoup these gains as they have done in the past, particularly given the State budget deficits currently and in the foreseeable future in addition to declining federal funds. It appears the earliest DHCS would recoup the funds is February 2026 but it is ultimately up to DHCS as to when this will happen. Total net equity as of the end of June 30, 2025, was approximately \$184.1M, which is approximately 667% above the minimum DMHC required TNE amount. Compared to DHCS standard, this is approximately \$194.5M which puts the Plan approximately \$10.4M short; however, as noted in the past, DHCS allows the Plan to meet that standard by the fact that they pay the Plan one month in arrears. However, it is important to note that the financial measure by which DHCS assesses a health plan's financial condition is at least one month of average annual contract revenues. Interest income actual recorded was approximately \$11.4M, which is approximately \$7.4M more than budgeted due to interest rates being higher than		<i>Motion: Commission approved standing reports</i> <i>12 – 0 – 0 – 5</i> <i>(Naz / Fields-Keene)</i> <i>Kerry Hydash left at 3:16 pm, not included in vote</i>

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	projected. Premium capitation income actual recorded was approximately \$2.33B which is approximately \$517.6M more than budgeted due to MCO taxes being approximately \$284.6M more than projected as they were revised by DHCS and approved by CMS in December 2024 which substantially increased the MCO taxes. The remaining difference is due to enrollment and rates being higher than projected. Total cost of Medical Care expense was approximately \$1.41B which is approximately \$225.9M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately \$57.4M, which is approximately \$3.7M more than budgeted due to enrollment being higher than projected. Grants expense actual recorded was approximately \$3M which is approximately \$1.3M less than budgeted due to the allocation of approximately \$800K for Community Reinvestment requirement from DHCS. The Plan received the final APL (All Plan Letter) from DHCS February 2025 in which it stated that DHCS will not review and approve Plans' Community Reinvestment Plan until Q3 2026. License expense actual recorded was approximately \$1.5M which is approximately \$62K more than budgeted due to the DMHC assessed fee being higher than anticipated. Taxes actual recorded was approximately \$848.4M, which is approximately \$284.6M more than projected due to the revised MCO taxes. All other expense line items are in line or below what was budgeted for FY 2025. Net income for Fiscal Year End 2025 actual recorded was approximately \$22.4, which is approximately \$13.8M more than budgeted primarily due to interest income being higher than projected by \$7.4M, and rates and enrollment being higher than projected. <u>Financials as of July 31, 2025</u> As of July 2025, total current assets were approximately \$396.8M; total current liabilities were approximately \$221.7M. Current ratio is approximately 1.79. Amount due to DHCS was approximately \$21.6M. TNE as of July 2025 was approximately \$184.7M which is approximately 669% above the minimum DMHC required TNE amount. For DHCS standard, the minimum required TNE is approximately \$192.2M, which the Plan is short by approximately \$7.5M.	<i>Joe Prado asked if there was a decrease in enrollment for other Plans?</i>	

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	Premium capitation income actual recorded was approximately \$192.2M which is approximately \$18.6M more than projected primarily due to higher enrollment. For the FY 2026 budget, we projected enrollment to steadily decline in early parts of 2025; however, enrollment has remained consistent during that time. However, we have started to see a decrease in enrollment primarily due to the end of the COVID redetermination flexibilities, noting that enrollment declined by approximately 3,000 in August. Total Cost of Medical Care expense actual recorded was approximately \$122.8M which is approximately \$18.3M more than budgeted due to enrollment being higher than projected. Admin Service Agreement fees expense actual recorded was approximately \$4.8M which is approximately \$198K more than budgeted due to enrollment being higher than projected. Under the One Big Beautiful Bill Act, the criteria for the MCO tax was modified as it relates to the requirements that MCO taxes need to be broad based and uniform; this modified criteria was effective 7/4/2025. Essentially, the modified provider (MCO) tax criteria stated that MCO taxes cannot substantially tax Medicaid plans more or less than commercial plans, which the California tax does. Therefore, the current MCO taxes in California are non-compliant as the California MCO tax structure substantially taxes Medi-Cal/Medicaid plans in comparison to commercial plans. However, the One Big Beautiful Bill Act did allow for up to a three-year transition period subject to the approval of the Director of the HHS. DHCS is currently working with CMS on getting approval. Early indications are that the federal government seem to be agreeable to a transition period, but it is still unknown at this time of their decision. The Plan is checking in with trade associations regularly for updates. DHCS did pay the MCO taxes for July 2025 as stated in the Income Statement; however, DHCS did communicate that they would not pay the MCO taxes after that. In terms of the budget, the Plan did budget for the full fiscal year of the MCO taxes. At this point the Plan will not book the MCO tax revenue or expenses moving forward until a final decision is received regarding approval/rejection on the transition period. If the federal government does approve it, the Plan would retroactively accrue for the MCO tax revenue and expenses. If they do not approve it, then the Plan would have to discuss bringing a revised budget to Finance Committee and Commission to account for the change.	<i>Daniel Maychen stated HN has seen a decrease as well.</i>	

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• Compliance M.L. Leone, CCO	All other expense line items are in line or below what was budgeted. Total net income through July 31, 2025, was approximately \$631K, which is approximately \$413K more than budgeted primarily due to enrollment being higher than projected. Compliance <u>Compliance Report</u> Year to date there have been 184 Administrative & Operational regulatory filings for 2025; 37 Member Materials filed for approval; 104 Provider Materials reviewed and distributed, and 71 DMHC filings. There have been 31 potential Privacy & Security breach cases reported year to date, with five being high risk. Since the 7/17/2025 Compliance Regulatory Report to the Commission, there were four new MC609 filings: • One case was a participating provider who was billing services not rendered and medically unnecessary services • One case is regarding a provider who routinely billed high-level Evaluation and Management (E/M) services at a rate that was significantly higher than their peers. • One case is a non-participating provider allegedly billing for services not rendered. • One case is regarding a non-participating wound care provider who allegedly had excessive high-unit prior authorization requests. The Annual Oversight Audits currently in progress since last reported include Marketing, Health Education, Call Center, Claims/PDRs, Appeals & Grievances, Fraud, Waste & Abuse, Privacy & Security, Provider Network, Utilization Management/Case Management, and Internal Compliance Audit. The one audit completed is Health Equity (CAP).		

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	Regarding the DHCS 2023 Focused Audit for Behavioral Health and Transportation, per DHCS' request, on 8/4/25, CalViva submitted an updated/Final CAP summary document to DHCS. The Plan is anticipating DHCS' acceptance and CAP closure. Regarding the DHCS 2025 Medical Audit, this Audit was conducted virtually from 6/2/2025-6/13/2025. The Plan submitted all required pre-audit documentation and follow-up requests. The DHCS indicated it would provide a Preliminary Final Report in September 2025 with a Final Report by 10/1/25. The Plan is awaiting both reports. Regarding the DMHC 2025 Medical Follow-Up Audit, the DMHC conducted the Follow-Up Audit on May 5, 2025. It has been five months since the DMHC requested any additional information. The Plan is awaiting the DMHC's Final Audit Report. "Inappropriately denying post-stabilization care" is the principal deficiency for which the DMHC must determine whether the Plan had corrected it by the time of the 5/5/25 Follow-Up Audit. Regarding the MY2023/RV2024 Timely Access and Annual Network Submission (TAR), on 8/12/25, the Plan submitted the Material Modification for alternate access standards and, on 9/10/25, the DMHC notified the Plan that it was postponing the review due to DMHC having additional comments. Regarding the MY2024/RV2025 Timely Access and Annual Network Submission (TAR), on 5/1/2025 the Plan submitted its Annual TAR filing to DMHC. The Plan is awaiting a response. Regarding the 2025 Network Adequacy Validation (NAV) Audit, on 8/21/25 by DHCS' external review organization (HSAG) virtual audit was conducted. Preliminary feedback from the HSAG Auditor was very positive as it relates to the thoroughness of the Plan's systems and processes that support network development, monitoring and overall integrity. The auditor was particularly impressed with the excellent slide presentations which clearly and thoroughly described those systems and processes and their various relationships/dependencies in generating the reports the Plan and the DHCS rely		

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	upon for network reporting. The Plan submitted follow up requests on August 26, 2025, and is awaiting a Final Report. Regarding the Annual Network Certifications, the 2024 Subnetwork Certification (SNC) Landscape Analysis was conducted on 1/3/2025, the Plan submitted the 2024 SNC deliverable. Within the submission, the Plan reported that CalViva issued Corrective Action Plans (CAPs) to certain providers due to network adequacy deficiencies. As a result, DHCS has requested that the Plan submit quarterly updates on the status of these CAPs until they are fully resolved. The most recent quarterly update was submitted on 7/1/2025. In addition, with regard to the 2024 Annual Network Certification (ANC), on 7/22/25, DHCS sent a Preliminary Determination with four AAS denials related to time/distance standards. The Plan responded to that letter on 7/24/25 and we are awaiting a response. With regard to California Advancing and Innovating Medi-Cal (CalAIM), Transitional Rent is a new Community Support service under CalAIM designed to provide up to six months of rental assistance to Medi-Cal members who are experiencing or at risk of homelessness and meet specific clinical and situational eligibility criteria. Coverage of Transitional Rent was optional for Medi-Cal managed care health plans beginning on January 1, 2025, and required for plans by January 1, 2026. CalViva submitted its Model of Care (MOC) documents on 9/2/2025 and is awaiting DHCS' review and approval for the Plan's 1/1/26 go-live. The MOUs for Fresno County Department of Public Health, and Kings County First 5 were executed and posted to the CVH website. The Public Policy Committee met on September 3, 2025. The following standing reports were presented: • Q1 and Q2 Semi-Annual Member Incentive Program • Q2 Appeals and Grievance Report, including additional perspective on specific issues/trends from Dr. Marabella. Additionally, information was shared regarding the 2025 EOC Errata, the DHCS Community Reinvestment Plan, and the 2025 Annual New Member Understanding Report. There were no recommendations or action items requiring a response		

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• Medical Management P. Marabella, MD, CMO	from the Commission. The next PPC meeting will be held on December 3, 2025, 11:30am -1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave #109, Fresno 93711. Medical Management <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Mid-Year 2025 Quarterly CAHPS Root Cause Analysis Report. The root cause analysis report aims to highlight member satisfaction based on the resolved appeals and grievances cases quarterly to better understand CAHPS results, rate movement, and areas of improvement. For year-over-year comparison for Q2 2025 with regard to Appeals & Grievances Volume by County, compared to Q2 2024, appeals volume increased by 41.6% in Fresno County, 60% in Kings County, and 15.8% in Madera County. Grievances volumes also rose during the same period: • Fresno County up 3.1% • Kings County up 28.5% • Madera County up 3.5% Regarding the one year look back of appeals & grievances volume comparison by county, in Q2 2025, appeals volume increased by 15.6% in Fresno County and 14.2% in Kings County, while Madera County demonstrated a 21.4% decrease compared to the previous quarter. Grievance volumes also rose across all three counties compared to Q1 2025: • Fresno County up 13.6% • Kings County up 19.5% • Madera County up 9.2% <u>Top Appeals & Grievances Trend by Classification Codes – Year over Year Comparison</u>		

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	In Q2 2025, appeals related to the Not Medically Necessary classification increased by 9.9% compared to Q2 2024. For grievances, three of the top five classifications saw increases: • Access to Care rose by 40% • Balance Billing increased by 12.3% • Transportation saw a 36% rise Two categories demonstrated declines compared to Q2 2024: • Quality of Care – PCP decreased by 44.9% • Administrative Issues dropped by 13.9% <u>Top Appeals & Grievances Trend by Classification Codes – One Year Look Back</u> In Q2 2025, appeals related to the Not Medically Necessary classification increased by 0.8% compared to the previous quarter. Among grievances, four of the top five classifications saw increases in volume compared to the prior quarter: • Access to Care up 28.9% • Balance Billing up 26.6% • Quality of Care – PCP up 42.1% • Transportation up 3% The Administrative Issues category demonstrated a 3.1% decline. <u>Trending Appeals (volume) by Category</u> In Q2 2025, in the Not Medically Necessary classification, increased trends were observed in four out of the six categories. Diagnostic – MRI and Diagnostic – CAT Scan were the only two categories with a decrease of 10.5% and 35.3% respectively, compared to Q2 2024. Compared to the previous quarter, Q2 2025 showed decreases in two of the six categories. However, Diagnostic – MRI, DME – CPAP Machine, and Diagnostic – CAT Scan demonstrated increases relative to Q1 2025. Diagnostic – Genetic Testing remained unchanged from the previous quarter.		

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	<u>Trending Grievances (volume) by Category</u> Compared to Q2 2024, several grievance categories showed notable increases: Prior Authorization Delay rose by 23.1%. PCP Referral for Services increased significantly by 121.4%. General Complaint – Vendor saw a 66.6% rise. In contrast, the following categories demonstrated decreases in volume: • Referral Process was down 37.7%. • Health Plan was down 42.3%. • Inappropriate Payment Demand (PAR) was down 18.6%. Most grievance categories demonstrated an increase in Q2 2025 compared to the previous quarter: • Prior Authorization Delay increased significantly by 82.8%. • Inappropriate Payment Demand (PAR) increased by 26.6%. However, declines were observed in: • Referral Process grievances, which decreased by 35.7%. • Health Plan grievances, which dropped by 31.9%. In summary, appeals volume continues to rise in 2025. In Q2 2025 there was an increase in appeal volume with 156 total appeals. 78% (122 appeals) were classified as Not Medically Necessary. Top drivers of appeals were: • Diagnostic MRI • DME-CPAP Machine • Self-injectable Medications • Diagnostic Genetic Testing • Diagnostic CAT Scan • Outpatient Procedures • Medically Tailored Meals Several opportunities for improvement were identified with activities in progress or planned to include education for providers on the criteria for medical		

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	procedures and medically supportive meals to avoid unnecessary denials and delays. In summary, for grievances, grievances have increased year over year, with Access to Care services remaining the most frequently cited category, particularly due to issues such as prior authorization delays and missed transportation appointments. In Q2 2025, a total of 608 grievances were received, with 196 categorized under Access to Care. Top drivers of grievances are: • Prior Authorization Delay • PCP Referral for Services • Transportation Missed Appointment • Prescription Delay • Network Availability • Specialist Referral for Services Several opportunities for improvement were identified with actions in progress or planned to reduce grievances. These actions included providers keeping members informed of prior authorization timelines for approval and streamlining the referral process. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) for Mid-Year 2025. • MCE (Medicaid Expansion): Acute admissions and utilization remained stable. • TANF (Temporary Assistance for Needy Families): Continued stability with slight declines in admissions and utilization compared to 2024. • SPD (Seniors and Persons with Disabilities): Marked and sustained declines across all acute care metrics in admissions (-20.3%) and bed days (-24.3%) versus 2024 benchmarks. • MCE (Medicaid Expansion): Q2 ALOS: 5.0 days, slightly below the Annual Goal. • TANF (Temporary Assistance for Needy Families): Q2 ALOS: 4.1 days, above the 2024 average of 3.7 days. • SPD (Seniors and Persons with Disabilities): Q2 ALOS: 5.9 days, below the Annual Goal of 6.5 days.		

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	30-Day Readmission Trends: • MCE: Declined from a 2024 average of 13.5% to 12.7% in Q2 2025, representing a 6% reduction. • TANF: Saw the most substantial improvement, dropping from a 4.8% average in 2024 to 3.7% in Q2 2025, a 23% reduction. • SPD: Also improved significantly, moving from a 20.2% 2024 average to 18.5% in Q2 2025, marking an 8% reduction. The data shows promising progress in reducing 30-day readmission rates across all major populations. These improvements likely reflect targeted care coordination efforts, better discharge processes, and enhanced patient support, especially for high-risk, complex populations. Next steps include maintaining rigorous utilization review practices in alignment with discharge planning; continued collaboration between utilization management and case management teams to ensure seamless care transitions; and TCS team will continue to outreach to hospitals to begin onsite presence, to improve enrollment of members into the TCS program, and help coordinate care. Physical Health Care Management (PH CM): • Referral volume increased 86% in Q2. • Q1 to Q2, the Engagement Rate increased from 54% to 57%. Transitional Care Services (TCS): • Total Number of Referrals increased 3% to 1638, from Q1 to Q2. • Engagement Rate decreased slightly to 90% in Q2 from 91% in Q1. • Total Cases Managed increased 1.66% for a total of 1227 in Q2. Behavioral Health Case Management (BH CM): • Q1 to Q2, Total Number of Referrals increased 11% to 429 in Q2. • Engagement Rate increased from 70% in Q1 to 76% in Q2. • Total Cases Managed decreased 16.6% to 282 cases in Q2. Perinatal Case Management: • Total Number of Referrals increased 17% to 908 in Q2.		

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	- Engagement Rate increased from 61% in Q1 to 65% in Q2. - Total Cases Managed increased 3.5% to 494 in Q2. First Year of Life: - Total Number of Referrals increased by 17%, Q1 to Q2. - Total Cases Managed increased 13% to 479 cases in Q2. Four (4) measures are tracked to evaluate the effectiveness of Care Management programs, these include Readmission rates, ED utilization, Overall health care costs, and member satisfaction. For post-enrollment from Behavioral Health and Physical Health, there was a 4.5% decrease in the readmission rate. This was just below our recently increased goal of 5%. For ED Claims before and after CM enrollment, ED claims decreased by 74 (22.5% for Q1), above our 10% goal. For Outcomes for Transitional Care Services, there was a 1.4% decrease in the readmission rate. This was below our 5% goal. Low reduction is attributed to one member with multiple readmissions. For ED Claims before and after CM enrollment, ED claims per 1,000 members per year decreased by 74 (22.8% for Q1) which exceeded the 10% goal. The effectiveness of Perinatal Case Management program is evaluated based on completion of the first Prenatal visit in the first trimester, reducing Pre-term deliveries, timely completion of the Postpartum visit, and Member Satisfaction. Two (2) of four (4) metrics met established goals. Increasing timely Prenatal visits did not meet the 5% goal at 1.4% and there were some member survey results with responses below the 90% goal. Actions are being taken to improve these metrics. <u>Credentialing Sub-Committee Quarterly Report</u> The Credentialing Sub-Committee met on July 17, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated		

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	services. Reports covering the first quarter for 2025 were reviewed for delegated entities, and the second quarter of 2025 for Health Net and Behavioral Health (BH). The Credentialing Adverse Actions report for Q2 for CalViva from Health Net Credentialing Committee was presented. There were no (0) CalViva cases presented for discussion in Quarter 2. The Adverse Events report for Q2 2025 was reviewed. 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 zero (0) cases to the Credentialing Committee in the second quarter of 2025. There were no (0) reconsiderations or fair hearings during the second quarter of 2025. There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the second quarter of 2025. 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 the second quarter of 2025. NCQA CR5.A.1-2 Reviews completed in April and May identified one (1) practitioner requiring removal from the Plan's network. Notification was provided to the impacted practitioner, as well as the impacted Plan departments, including Claims, Network Management, Delegation Oversight, Special Investigations Team, and Provider Data Management The Access & Availability Substantial Harm Report Q2 2025 was presented and reviewed. The purpose of this report is to identify incidents involving 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 Issue (PQI) 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 second quarter 2025 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).		

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	The 2025 Credentialing Oversight Audit Results were presented and reviewed. CalViva Health conducted an oversight audit of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function. Randomly selected practitioner files (201) were reviewed from Health Net (HN), HN Behavioral Health, and the other entities delegated for Credentialing/Re-Credentialing, including Santé, La Salle, ASH, IMG, Adventist, Envolve, CVMP, ChildNet, Grow Therapy, Clinica Sierra Vista, and UPN. A total of seventy-three (73) Primary Care Providers (PCPs), sixty-seven (67) Specialty Care Providers (SCP), thirty-four (34) mid-levels (NPs, PAs, midwives), and twenty-seven (27) Allied Health Professionals were included in the file review. Organizational provider files (16) were randomly selected for review and evaluation to ensure compliance with regulatory requirements. Appropriate file types were selected to include: one (1) Skilled Nursing Facility, two (2) Outpatient Dialysis Centers, one (1) Hospice, six (6) Urgent Care Centers, two (2) Acute Care Hospitals, two (2) Imaging Centers, one (1) Physical Therapy Center, and one (1) Community Support. ICE Credentialing/Re-Credentialing audit tools were used to evaluate file compliance. The timeliness of Re-Credentialing within the thirty-six-month (36) criteria was noted to be a factor for IMG in this audit, with one (1) case not meeting the compliance criteria at the required 100% level. The IMG case was recredentialed at forty (40) months and will require corrective action. Overall, HNCS was found to be consistently compliant with 85 out of 86 standards evaluated, with a 98.8% compliance rate. The Initial Credentialing and Re-Credentialing file reviews of practitioners were excellent with both at 99% compliance, and the Organizational Provider files demonstrated 100% compliance. The Credentialing Sub-Committee Reports for Q2 2025 were reviewed. The county-specific Credentialing Subcommittee Reports of significant subcommittee activities for April through June 2025 were presented. Three (3) Corrective Action Plans were identified in these reports for Q2 2025; one (1) in Fresno County and two (2) in Madera County. <u>Peer Review Sub-Committee Quarterly Report</u>		

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	The Peer Review Sub-Committee met on July 17th, 2025. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2025 were reviewed for approval. There were no significant cases to report. The Q2 2025 Adverse Events 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. There were nineteen new (19) cases identified in Q2 that met the criteria and were reported to the Peer Review Committee. Four (4) cases involved a practitioner, and fifteen (15) cases involved organizational providers (facilities). Of the nineteen (19) cases, two (2) were tabled, zero (0) were tabled with a letter of concern, two (2) were placed on monitoring, two (2) were placed on pending closure, none (0) were deferred, three (3) were closed to track and trend with a letter of concern, zero (0) were closed to track and trend with a letter of education, and ten (10) were closed to track and trend. Eighteen (18) cases were quality of care grievances, one (1) was a potential quality issue, none (0) were lower-level cases, and none (0) were track and trend cases. Six (6) cases involved seniors and persons with disabilities (SPDs). Zero (0) cases involved behavioral health. There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2025. NCQA.CR 5.A.4: Reviews completed in March and April did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. NCQA CR 5.A.5: There were zero (0) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. There were eight (8) cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. One (1) case referred to peer review for further review. Further review includes an examination of trended grievances, as well as a review of licenses and sanctions/exclusions. The case did not require escalation for presentation at the Peer Review Committee. No (0) cases required reporting for 805.01 in Q2 2025.		

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Equity Report S. Xiong-Lopez, EqO	The Access & Availability Substantial Harm Report for Q2 2025 was also presented. The purpose of this report is 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 Issue (PQI) cases related to identified appointment availability issues. Each case is assigned a tracking number, and all pertinent information is gathered for presentation to the Peer Review Committee. Each case is assigned a severity outcome score, and cases requiring follow-up are tracked to conclusion. Twenty-three (23) cases were submitted to the Peer Review Committee in Q2 2025. Of the 23 cases, two (2) cases were related to appointment availability issues without significant harm, and six (6) were related to significant harm without appointment availability issues. Behavioral Health cases are included in this report. There were no BH cases for review in Q2 2025. Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q2 2025. The Q2 2025 Peer Count Report was presented and discussed with the committee. Twenty-three (23) cases were reviewed. Sixteen (16) cases were closed and cleared. Zero (0) cases were closed/terminated. Zero (0) cases were deferred. Three (3) cases were tabled for further information. There were two (2) cases with CAPs outstanding/continued monitoring, and two (2) cases are pending closure for CAP compliance. Follow-up will be initiated to obtain additional information for the tabled cases and ongoing monitoring and reporting will continue. Equity <u>Equity Report</u> Updates to Health Equity since last reported are as follows: <u>Perimenopause/ Menopause Project- Hanford -</u>		

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	6/2025- Pear Suite has been designated as a community-based organization (CBO) in Kings County to collaborate for the project. Pear Suite is an existing contracted CHW provider with CVH in Kings County and can assist with broadening the project's reach and ensure that more individuals are reached while also streamlining the referral system for the target population. The PearSuite Data platform will track the number of women referred to the Community Health Worker (CHW) for education and the number referred to a physician's office for clinical assessment. Additionally, the Pear Suite team will conduct a comprehensive needs assessment to gather data on how many of these women were referred to CalAim Services, such as Enhanced Care Management (ECM) and Community Supports (CS), specialty healthcare, or other Social Determinants of Health (SoDH). Dr. Talk is our identified provider champion in this project. He will be assisting in taking care of the referred clients who scored high on their pre-assessment. Additionally, we will be reporting out on how many of the referred individuals were seen by his office or have an established appointment. 8/2025 Connected Valley Voices, an existing CBO and trusted partner of Kings County Public Health, with Pear Suite. Valley Voices is now a subcontractor of Pear Suite CHW Team to assist with the project and will be able to bill Medi-Cal for CHW reimbursement. Data, referral, perimenopause/menopause pre-assessment, and workflow were created, along with a flyer. The Perimenopause campaign was launched in early September 9th for Perimenopause Awareness Month. KAO, Jeff Gardner and his team are assisting in the pilot project by providing their Auditorium Room for one of the three focus groups that will be held on October 6. The other two focus group will be held in Avenal and Corcoran for to eliminate any transportation barriers for women who wish to participate. <u>Diversity, Equity and Inclusion Survey and training -</u> Changes in the provided Equity Report: The plan was to distribute the Annual DEI Surveys will be distributed this month, 9/2025. However, due to the timeline of our NCQA Health Equity look back period, we were advised to push the survey distribution to early Q1 2026. Changes in the NCQA verbiage has changed, therefore the survey verbiage will be updated to align with NCQA. Please be on the lookout for the survey Q1 2026.	<i>Supervisor Bredefeld requested a copy of the DEI Survey.</i>	

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	<u>NCQA Health Equity Accreditation-</u> 6/2025- CVH received its NCQA Health Equity Accreditation on June 4. Out of the 26 applicable points, CalViva Health received all 26 points <u>Health Equity Annual Oversight Audit- HN –</u> Oversight Audit Started April 2025; HealthNet Oversight audit completed with 100% Compliance, September 2, 2025. <u>Community: Closing Activities:</u> <u>Mobile Health Clinic:</u> Mobile health clinics were identified in Madera, Fresno, and Kings County. The goal was to strategize a way to bring these clinics together, identify the services they provide, and determine if there are any gaps in those services. Many of the mobile clinics expressed interest in collaborating with CVH to address areas such as well-child visits and vaccinations. However, when invited to join a collaborative meeting of all mobile health clinics, there was no response. At this time, we have concluded that many of the mobile health clinics are satisfied with their existing routines and established locations and are not yet ready to unite as a collective workforce. <u>Network Improvement Community: Cradle to Career - Closing Activity May 2025:</u> Data showed that 89% of the total identified students, or 32 students, were tested and reading at grade level. CVH participated in the NIC pilot as a community and strategy partner to identify more effective ways to assist families. CVH initiated a gathering of all Community-Based Organizations (CBOs) to align services and resources, making them more accessible to school sites. CVH also participated in and presented Cal Aim Services at the Central Valley Regional Assistance Center for Community Schools, aiming to address key challenges such as access to healthcare (including mental health and behavioral health), as well as food and economic insecurities through Medicaid-covered services such as Enhanced Case Management, Community Supports, and Community Health Workers (CHWs). The pilot cohort proved effective. By providing families with resources to tackle these challenges, school staff were able to focus exclusively on helping each student meet their reading level goals. There were many trials and errors		

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Executive Report J. Nkansah, CEO	throughout the year, and can improve by having a robust resource directory would enable the school system to swiftly allocate resources, eliminating time-consuming and frantic searches during urgent situations WIC Pilot Program: Initially, the WIC pilot project aimed to assist and educate members about dual eligibility between Medi-Cal and WIC services. The goal was to provide a list of CVH members to the workgroup by July 2025. CVH planned to use contracted Community Health Workers (CHWs) to make outbound calls in the identified members list and provide education on dual eligibility. However, changes during the pilot's transition from the Department of Health Care Services (DHCS) to the Center for Data Insights and Innovation (CDII) which shifted the project's objectives. The new goal is to interview county program staff, community-based organizations (CBOs), and beneficiaries to identify barriers and experiences, ultimately establishing best practices for delivering services for CBOs. CVH HE Dept. does not work directly with members to provide the specific service; therefore, referred CDII to trusted partners and stakeholders in the community who work more closely with women, families, and community members who utilizes WIC and/or medical services. Executive Report <u>Executive Dashboard</u> Enrollment as of July 2025 is 435,044. Enrollment for Anthem is approximately 204,488, and the enrollment for Kaiser is approximately 11,916. Market Share is currently approximately 66.78%. Regarding Information Technology Communications & Systems, Microsoft will stop providing security updates for Windows 10 as of October 14, 2025. All workstations have been upgraded. Regarding the Call Center and CVH Website, the number of users to the CVH website declined because the plan's pay-per-click online advertising model was		

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	not in effect for the whole quarter. The CalViva Health Member Portal has launched. There are approximately 2K members registered. Provider Network & Engagement Activities, Claims Processing, and Provider Disputes, there are no significant issues or concerns at this time.		
#13 Final Comments from Commission Members & Staff	Jeff Nkansah announced a lease agreement has been signed for the vacant space in the building, the new tenants are Compass Health Administrators.		
#14 Announcements	None.		
#15 Public Comment	None.		
#16 Adjourn	The meeting adjourned at 3:37 pm. The next Commission meeting is scheduled for October 16, 2025, in Fresno County.		

Submitted this Day: Oct. 16, 2025
 Submitted by: Cheryl Hurley
 Cheryl Hurley
 Clerk to the Commission