

FRESNO - KINGS -
MADERA
REGIONAL
HEALTH
AUTHORITY

Commission

Fresno County

Joe Prado, Interim Director
Public Health Department

David Cardona, M.D.
At-large

David S. Hodge, M.D.
At-large

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D.
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

Jeff Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

Phone: 559-540-7840
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www.calvivahealth.org

DATE: October 10, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

Please find the agenda and supporting documents enclosed for the upcoming Commission meeting on:

**Thursday, October 16, 2025
1:30 pm to 3:30 pm**

Where to attend:

- 1) CalViva Health
7625 N. Palm Ave., #109
Fresno, CA
- 2) Family Healthcare Network
114 W. Main St.
Visalia, CA 93291
- 3) Woodward Park Library
Large Study Room
944 E. Perrin Ave.
Fresno, CA 93720

Meeting materials have been emailed to you.

Currently, there are **12** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority Commission Meeting

October 16, 2025

1:30pm - 3:30pm

Meeting Location:

1) CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

2) Family HealthCare Network
114 W. Main St.
Visalia, CA 93291

3) Woodward Park Library
Large Study Room
944 E Perrin Ave.
Fresno, CA 93720

Item	Attachment #	Topic of Discussion	Presenter
1.		Call to Order	J. Neves, Co-Chair
2.		Roll Call	C. Hurley, Clerk
3. Action		Consent Agenda:	J. Neves, Co-Chair
	Attachment 3.A	- Commission Minutes dated 9/18/25 - Finance Committee Minutes dated 7/17/25 - QI/UM Committee Minutes dated 7/17/25	
	Attachment 3.B	- Commission Calendar - Finance Committee Calendar - QIUM Committee Calendar - Credentialing Sub-Committee Calendar - Peer Review Sub-Committee Calendar	
	Attachment 3.C	- Public Policy Committee Calendar - Compliance Report	
		<i>Action: Approve Consent Agenda</i>	
		<i>PowerPoint Presentations will be used for item 4</i>	
4. Information	No attachment	State and Federal Impacts	J. Nkansah, CEO
5. Action		CalViva Health Community Support and DHCS Community Reinvestment Program (Grants Budget)	J. Nkansah, CEO
	Attachment 5.A	BL 25-013 Community Support & DHCS Reinvestment Program	
	Attachment 5.A.1	Revised Grant Recommendations 2025-2026	
	Attachment 5.A.2	Ad-Hoc Committee Meeting Minutes	
		<i>Action: Approve Revised Community Funding Grant Recommendations</i>	

6. Action	Attachment 6.A	Financial Audit Report for Fiscal Year 2025 Baker Tilly LLP Board Presentation of Audit <i>Action: Approve Audit Report</i>	R. Siucco, Baker Tilly LLP
Handouts will be available at meeting PowerPoint Presentations will be used for items 7-9			
7. Action	Attachment 7.A Attachment 7.A.1	2025 Heath Equity - Executive Summary - Work Plan Mid-Year Evaluation <i>Action: Approve 2025 Health Equity Executive Summary and Work Plan Mid-Year Evaluation</i>	S. Xiong-Lopez, EqO
8. Action	Attachment 8.A	2025 Quality Improvement Health Equity Transformation Program <i>Action: Approve 2025 QI Health Equity Transformation Program</i>	P. Marabella, MD, CMO
9. Action	Attachment 9.A	Skilled Nursing Facility Quality Assurance Performance Improvement Dashboard Report Q2 2025 <i>Action: Approve Skilled Nursing Facility Quality Assurance Performance Improvement Dashboard Report Q2 2025</i>	P. Marabella, MD, CMO
10. Action		Standing Reports	
	Attachment 10.A	Finance Report Financials as of August 31, 2025	D. Maychen, CFO
	Attachment 10.B Attachment 10.C Attachment 10.D	Medical Management - Appeals and Grievances Report - Key Indicator Report - Quarterly Summary Report	P. Marabella, MD, CMO
	Attachment 10.E	Equity Equity Report	S. Xiong-Lopez, Eq.O
	Attachment 10.F	Executive Report Executive Dashboard <i>Action: Accept Standing Reports</i>	J. Nkansah, CEO
11.	Final Comments from Commission Members and Staff		
12.	Announcements		
13.	Public Comment <i>Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on</i>		

the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.

14.

Adjourn

J. Neves, Co-Chair

Supporting documents will be posted on our website 72 hours prior to the meeting.
If you have any questions, please notify the Clerk to the Commission at: Churley@calvivahealth.org

If special accommodations are needed to participate in this meeting, please contact
Cheryl Hurley at 559-540-7842 during regular business hours (M-F 8:00 a.m. – 5:00 p.m.)

Next Meeting scheduled for November 20, 2025, in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

**“To provide access to quality cost-effective healthcare and promote the health and well-being of the communities
we serve in partnership with health care providers and our community partners.”**

Item #3

Attachment 3.A – C.

Consent Agenda

3.A – Minutes

- Commission Minutes dated 9/18/25
- Finance Committee Minutes dated 7/17/25
- QI/UM Committee Minutes dated 7/17/25

3.B – 2026 Calendars

- Commission Calendar
- Finance Committee Calendar
- QIUM Committee Calendar
- Credentialing Sub-Committee Calendar
- Peer Review Sub-Committee Calendar
- Public Policy Committee Calendar

3.C – Compliance Report

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.		<i>A roll call was taken.</i>

Commission Meeting Minutes

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
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>	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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/HN 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:		Motion: See item #8 for motion

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	- 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>	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• 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>	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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 UMCM 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: <i>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</i> 13 – 0 – 0 – 4

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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)

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	○ Updated UCMC 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.		

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#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		Motion: Commission approved standing reports 12 – 0 – 0 – 5 (Naz / Fields-Keene) <i>Kerry Hydash left at 3:16 pm, not included in vote</i>

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	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/Ry2024 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/Ry2025 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	- 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).		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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>		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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>		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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>	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
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 <u>WIC Pilot Program</u>: 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		

Commission Meeting Minutes

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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: _____

Submitted by: _____

Cheryl Hurley
Clerk to the Commission



**CalViva Health
Finance
Committee Meeting Minutes**

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

July 17, 2025

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
	Paulo Soares		Hector Torres, Sr. Accountant & MIS Analyst
✓	Joe Neves		
	Supervisor Rogers		
✓	John Frye		
	Rose Mary Rahn		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:31 am, a quorum was present.		
#2 Finance Committee Minutes dated March 20, 2025 Attachment 2.A Action, D. Maychen, Chair	The minutes from May 15, 2025, Finance meeting were approved as read.		Motion: Minutes were approved 4-0-0-3 (Frye / Neves)
#3 Financials – as of May 31, 2025 Action D. Maychen, Chair	As of May 2025, total current assets were approximately \$471.3M; total current liabilities were approximately \$300.1M. Current ratio is approximately 1.57. TNE as of May 2025 was approximately \$180.9M, which is approximately 736% above the minimum DMHC required TNE amount. For DHCS standard, the minimum required TNE is approximately \$194.2M, which the Plan is short by approximately	John Frye asked is the "Other" income is the vacant suite. Daniel Maychen stated	Motion: Financials as March 31, 2025, were approved 4-0-0-3 (Neves / Frye)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	\$13.3M; however, the DHCS financial performance measure does fluctuate as revenues fluctuate. As of May 2025, interest income actual recorded was approximately \$10.8M, which is approximately \$7.1M more than budgeted due interest rates being higher than projected. Premium capitation income actual recorded was approximately \$2.14B which is approximately \$468.3M more than projected primarily due to higher MCO taxes which increased by approximately \$268M as a result of the recent revision to the MCO taxes in December 2024 in addition to higher capitation rates and enrollment than projected. Total Cost of Medical Care expense actual recorded was approximately \$1.28B which is approximately \$193.8M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately 52.6M which is approximately \$3.3M more than budgeted due to enrollment being higher than projected. License expense, by DMHC, actual recorded was approximately \$1.4M which is approximately \$57K more than projected due to the DMHC assessment fee being higher than projected. Taxes actual recorded was \$785.6M, which is approximately \$268.8M more than budgeted due to the revised MCO taxes by CMS which materially increased the MCO taxes. Telephone & Internet expense actual recorded was approximately \$45K, which is approximately \$6K more than projected due to the previous phone vendor increasing rates as the Plan was on a legacy platform and the Plan switched voice service providers at a lower cost. Total net income through May 31, 2025, was approximately \$19.2M, which is approximately \$11.2M more than budgeted primarily due to interest income being approximately \$7.1M higher than projected, and rates and enrollment being higher than projected.	<i>that it is correct, it's the rental income from an occupied suite.</i>	
#4 Announcements/Comments	John Frye inquired about the MCO tax change for California. Daniel Maychen stated the Provider Tax change as a result of the One Big Beautiful Bill Act was effective the day the Bill was signed (i.e., July 4, 2025). The potential material change is that it requires the MCO taxes to be uniform; currently in California the MCO taxes are not uniform. Medi-Cal Plans are charged approximately \$274 per member month, and commercial Plans are charged approximately \$2 per member month. As of now, the State is scheduled to pay Plans the July 2025 MCO tax revenues, but they will stop paying after that. The State is waiting for CMS		

			Finance Committee
AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	guidance/approval because there is an exception under the One Big Beautiful Bill Act to allow a transitional period if approved by the Director of HHS, noting that the State is looking into requesting a transitory period. Jeff Nkansah announced the Plan is very close to signing on a new tenant to occupy the vacant space; anticipating September 1, 2025, if tenant improvements can be completed in time.		
#5 Adjourn	Meeting was adjourned at 11:39 am		

Submitted by: *Cheryl Hurley*
Cheryl Hurley, Clerk to the Commission

Dated: 9-18-25

Approved by Committee: *Daniel Maychen*
Daniel Maychen, Committee Chairperson

Dated: 9/18/2025

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
July 17th, 2025

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	✓	Maria Sanchez, Senior Compliance Manager
	Carolina Quezada, M.D., Internal Medicine/Pediatrics, Family Health Care Network	✓	Patricia Gomez, Senior Compliance Analyst
✓	Joel Ramirez, M.D., Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	Nicole Foss, RN, Medical Management Services Manager
✓	DeAnna Waugh, Psy.D., Psychology, Adventist Health, Fresno County		Zaman Jennaty, RN, Medical Management Senior Nurse Analyst
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA (Alternate)	✓	Norell Naoe, Medical Management Administrative Coordinator
	Guests/Speakers		
	None were in attendance.		

✓ = in attendance

* = Arrived late/left early

** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D., Chair	The meeting was called to order at 10:03 a.m. A quorum was present.	
#2 Approve Consent Agenda Committee Minutes: May 15, 2025	May 15th, 2025, QI/UM minutes were reviewed, and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member.	Motion: Approve Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Specialty Referrals Report (Q1 2025) - Standing Referrals Report (Q1 2025) - Provider Preventable Conditions (Q1 2025) - County Relations Quarterly Report (Q1 2025) - Initial Health Appointment (IHA) Quarterly Report (Q1 2025) - Enhanced Care Management and Community Supports Performance Report (Q1 2025) - Evolent (NIA) (Q1 2025) - SPD HRA Outreach (Q1 2025) - TurningPoint Musculoskeletal Utilization Review (Q1 2025) - Medical Policies Provider Updates (Q2 2025) - Pharmacy Provider Updates (Q2 2025) - Accessibility of Service Report (Primary, BH, & Specialty Care) - Assessment of Network Adequacy (BH & Non-BH) - Access Work Group Minutes from 1/28/25, 3/25/25 (Attachments A-O) Action Patrick Marabella, M.D., Chair	A link for the Medi-Cal Rx Contract Drug List was available for reference. *Dr. Pascual arrived at 10:05 a.m.	(Ramirez/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business/A&G: - A&G Dashboard (May 2025) (Attachments P) Action Patrick Marabella, M.D., Chair	The Appeals & Grievances Dashboard Report through May 2025 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. Grievances: • A total of 177 grievances were received during May 2025, a decrease from April (192) and March (225), respectively. • During this quarter, 185 grievances were categorized as Quality of Service (QOS), primarily due to issues with prior authorizations and network access. • Administrative issues decreased since March, largely due to changes in staff behavior, correcting eligibility issues, and correctly filing paperwork. • Balanced Billing/no ID cards remains an issue, and hospitals need improvement on prior authorizations, provider disputes, and provider appeals. • Transportation Access – Missed appointments remain an issue at eight (8) this month. • There were eighteen (18) Quality of Care (QOC) grievances in May. • Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes for this category decreased to 155 in May. Appeals: The total number of Appeals has increased (56) in May. • A new category we are tracking is CalAim: five (5) were related to medically tailored meals, and two (2) were for housing assistance. • DME has increased with more requests made for pediatric skull molding helmets and other prostheses. • Advanced Imaging in both Cardiac and Non-Cardiac categories has increased. • The Upholds (37.5%) and Overturn (54.2%) rates are upside down for May.	Motion: Approve - A&G Dashboard (May 2025) (Faulkenberry/ Ramirez) 6-0-0-2
#3 QI Business/A&G: - Behavioral Health Performance Indicator Report (Q1 2025) (Attachments Q) Action	The Behavioral Health Performance Indicator Report Q1 2025 indicates behavioral health risk rating and authorization of decision timeliness metrics, which reflect current performance and reveal emerging patterns over time. • In Q1 2025, all metrics met or exceeded their targets. • CalViva membership in Q1 2025 was 432,972 (a 0.7% decrease from the previous quarter). • The Q1 2025 utilization rate for behavioral health is not available due to reporting issues. This data will be available later in Q2 2025.	Motion: Approve - Behavioral Health Performance Indicator Report (Q1 2025) (Waugh/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D., Chair	- Appointment availability met the target at 100%, and there were two (2) Urgent cases. - Authorization timeliness is reported at 100%, with a breakdown of 48 non-ABAs and 1,424 ABAs for Q1 2025.	
#3 QI Business/A&G: - Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2024) (Attachments R) Action Patrick Marabella, M.D., Chair	The Facility Site & Medical Records and PARS Reviews (Q3 and Q4 2024) Report displays completed activity and results of the DHCS required PCP Facility Site (FSR) and Medical Record Reviews (MRR) for CVH in all contracted Medi-Cal counties, using the DHCS APL 22-017 for FSR/MRR. The new FSR/MRR tools and standards began on 7/1/22, including Policy Letters 12-006 and 15-023 for Physical Accessibility Review Survey (PARS) assessment of providers. The results are analyzed for the purpose of monitoring and improving the performance of PCPs against DHCS and CVH standards. - Fifteen (15) FSRs and eighteen (18) MRRs were completed during Q3-Q4 2024. - The FSR mean rate for Q3-Q4 2024 was 97%. - The MRR mean rate for Q3-Q4 2024 was 92%. - The Adult Preventive Care mean score over all counties for Q3-Q4 was 89%. - The Pediatric Preventive Care mean score over all counties for Q3-Q4 was 89%. - Interim Review is a DHCS-required monitoring activity to evaluate the PCP site between the three (3)-year periodic FSR cycle. In Q3-Q4 2024, one (1) interim review was completed in the three (3) CVH counties. - Two (2) "dirty office" complaints were received. The FSR department conducts a site visit for provider sites that have three (3) complaints in a rolling six (6) month period per FSR and Credentialing policies. - One (1) MMR required an on-site focused review to verify corrections. One (1) failed review occurred during this period. - Six out of the eight (6/8) MRR metrics measured in Q4 2024 had a compliance score of 93% to 100%. WCV scored 83% and Blood Lead Screening scored 79%. - Corrective Action Plans (CAPs) have three (3) components: FSR Critical Element (CE) CAP, FSR CAP, and MRR CAP. CE CAPs are due in ten (10) business days from the date of the FSR. FSR and MRR CAPs are due in thirty (30) calendar days from the date of the review. PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal to 90% do not have to submit a CAP (exempt pass). - Thirteen (13) PARS were completed in Q3-Q4 2024, with seven of the thirteen (7/13) PARS	Motion: Approve - Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2024) (Pascual/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	having Basic level access. • Certified Site Review Nurses provide educational training prior to the actual FSR/MRR evaluation. Educational Trainings allow provider sites to become familiar with the DHCS regulations and FSR/MRR processes and can be done on-site if requested. Sixteen (16) onsite educational trainings were completed in Q3-Q4 2024.	
#3 QI Business/A&G: - Lead Screening Quarterly Report (Q4 2024) (Attachments S) Action Patrick Marabella, M.D., Chair	The Lead Screening Quarterly Report (Q4 2024) was presented to monitor the assessment of Blood Lead Screening in Children. Screening compliance describes clinical guidelines for blood lead screening, reporting requirements related to blood lead screening and ensures Medi-Cal members receive anticipatory guidance related to lead poisoning prevention, blood lead level testing, and follow-up services from providers. The Q4 2024 report provides CVH's performance on blood lead level screenings and anticipatory guidance monitoring from Q1 2024 – Q4 2024. • In Q4 2024, the overall compliance rate was 32.72%, which is a 17.27% increase from Q1 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. • The Q4 2024 overall compliance for CPT Code 83655 (only) was 32.68%, which demonstrates a 17.92% increase compared to Q1 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. • The Q4 2024 overall compliance for Anticipatory Guidance was 4.09%, which is a 3.57% increase compared to Q1 2024. Due to the persistent low compliance, the QI team continues to explore potential barriers and solutions. • Barriers to increasing rates include: ○ Incorrect coding used by the providers. ○ Low point of care (POC) LSC testing in provider offices and a delay in receiving testing equipment due to a manufacturer backorder. ○ Members do not want to go to lab locations for services due to the impeded process and lack of transportation. ○ Members do not show up for scheduled appointments. ○ Providers need to establish new workflow processes and obtain regulatory approval before implementing complete onsite point of care screening. ○ An effective and efficient method for documenting that anticipatory guidance was provided still needs to be established.	Motion: Approve - Lead Screening Quarterly Report (Q4 2024) (Faulkenberry/ Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Conflicting guidance has been given to us by the state, as using a specific code invalidates the LSC when combined with a WCV code. Next steps include: • Identify high-volume low-performing providers who are not conducting POC blood lead level screenings. • Establish a process to order blood lead analyzers for providers who are high-volume and low-performing. • Meet with the QIRA team to identify a better method of documenting and reporting on anticipatory guidance. <i>Discussion: The doctors agreed that it is difficult to document anticipatory guidance with conflicting directions from the State. Clarification is needed.</i>	
#4 Key Presentations - Care Management Program Evaluation & Executive Summary 2024 (Attachment T) Action Patrick Marabella, M.D., Chair	The Care Management Program Evaluation and Executive Summary for 2024 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's purpose is a means for achieving 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 efficient utilization of patient care resources. The Goals for 2024 were both met: • Increase the number of cases managed: Total 3,649 cases in 2024, compared to 3,571 in 2023. Or 0.93% of the entire population managed within physical, behavioral, or perinatal case management. • Maintain 90% Compliance for Documentation in the medical record: Each program scored 90% or greater on file reviews in 2024. CM Quarterly Audit Results of Complex & Non-complex File Reviews by Program in 2024 (Overall Average Scores: PH = 98%, BH = 94%, Perinatal = 98%, and TCS = 93%. There was a 2.3% reduction in readmissions and a 23% reduction in ED visits (per 1,000 Members per year) for those members enrolled in CM. Inpatient, Outpatient, and Pharmacy Claim volume all decreased for those in CM when compared to the 90 days prior to CM enrollment. Clinical Outcomes for High-Risk OB:	Motion: Approve - Care Management Program Evaluation & Executive Summary 2024 (Ramirez/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• First Prenatal Visit in 1st Trimester - improved 6.3% (Goal 5%) • Reduction in Pre-term Deliveries by 1.0% (Missed - Goal 2%) • Timely Post-partum Visit – improved 8.0% (Goal 5%) Member Satisfaction Survey Results for 2024: 72 respondents with twelve of the fourteen (12/14) questions answered. • The goal of a 90% positive response (very satisfied – satisfied) was met. • 86% are satisfied with the ability to reach their CM. • 83% reported CM helped them to reach their health goals. • 89% reported CM helped to organize care with their MD and other caregivers. • There were two (2) complaints in 2024. • <i>It was noted that a BH Satisfaction Survey should be added for 2025.</i> Key Accomplishments for 2024: • Successful coordination of CalAIM ECM member self-referrals. • Successful CalAIM Community Supports referrals. • Filled open CM positions. • Managed more members compared to 2023 in the BH, Perinatal, TCS, and FYOL programs. • Enhanced the TCS program to meet Population Health requirements: ○ Outreach for all Acute Inpatient Admissions. ○ On-site staff at Community Regional Medical Center. ○ Increased engagement in programs. ○ Enhanced coordination with Telehealth Care (telehealth docs) for post-discharge follow-up referrals. Program Goals for 2025: • Increase member enrollment in the TCS program. ○ Increase the number of hospitals with onsite staff presence. • Manage more members across CM programs. • Launch texting program with members. • Reduce further the readmission rate and ED visits for members in CM. • Increase Prenatal and Postpartum visit goals for the Perinatal program. • Support CalAIM Community Supports programs and referrals for members through FindHelp. <i>The Committee had no further questions or recommendations.</i>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#4 Key Presentations - 2024 Provider Satisfaction Survey Results (Attachment U) Action Patrick Marabella, M.D., Chair	The Provider Satisfaction Survey RY2025 Results & Approach were presented and reviewed. Provider satisfaction impacts the Plan's ability to create robust networks and partner with providers to care for members and reach quality performance goals. Provider network, claims operations, call center, commercial sales, and provider engagement teams are all impacted by this. The goal is to reach the 90th percentile in overall provider satisfaction by 2027, measured by the annual Provider Satisfaction Survey. The strategy includes collecting provider feedback (including Satisfaction Surveys), identifying key initiatives for improvement, designing and implementing projects, and monitoring experience and performance metrics. <u>Key Values for Provider Satisfaction – Tenets:</u> • Align on best practices with a provider-centric mindset. • As a data-driven organization, we continuously listen to provider feedback to improve. • We collaborate across Departments. No one department owns the end-to-end experience. • We all impact the provider experience, whether we work directly with providers or not. <u>Survey Methodology – Annual Survey:</u> • Completed Q4 of 2024 (Sept-Nov) • Surveyed PCP, Specialist, and BH offices • Administered via mail, phone, & internet • Response Rate: ~8% ○ Response rate increased by 4 pts, but is still low. ○ 137 total responses • Main Question Areas Include: ○ Overall Satisfaction ○ Likelihood to Recommend ○ Comparative Rating to All Other Plans ○ Finance Issues ○ Utilization and Quality Management ○ Network/Coordination of Care ○ Pharmacy ○ Health Plan Call Center Service Staff ○ Provider Relations ○ Bonus/Custom Question Areas: ▪ Discharge Planning	Motion: Approve - 2024 Provider Satisfaction Survey Results (Cardona/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Access & Availability <u>Provider Satisfaction Performance:</u> • BH providers had a high response rate and were about ~30% of responses, indicating a group needing additional attention. • BH Providers brought the overall satisfaction score lower. • Overall Satisfaction (CVH only): 81.3% • High Performance in the following areas: - Access & Availability: ○ Referral and/or prior authorization process necessary for patients to access covered services. ○ Access to urgent care. ○ Access to non-urgent primary care. ○ Access to non-urgent specialty services. ○ Access to non-urgent ancillary diagnostic and treatment services. ○ Access to current and accurate provider directory data. - Health Plan Call Center Service Staff: ○ Overall satisfaction with the Plan's call center service. - Discharge Planning: ○ Assistance with appropriate discharge planning referrals. • Need to Maintain Performance in the following areas: - Discharge Planning: ○ Assistance with transitioning patients to alternate levels of care. - Utilization and Quality Management: ○ Access to knowledgeable UM staff • Low Performance in the following areas: - Provider Relations (BH Providers*): ○ Ability to answer questions/solve problems related to core business functions. ○ Quality of online tools supporting the delivery of patient-centered, quality care. ○ Quality of online tools supporting core business functions. - Health Plan Call Center Service Staff: ○ Helpfulness of health plan call center staff in obtaining the resolution of claims issues. * Survey overlapped the transition period from MHN to HN BH. Gaps should be rectified.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>2025 Focus:</u> Goal: Overall Satisfaction 79% by: • Mirror Winning Approaches from Medi-Cal in Sharing Information: ○ Obtaining member information. ○ Obtaining referrals. ○ Answer questions on quality/Value-Based Care (VBC). • Provider Support and BH Integration: ○ Answer questions/solve problems for core business functions. ○ Online tools supporting the delivery of patient-centered care. ○ Messaging and change management supporting core business functions. • Claims Support and Issue Resolution: ○ Continuing support of claims issue resolution. <u>2025 Strategy – Project Snapshot:</u> Highlights from several areas as we continue to work through project implementation and process improvements. • Enhanced Coordination and Messaging ○ Reviewing website messaging and instructions for clarity. ○ Implementing auto-reply messaging to external email addresses to confirm receipt. • Issue Resolution ○ Increased provider engagement staffing, and structure to support BH providers. ○ Reviewing Pulse survey data monthly for continuous improvement and follow-up. • Provider Data Management ○ Improving workflows for intake and validation of provider data changes, including integration with the state-wide registry Symphony. • Provider Services ○ Rolled out a new Availity platform to support providers online with enhanced and new self-service tools. ○ Completed CC training on the ability to handle claims resolution without the need for additional escalation. <i>Discussion:</i> <i>Dr. Pascual commented that she recently met her Provider Engagement representative but hadn't had any previous interaction with the Provider Engagement team.</i>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<i>Dr. Marabella agreed that the model is not as robust as it could be. Provider Engagement meets with those who are available during their visit, which may often be only the front office staff. Dr. Ramirez asked how the Voice of the Customer (VOC) program would work. Amy Schneider reported that discussions are just beginning in this area, so details on specific programs have not yet been shared, but provider and member satisfaction are components of NCQA Accreditation, and now that CalViva is accredited, there will be greater emphasis in this area. The Plan is up for reaccreditation in 2027: preparations begin now and continue through next year. We're currently in our "look back period." We will update the Committee as we learn more from the HN Management team.</i>	
#5 UM/CM Business - Key Indicator Report & Turnaround Time Report (May 2025) - UM Concurrent Review (Q1 2025) (Attachments V, W) Action Patrick Marabella, M.D., Chair	The Key Indicator Report and Turnaround Time Report May 2025 and the Utilization Management Concurrent Review (CCR) Report Q1 2025 were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Membership remained relatively stable for May 2025. • Pre-service Routine Deferral Notification TAT Non-Compliance (66%): Seventeen out of the fifty (17/50) cases reviewed failed to meet the required TAT for deferral notifications. Fifteen (15) letters were not sent in the members' preferred language. The root cause of most of these delays is the failure of new staff to allow adequate time for translation of letters into languages other than English. Steps have been taken to address this issue and improve compliance. • MCE ○ Admissions and utilization are up slightly, suggesting a gradual rise in acute care needs. ○ Bed days remain stable, indicating that the ALOS (Average Length of Stay) or care has not changed significantly. ○ Next steps include Monitoring for Continued Increases: ▪ Track Q2 2025 data to see if the upward trend continues. ▪ Once Q2 data is in review for any changes in demographics, provider access, or high-cost utilizers. ○ 30-Day Readmission Trends: Declined in Q1 2025, representing an 11% reduction. This improvement indicates potential success in post-discharge care coordination and follow-up. • TANF ○ Volumes and utilization are flat, with minimal change across all metrics.	Motion: <i>Approve</i> - Key Indicator Report & Turnaround Time Report (May 2025) - UM Concurrent Review (Q1 2025) (Faulkenberry/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Indicates a stable population with consistent care patterns. ○ Next steps include maintaining current oversight: Given its stability, no immediate action is needed. ○ 30-Day Readmission Trends: Saw the most substantial improvement, a 37% reduction, suggesting effective management of low-acuity populations and reduced preventable returns to the hospital. • SPD ○ Sharp decreases in admissions, admits, ALOS, and bed days. ○ Next steps include: ▪ Evaluate Quality and Outcomes to ensure reduced utilization is not negatively affecting member outcomes. ▪ Engage CM and Population Health Teams, align strategies to ensure high-risk members are receiving appropriate care levels. ○ 30-Day Readmission Trends: Also improved significantly, marking an 18% reduction. • Next steps for ALOS include: ○ Correlate ALOS with Quality Metrics: Examine 30-day readmission rates, discharge destinations, and patient outcomes to ensure reduced ALOS is appropriate and not compromising care quality. ○ Monitor for Sustainability: Continue tracking ALOS quarterly to ensure reductions remain stable and aligned with clinical appropriateness. ○ Explore Further Optimization: Consider enhanced coordination with SNFs, home health, or Community Supports for sustained impact. <i>Discussion:</i> <i>Dr. Pascual asked which document is not being translated (regarding the TAT report)?</i> <i>Dr. Marabella explained that it was specifically the deferral letter to members, explaining in their preferred language (most often Spanish) that more information is needed to decide their case. The issue was not with the translation company's TAT; it was with the new UM staff requesting the translation promptly.</i> <i>Dr. Cardona asked how CVH's quality and utilization metrics compare with other plans.</i> <i>Dr. Marabella stated that CVH is comparable to other HN-run plans. CVH also monitors PPG benchmarks for the region.</i>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 UM/CM Business - UM Report – Top 10 Inpatient Diagnoses MY2024 (Attachment X) Action Patrick Marabella, M.D., Chair	The UM Top 10 Diagnoses Report 2024 provides an annual evaluation of the hospital admissions per one thousand (Adm/k), bed days per one thousand (Days/k), and ALOS (Average Length of Stay) for the top ten (10) diagnoses, among the TANF (Temporary Assistance for Needy Families), SPD (Seniors and Persons with Disabilities), and MCE (Medicaid Covered Expansion) populations. Identification of utilization trends provides a source from which to establish opportunities for collaboration and outcome improvement. • Sepsis: Remained the leading diagnosis with a 16% increase in admissions and a 4.5% increase in bed days per thousand members. However, the ALOS was reduced by nearly 10% from 2023 to 2024. • Diabetes: Admissions increased by 1.4%, and the ALOS increased by 5.9%. • Cardiac Diagnoses (Hypertensive heart and chronic kidney disease and Hypertensive heart disease): Showed a 7.7% reduction in admissions and days per thousand members from 2023 to 2024. • Respiratory Diagnoses (Respiratory failure, not elsewhere classified, and Pneumonia, unspecified organism): Showed a 9% increase in admissions per thousand members and a 0.8% reduction in the bed days per thousand members. • Each population (SPD, TANF, MCE) exhibited variations in its top diagnoses for 2024.	Motion: <i>Approve</i> - UM Report – Top 10 Inpatient Diagnoses MY2024 (Faulkenberry/Waugh) 6-0-0-2
#5 UM/CM Business - Care Management & CCM Report (Q1 2025) - MedZed Integrated Care Management Report (Q1 2025) (Attachments Y, Z) Action Patrick Marabella, M.D., Chair	The Care Management and CCM Report Q1 2025 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 2024 to Q1 2025, the referral volume for PH CM increased by 20%, while TCS referrals decreased by 23%, and BH CM referral volume increased by 38%. Referrals also increased for PCM and FYOL programs in Q1. The volume of managed cases decreased across all programs in Q1, except FYOL. • TCS has shown a decrease in the volume of members referred in Q1 2025, but the engagement rate has increased this quarter to 91%, up from 54%. • While there hasn't been a major shift in the percentage of PCP visits within 7/14/30 days post-discharge, the performance is considered acceptable at 57% in Q4 2024. • BH CM referrals have increased in Q1 2025, but the engagement rate decreased slightly (70%).	Motion: <i>Approve</i> - Care Management & CCM Report (Q1 2025) - MedZed Integrated Care Management Report (Q1 2025) (Cardona/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- PCM's total referral numbers are up compared to last quarter, with an increase in engagement rate (from 49% to 61%). All outcome measures for PCM showed improvement for enrolled members compared to those not enrolled. - FYOL referrals have increased in Q1 2025, but the engagement rate decreased slightly (96%). - The Readmission rate was 2.3% lower ninety (90) days following CM enrollment compared to ninety (90) days prior to CM. - ED claims per 1,000 members per year decreased by 599 (23.9% for Q4) after CM enrollment. - Thirty-seven (37) members completed a Member Satisfaction Survey, with 92% being satisfied with the CM program. Going forward, the team will work to obtain accurate contact information and increase participation in the satisfaction survey. The MedZed Integrated Care Management Report Q1 was presented to monitor the volume and engagement of members referred to the MedZed Care Management Program, as well as key service-level agreements (SLAs). Over the past six (6) months, MedZed has experienced a decline in its performance and the quality of services to members enrolled in the program. For Q1 2025, one (1) out of four (4) SLAs has met the target. The health plan will terminate the MedZed agreement effective June 30, 2025. Care Management (TCS) will perform outreach to ensure members have an established relationship with a primary care provider (PCP) for medical needs, behavioral health needs, and to provide resources and support. - Engagement (engaged/# of qualified referrals) has decreased in Q1 2025 to 24% from 32% in Q4 2024 (Table 1). - Post-discharge visits did not meet the goal at 38% for the first time in six (6) quarters (Table 3). - Medication reconciliation met the goal at 98% for Q1 2025, an increase from 85% in Q4 2024 (Table 4). - The timely response to member calls on the provider triage line continues below goal at 94%; however, it increased from 84% in Q4 2024 (Table 5). - Member graduation did not meet the goal at 82%, a decrease from 84% in Q4 2024 (Table 6). Dr. Cardona left the meeting at 11:10 a.m. and returned at 11:11 a.m.	
#6 Policy & Procedure Business - Quality Improvement Policy	The Quality Improvement Policy & Procedure Annual Review was presented to the committee. The following policies were presented for annual review with no changes made :	Motion: <i>Approve</i> - Quality

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
& Procedure Annual Review (Attachment AA) Action Patrick Marabella, M.D., Chair	QI-006 Annual HEDIS Production and Reporting QI-007 Health Equity Quality Review and Engagement Strategies QI-008 Data Collection and Disparity Analysis QI-010 Medical Records Documentation Standards 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 QI-018 Initial Health Appointment (IHA) QI-019 Childhood Blood Lead Screening The following policies were presented for annual review and were approved with the following changes: QI-005 Quality Improvement and Health Equity Transformation Program (QIHETP) Requirements: Updated the Consumer Satisfaction Survey Requirements to include DMHC, along with DHCS. QI-011 Medi-Cal PCP Facility Site Medical Record Review: Updated attachments for FSR Standards and Guidelines, FSR Tool, MMR Standards and Guidelines, and MMR Tool. <i>Committee members agreed with the policy changes as stated and voiced no questions or concerns.</i> Dr. Pascual left the meeting at 11:18 a.m. and returned at 11:25 a.m.	Improvement Annual Policy & Procedure Review (Ramirez/ Faulkenberry) 6-0-0-2
#7 Oversight Audit Business - Behavioral Health MY2024 - Quality Management MY2024 - Credentialing MY2024 (Attachments BB-DD) Action Patrick Marabella, M.D., Chair	The 2025 Behavioral Health Oversight Audit Results were presented and reviewed. CVH Medical Management staff conducted an oversight audit of Health Net Community Solutions' Behavioral Health (HNCS BH) functions (formerly MHN) for the period January 1 to December 31, 2024. The audit, performed April 10 through June 10th, 2025, encompassed nine categories: Access & Availability of BH/SUD Services; Challenges Finding In-Network Providers; Utilization Management; Customer Service; Appeals & Grievances; Provider Referral Practices; Quality Assurance; Network Adequacy; and Health Equity & Cultural Competence. Health Net Community Solutions demonstrated 95% compliance with the 114 standards evaluated (107 out of 113 met, one N/A) for the Behavioral Health function. The following case types were reviewed with their associated results: • Case Management of ABA Cases (Autism) = 8 (100%) • Prior Authorization Case Denials = 8 (100%)	Motion: Approve - Behavioral Health MY2024 - Quality Management MY2024 - Credentialing MY2024 (Ramirez/Waugh) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Inbound Calls = 8 (100%) • Referral Request Calls = 8 (100%) • PQI Case Files = 3/3 (100%) • Crisis Call Management = 8 (100%) The initial report of opportunities for improvement includes: • 1B-3 Call Wait Time: The review of call statistics revealed that there were multiple instances where wait times exceeded 10 minutes, particularly during peak hours. The data indicates inconsistent performance in maintaining the required wait time threshold. • 1D-4 Appointment Availability: Appointment availability survey results indicated that, in multiple instances, urgent BH appointments did not meet the required wait time standards. • 2A-4 Timely Out-of-Network Services: The review of documentation revealed that there are efforts to secure out-of-network services, there were instances where follow-up services were not adequately arranged after the initial out-of-network visit. In some cases, members reported delays in receiving necessary follow-up care due to coordination issues between in-network and out-of-network providers. • 2B-2 Network Capacity-ED Length of Stay: The review of documentation revealed that there are efforts to secure out-of-network services; there were instances where follow-up services were not adequately arranged after the initial out-of-network visit. In some cases, members reported delays in receiving necessary follow-up care due to coordination issues between in-network and out-of-network providers. • 3A-2 Annual Review of BJ UM Criteria: The Medical Advisory Committee (MAC) minutes indicate some discussion regarding UM criteria updates, but there is insufficient evidence to demonstrate that a comprehensive annual review was conducted for all BH UM criteria. • 9B-2 BH Call Center Staff CLAS Training: There is no evidence of BH Call Center staff completing CLAS training during the audit period. This overlapped the transition from MHN to HN. Behavioral Health is preparing its initial response. <i>Discussion:</i> <i>Dr. Waugh commented that MH/SUD patients would likely leave the ED if asked to wait for an extended time (8 hours). The actual number of patients seen in the ED may be deflated.</i> <i>Dr. Marabella indicated that HN will need to reassess network contracting to ensure there is adequate coverage. The Plan uses Community Health Workers (CHWs) or Substance Use</i>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<i>Navigators (SUNs) to help with SUD referrals downtown (Fresno) and in Madera at Camarena.</i> The 2025 Quality Management Oversight Audit Results were presented and reviewed. CVH conducted an Oversight Audit of Health Net Community Solutions' (HNCS) support of the Quality Management function for CVH. Program Descriptions, Annual Work Plans, and Mid-year and Annual Evaluations were reviewed to provide evidence of compliance for several standards. Additionally, several policies and procedures, audits, reports, contracts, and other documentation were reviewed as evidence of compliance with established standards and regulations. Based upon review of these documents and ongoing communication with appropriate leadership and staff from QI, UM, and Population Health, and through the QI/UM Workgroup, QI/UM Committee, and other formal and informal improvement teams, CVH observed overall a 100% compliance rate for this function. The 2025 Credentialing Oversight Audit Results were presented and reviewed. CVH conducted an oversight audit of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function. An evaluation of compliance with credentialing system controls to maintain the accuracy and security of practitioner and provider data revealed appropriate application, monitoring, and reporting of credentialing controls. HNCS provided a number of policies and procedures, contracts, reports, logs, and other documentation as evidence of compliance. • Randomly selected practitioner files (201) were reviewed from Health Net (HN), HN Behavioral Health, and the other entities delegated for Credentialing (101)/Re-Credentialing (100), including Santé, La Salle, ASH, IMG, Adventist, Envolve, CVMP, ChildNet, Grow Therapy, Clinica Sierra Vista, and UPN. • Organizational provider files (16: 8 initial credentialing, 8 recredentialing) were randomly selected for review and evaluation to ensure compliance with regulatory requirements. File types included Skilled Nursing Facilities, Outpatient Dialysis Centers, Hospice, Urgent Care Centers, and Acute Care Facilities, etc. • 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 100% compliance criteria. This case was recredentialed at forty (40) months; however, IMG will require corrective action. Overall, HNCS was found to be compliant with 85 out of 86 standards evaluated (98.8% compliance rate). The Initial Credentialing and Re-Credentialing file reviews of practitioners were excellent at	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	99% and 99% respectively, and the Organizational Providers demonstrated 100% compliance.	
#8 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q2 2025) (Attachment EE) Action Patrick Marabella, M.D., Chair	The Credentialing Sub-Committee Quarterly Report Q2 2025 was presented. The Credentialing Sub-Committee met on May 15, 2025, to review routine credentialing and re-credentialing reports for both Q4 2024 delegated and Q1 2025 non-delegated entities (Health Net (HN) and HN Behavioral Health (BH)). • The Credentialing Adverse Actions report for Q1 2025 for CVH from the HN Credentialing Committee was presented with no (0) cases presented for discussion for Q1 2025 for CVH. • The Adverse Events Q1 2025 report was presented. ○ Credentialing submitted zero (0) cases to the Credentialing Committee in Q1 2025. ○ There were no (0) reconsiderations or fair hearings during Q1 2025. ○ There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 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 Q1 2025. • The Access & Availability Substantial Harm Report Q1 2025 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. ○ After a thorough review of all Q1 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). • The NCQA System Controls CR Oversight Report 2025 was presented and reviewed to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policies describe: ○ How primary source verification information is received, dated, and stored. ○ How modified information is tracked and dated from its initial verification. ○ Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. ○ Security controls that are in place to protect the information from unauthorized modification.	Motion: Approve - Credentialing Subcommittee Report (Q2 2025) (Pascual/ Faulkenberry) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ How the organization monitors its compliance with the policies and procedures at least annually and takes appropriate action when applicable. • Quarterly audits were performed of all CVH credentialing files processed with two (2) modifications to CVH provider records identified in 2024. These two (2) cases were audited against the information management criteria included in the policy and were found to be fully (100%) compliant. Modifications were made by individuals authorized to do so; when and why the modification was made was documented and consistent with policy; what was modified and who made the modification were also documented. Quarterly monitoring will continue with annual auditing and reporting. Appropriate actions will be taken when indicated. • The Credentialing Sub-Committee Charter for 2025 was reviewed and approved by the committee. There were no changes to the Charter this year.	
#8 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q2 2025 (Attachment FF) Action Patrick Marabella, M.D., Chair	The Peer Review Sub-Committee Quarterly Report Q2 2025 was presented. The Peer Review Sub-Committee met on May 15, 2025, to review Q1 2025 data provided in the following reports: • The county-specific Peer Review Sub-Committee Summary Reports for Q1 2025 were reviewed for approval. No (0) significant cases to report. • The Q1 2025 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. ○ There were nine (9) cases identified in Q1 that met the criteria for reporting and were submitted to the Peer Review Committee. Three (3) of these cases involved a practitioner, and six (6) cases involved organizational providers (facilities). ○ Of the nine (9) cases, three (3) were tabled, zero (0) were deferred, one (1) was tabled with a letter of concern, one (1) was closed to track and trend with a letter of concern, zero (0) were closed to track and trend with a letter of education, and four (4) were closed to track and trend. ○ Seven (7) cases were quality of care grievances, two (2) were potential quality issues, zero (0) were lower level, and zero (0) were track and trend. ○ Zero (0) cases involved Seniors and Persons with Disabilities (SPDs), and none (0) involved Behavioral Health. ○ There were no (0) incidents involving appointment availability resulting in substantial harm	Motion: Approve - Peer Review Subcommittee Report Q2 2025 (Faulkenberry/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	to a member or members in Q1 2025. ○ Reviews completed in December, January, and February did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. ○ 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. (NCQA CR.5.A.4) ○ There were thirteen (13) 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. • The Access & Availability Substantial Harm Report for Q1 2025 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. ○ Seventeen* (17) new cases were submitted to the Peer Review Committee in Q1 2025. There were three (3) incidents found involving appointment availability issues without significant harm to a member. Three (3) cases were determined to be related to significant harm to a member, but without appointment availability issues. No cases (0) were related to behavioral health issues. *One (1) case appeared twice (2) in the quarter. • The Q1 2025 Peer Count Report was presented with a total of seventeen (17) cases reviewed with the committee. Ten (10) cases were closed and cleared. Five (5) cases were tabled for further information. No (0) cases were closed/terminated. One (1) case had a CAP outstanding/continued monitoring, and one (1) was pending closure for CAP compliance. • The Peer Review Sub-Committee Charter for 2025 was reviewed and approved by the Committee. There were no changes to the Charter this year.	
#9 Access Business - Access Workgroup Quarterly Report (Q2 2025) (Attachment GG) Action	The Access Work Group Quarterly Report Q2 2025 was presented and reviewed to provide the QI/UM Committee with an update on the CVH Access Workgroup activities since the last report to the QI/UM Committee. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. Key Report Highlights of the 5/27/25 meeting include: • Q1 2025 Network Adequacy Report: ○ PCP: DMHC PCP standard met for Kings County and Madera County now meets at 100%.	Motion: Approve - Access Workgroup Quarterly Report (Q2 2025) (Cardona/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D., Chair	Fresno County increased from 99.2% to 99.6%. For Fresno County zip codes that do not meet, Alternative Access Standards were requested. ○ Specialties by Combined Counties: All specialties in all counties met internal standards of 90% or higher. • Specialties by County: All specialties in Fresno and Madera Counties met internal standards. For Q1 Anesthesiology, Geneticists, HIV/AIDS, Maternal/Fetal Medicine, and Neurological Surgery specialties now meet in Kings County. • MY2024 Access & After-Hours CAP & Evaluation: It was reported that the identification of non-compliant providers and the corrective action plan (CAP) are expected to be completed by the end of June. • Q1 2025 Behavioral Health Services Triage and Screening Report: After three previous quarters of not meeting the Average Speed to Answer within 30 minutes, 100% of the calls in Q1 2025 were handled within 30 minutes. • Q1 2025 Appeals & Grievances: Access to Care, Prior Authorization Delay remains the top Grievance. • Q1 2025 Transportation Oversight Report: The report showed utilization decreased slightly to 10.3% in Q1 from 10.6% in Q4, with dialysis as the top treatment. The ModivCare CAP for the PCS process was closed due to delegation changes, but the telephone authorization CAP remains open with ongoing validation. Open CAPs from 2024 include denial reasons and exempt grievance resolutions. ModivCare completed remediation, with validation scheduled for April. • Telehealth Activity Report: In addition to the number of e-consults that were reported (232 General Medical/49 BH), the report also provides the number and type of Teladoc visits.	
#10 Compliance Update -Compliance Regulatory Report (Attachment HH)	Maria Sanchez presented the Compliance Report. CalViva Health Oversight Activities: Health Net: CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings, and discuss any issues or questions during the monthly oversight meetings with HN. CVH and HN also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access and availability, specialty referrals, utilization management data, grievances, and appeals etc. Oversight Audits: The following annual audits are in progress: Health Education, Marketing, Call	-Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Center, Claims/PDR, A&G, Health Equity, Member Rights, Privacy and Security, and Provider Network. The following annual audits have been completed since the last Commission report: Behavioral Health (CAP), Credentialing (CAP), Quality Improvement (No CAP) Fraud, Waste, and Abuse: Since the 5/8/2025 Compliance Regulatory Report to the Committee, there were three (3) new MC609 filings: One (1) case was a non-participating laboratory with allegations of false representation and billing for services not rendered; One (1) case was a provider who was billing rare CPT codes and didn't seem to be using the treatment appropriately and members' conditions were not improving; One (1) case was a pain medicine specialist that frequently sends requests for trigger point injections with lack of documentation to prove medical necessity. Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation: The Plan is on track to complete its stated corrective actions and will provide its next and final monthly update by 7/21/25. Department of Health Care Services ("DHCS") 2024 Medical Audit: Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit: The Plan responded to all outstanding inquiries, and on May 14, 2025, the Department of Health Care Services (DHCS) formally closed the Corrective Action Plan (CAP). Department of Health Care Services ("DHCS") 2025 Medical Audit: The 2025 DHCS 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. Memorandum of Understanding (MOU): Annual Network Certifications: Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOUs, which have also been posted to CVH's website: • Amendment to DMC State Plan MOU Kings County (RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR): On April 18, 2025, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access to PCPs and Hospitals, and Provider Data Accuracy. The Plan is preparing a formal response, which will be submitted by the July 17, 2025, deadline. (RY)2025 (MY)2024 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. New DHCS Regulations/Guidance: Please refer to Appendix A for a complete list of DHCS and	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	DMHC All Plan Letters (APLs) that have been issued in CY 2025. Public Policy Committee (PPC): The Public Policy Committee met on June 4, 2025, with the following reports presented: • 2024 Health Education EOY Summary Work Plan Evaluation • 2025 Health Education Work Plan • 2024 Health Equity EOY Summary and Work Plan Evaluation • 2024 Language Assistance Program EOY Work Plan Evaluation • 2025 Health Equity Program Description • 2025 Health Equity Work Plan The next PPC meeting will be held on September 3, 2025, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.	
#11 Old Business		
#12 Announcements	The next meeting is scheduled for September 18, 2025.	
#13 Public Comment	None.	
#14 Adjourn	The meeting adjourned at 11:47 a.m.	

NEXT MEETING: September 18th, 2025

Submitted this Day: September 18th, 2025

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

Acknowledgment of Committee Approval:

x Patrick Marabella
 Patrick Marabella, MD, Committee Chair

Fresno-Kings-Madera Regional Health Authority 2025 Commission Meeting Schedule

Meeting Location:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Date	Time	County	Meeting Location
January			No Meeting
February 19, 2026	1:30 to 3:30	Fresno	CalViva Health
March 19, 2026	1:30 to 3:30	Fresno	CalViva Health
April			No Meeting
May 21, 2026	1:30 to 3:30	Fresno	CalViva Health
June			No Meeting
July 16, 2026	1:30 to 3:30	Fresno	CalViva Health
August			No Meeting
September 17, 2026	1:30 to 3:30	Fresno	CalViva Health
October 15, 2026	1:30 to 3:30	Fresno	CalViva Health
November 19, 2026	1:30 to 3:30	Fresno	CalViva Health
December			No Meeting

Fresno-Kings-Madera Regional Health Authority
Finance Committee
 2026 Meeting Schedule

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

Date	Time	County	Meeting Location
<i>January</i>			No Meeting
February 19, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
March 19, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
April 16, 2026	11:30 am to 12:00 pm TENTATIVE	Fresno	CalViva Health
May 21, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
<i>June</i>			No Meeting
July 16, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
August			No Meeting
September 17, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
October 15, 2026	11:30 am to 12:00 pm * *Auditors presentation	Fresno	CalViva Health
November 19, 2026	11:30 am to 12:00 pm	Fresno	CalViva Health
December			No Meeting

Fresno-Kings-Madera Regional Health Authority
Quality Improvement/Utilization Management
2026 Meeting Schedule

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

Date	Time	County	Meeting Location
January			No Meeting
February 19, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
March 19, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
April			No Meeting
May 21, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
June			No Meeting
July 16, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
August			No Meeting
September 17, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
October 15, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
November 19, 2026	10:30 am – 12:00 pm	Fresno	CalViva Health
December			No Meeting

Fresno-Kings-Madera Regional Health Authority
Credentialing Sub-Committee
 2026 Meeting Schedule

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

Date	Time	County	Meeting Location
January			No Meeting
February 19, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 1st Quarter
March			No Meeting
April			No Meeting
May 21, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 2nd Quarter
June			No Meeting
July 16, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 3rd Quarter
August			No Meeting
September			No Meeting
October 15, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 4th Quarter
November			No Meeting
December			No Meeting

Fresno-Kings-Madera Regional Health Authority
Peer Review Sub-Committee
2026 Meeting Schedule

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

Date	Time	County	Meeting Location
January			No Meeting
February 19, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 1st Quarter
March			No Meeting
April			No Meeting
May 21, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 2nd Quarter
June			No Meeting
July 16, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 3rd Quarter
August			No Meeting
September			No Meeting
October 15, 2026	12:00 pm – 12:30 pm	Fresno	CalViva Health 4th Quarter
November			No Meeting
December			No Meeting

CalViva Health
Public Policy Committee
2026 Meeting Schedule

Date	Time	Meeting Location
January		No Meeting
February		No Meeting
March 4, 2026	11:30am – 1:30pm	Fresno County
April		No Meeting
May		No Meeting
June 3, 2026	11:30am – 1:30pm	Fresno County
July		No Meeting
August		No Meeting
September 2, 2026	11:30am – 1:30pm	Fresno County
October		No Meeting
November		No Meeting
December 2, 2026	11:30am – 1:30pm	Fresno County

Meeting Location:

Fresno County:

CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711



Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of DHCS Filings													
Administrative/ Operational	35	23	25	26	21	15	18	15	15	5			198
Member Materials Filed for Approval;	5	2	5	1	5	8	7	3	9	0			45
Provider Materials Reviewed & Distributed	11	13	12	12	8	14	16	17	16	3			122
# of DMHC Filings	6	9	12	8	13	4	9	7	11	1			80

DHCS Administrative/Operational filings include ad-hoc reports, policies & procedures, Commission changes, Plan and Program documents, etc.

DHCS Member & Provider materials include advertising, health education materials, flyers, letter templates, promotional items, etc.

DMHC Filings include ad-hoc reports, Plan and Program documents, policies & procedures, advertising, bylaw changes, Commission changes, undertakings, etc.

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	5	4	2	4	4	5	3	2	3	0			32
High-Risk	0	1	0	0	0	0	2	2	0	0			5

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of New MC609 Cases Submitted to DHCS	1	0	1	1	1	3	1	2	1	0			11
# of Cases Open for Investigation (Active Number)	29	28	28	28	30	31	30	27	28	28			

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 9/18/2025 Compliance Regulatory Report to the Commission, there were no new MC609 filings.

Report Date 10/16/2025



Compliance Oversight & Monitoring Activities:	Status
CalViva Health Oversight Activities	Health Net CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc.
Oversight Audits	The following annual audits are in progress: Access & Availability, Marketing, Call Center, Claims/PDR, Internal Compliance FWA, UCM, Privacy and Security, Transportation and Provider Network. The following annual audits have been completed since the last Commission report: A&G (No CAP), Health Education (CAP issued to Health Net), Member Rights (No CAP) 
Regulatory Reviews/Audits and CAPS:	Status
Department of Health Care Services ("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 continues to await DHCS' acceptance and CAP closure.
Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit	The DMHC conducted the Follow-Up Audit on May 5, 2025. The Plan continues to await 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.
Department of Health Care Services ("DHCS") 2025 Medical Audit	The 2025 DHCS Audit was conducted virtually from 6/2/2025-6/13/2025. The Plan submitted all required pre-audit documentation and follow-up requests. The Plan is in the process of scheduling the Exit Interview for October.
2025 Network Adequacy Validation (NAV) Audit	The virtual audit was conducted on 8/21/25 by DHCS' external review organization (HSAG). The Plan submitted follow-up requests on August 26, 2026, and is awaiting a Final Report. 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 upon for network reporting.
New Regulations / Contractual Requirements/DHCS Initiatives:	Status



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. Following its review, DHCS requested clarification on a number of items. The Plan submitted a response on 10/7/2025 and is awaiting final review and approval from DHCS.
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has not executed any MOUs.
Annual Network Certifications	➤ <u>2024 Subnetwork Certification (SNC) Landscape Analysis</u> – 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 9/25/2025. ➤ <u>2024 Annual Network Certification (ANC)</u> - On 7/22/25, DHCS sent a Preliminary Determination with four AAS denials. The Plan responded to that letter on 7/24/25 and we are awaiting a response. ➤ <u>2025 Subnetwork Certification (SNC) Landscape Analysis</u>- On 9/26/2025, DHCS sent guidance for the 2025 SNC Landscape Analysis deliverable. The Plan is preparing a response which will be submitted by the 10/31/2025 deadline.
(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR)	➤ On 4/18/25, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access standards (i.e., time and distance) for PCPs and Hospitals, and for Provider Data Accuracy. The Plan submitted a formal response on 7/17/25 which indicated a separate Material Modification would be submitted to the DMHC to request new time and distance standards for specific zip codes. ➤ 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.
(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR)	➤ On 5/1/2025 the Plan submitted the Annual 2025 TAR filing to DMHC. The Plan is awaiting a response.



Plan Administration:	Status
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 2025.
Committee Report:	Status
Public Policy Committee (PPC)	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.



APPENDIX A

2025 DHCS All Plan Letters:

- 📁 APL 25-002 SNF WQIP
- 📁 APL 25-004 Community Reinvestment Requirements
- 📁 APL 25-005 Threshold Languages
- 📁 APL 25-006 Timely Access Requirements
- 📁 APL 25-007 Enforcement Actions
- 📁 APL 25-008 Hospice Services
- 📁 APL 25-009 CACs
- 📁 APL 25-010 Adult & Youth Screening & Transition of Care Tools
- 📁 APL 25-011 HOUSE RESOLUTION (H.R.) 1 – FEDERAL PAYMENTS TO PROHIBITED ENTITIES
- 📁 APL 25-012 Targeted Provider Rate Increases
- 📁 APL 25-013 Medi-Cal RX Pharmacy Benefits, and Cell and Gene Therapy Coverage
- 📁 APL 25-014 Update to the Provider Directory Requirements
- 📁 APL 25-015 Data Sharing and Quality Rate Production

2025 DMHC All Plan Letters:

-  APL 25-008 - Annual Provider Directory Filing
-  APL 25-013 – Amendments to Rules 1300.51, 1300.52, 1300.52.4,
-  APL 25-014 - (OPM) Provider Appointment Availability Survey Manual
-  APL 25-001 - Southern California Fires and Enrollees' Continued Access to Health Care Services (1.9.2025).pdf
-  APL 25-007 - Assembly Bill 3275 Guidance (Claim Reimbursement) (4.1.2025).pdf
-  APL 25-009 – 2025 Health Plan Annual Assessments (4.15.2025).pdf
-  APL 25-011 - Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP).pdf
-  APL 25-012 - Closure of Rite Aid Pharmacies (6.9.2025).pdf
-  APL 25-015- AssemblyBill144andCoverageofPreventiveCareServices(9_18_2025).pdf

Item #5

CVH Community Support and DHCS Community
Reinvestment Program (Grants Budget)

5.A BL 25-013

5.A.1 Revised Grant Recommendations

5.A.2 Ad-Hoc Committee Meeting Minutes

FRESNO - KINGS -
MADERA
REGIONAL
HEALTH
AUTHORITY

Commission

Fresno County

Garry Bredefeld
Board of Supervisors

Joe Prado, Interim Director
Public Health Department

David Cardona, M.D.
At-large

David S. Hodge, M.D.
At-large

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D. - At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

Aftab Naz, M.D.- At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

Jeffrey Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

Phone: 559-540-7840
Fax: 559-446-1990
www.calvivahealth.org

DATE: October 16, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: CalViva Health Community Support and DHCS Community Reinvestment Program (Grants Budget)

BL #: **25-013**

Agenda Item **5**

Attachment **5.A**

In May 2017, the Fresno-Kings-Madera Regional Health Authority established a process to review and consider funding for programs/initiatives in excess of twenty thousand dollars (\$20,000) or more per fiscal year.

Guidelines and review process were established and approved during this time. As a reminder, the Commission has approved Community Support funds over the past seven years to support our community programs.

In February 2025, the Commission were presented with new guidelines and a review process. These new guidelines were approved during this time. The new guidelines and review process includes the original Community Support programs/initiatives, the addition of the new DHCS Community Reinvestment Requirements per DHCS contractual requirement and DHCS All Plan Letter 25-004.

The new guidelines and review process also included an increase in the threshold for the Commission to review and consider funding from the in excess of twenty thousand dollars (\$20,000) or more per fiscal year amount to in excess of twenty-five thousand (\$25,000) or more per fiscal year.

The current Community Support and Community Reinvestment funding recommendations are intended for Contingency, Education Scholarships and Community Workforce Support. The remaining funds are allocated for State/Federal Local Community Support Response.

The Ad-hoc committee reviewed the Community Support and Community Reinvestment funding recommendations (attachment **10.B and 10.C**) on October 7, 2025 and voted to bring them to the full commission.

Grants Budget

Community Support & Community Reinvestment Grant Recommendations 2025-2026

	Fresno County	Madera County	Kings County	2025-2026 Proposed Funding
Provider Network Support				
Funding for PCPs/Specialists/Extenders/Behavioral Health	x	x	x	\$600,000
Tzu Chi-See 2 Succeed Vision Program (Mobile Clinic)	x			\$100,000
Member Support				
Enrollment Support	x	x	x	\$65,000
Education Scholarships & Community Workforce Support				
California State University Fresno	x	x	x	\$100,000
Community Colleges	x	x	x	\$100,000
Community Regional Medical Centers Nursing Scholarships	x	x	x	\$150,000
Image Church Certified Nursing Assistant Program	x			\$25,000
Fresno Pacific University (Nursing Program - Simulation Training Lab)	x	x	x	\$250,000
Community Infrastructure Support				
Food Bank Funding	x	x	x	\$100,000
Outdoor Play and Green Space	x	x	x	\$100,000
Community Based Organizations				
Big Brother Big Sisters Fresno and Madera Counties, CASA Fresno and Madera Counties, Every Neighborhood Partnership, Exceptional Parents Unlimited, Fresno Cradle 2 Career, Generation Changers, Habitat for Humanity Acts of Kindness, Kings County Action Organization, Marjaree Mason Center, Poverello House, Reading Heart	x	x	x	\$930,000
DHCS Community Reinvestment				
Cultivating Neighborhoods and Built Environment	x	x	x	
Cultivating a Health Care Workforce	x	x	x	

Cultivating Well-Being for Priority Populations	X	X	X	
Cultivating Local Communities	X	X	X	
Cultivating Improved Health	X	X	X	
DHCS Community Reinvestment Categories Combined				\$0
Other				
Recreation Sports	X	X	X	\$100,000
State/Federal Local Community Support Response	X	X	X	\$1,008,000
Contingency				\$750,000
				\$4,378,000



Ad-Hoc Committee Meeting Minutes October 7, 2025

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

Ad-Hoc Committee Members	
✓	David Hodge, M.D., Chair, Fresno County At-large Appointee
✓	Aftab Naz, M.D., Madera County At-large Appointee
	Paulo Soares, Madera County At-large Appointee
✓	Jeff Nkansah, Chief Executive Officer (CEO)
✓	Daniel Maychen, Chief Finance Officer (CFO)
✓	Courtney Shapiro, Director, Community Relations and Marketing
✓	Sia Xiong-Lopez, Equity Officer

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Jeff Nkansah	The meeting was called to order at 1:30 pm. A quorum was present.	
#2 Community Support/DHCS Community Reinvestment Grant Recommendations	Jeff Nkansah and Courtney Shapiro presented a funding matrix with potential grantees listed on it. They provided background on how staff evaluate current funded partners and determine the services our members need most. They also determined that these funded partners have completed the DHCS Community Reinvestment template for funding. Jeff Nkansah also reviewed the new funding line item in response to the cuts at the State /Federal level. These emergency response funds, totaling \$1,008,000, will be allocated for community support response. The contingency line item has \$750,000, and future funding from this line item will be brought back to the ad-hoc committee for review.	Motion: Approve Recommendations and bring to full Commission for approval 2-0-0-0 (Naz / Hodge)

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	After reviewing all other organizations and categories for recommended funding, the committee made a motion and second to move this to the full Commission in October.	

Item #6

Attachment 6.A

Financial Audit Report
Fiscal Year 2025



The Fresno-Kings-Madera Regional Health Authority dba CalViva Health

2025 Audit Results

Discussion with Management and
the Audit Committee

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Audit Objectives

1. Opinion on whether the financial statements of CalViva are reasonably stated and free of material misstatement in accordance with generally accepted accounting principles
2. Consideration of internal controls
3. Audit is required under the State of California Department of Managed Health Care

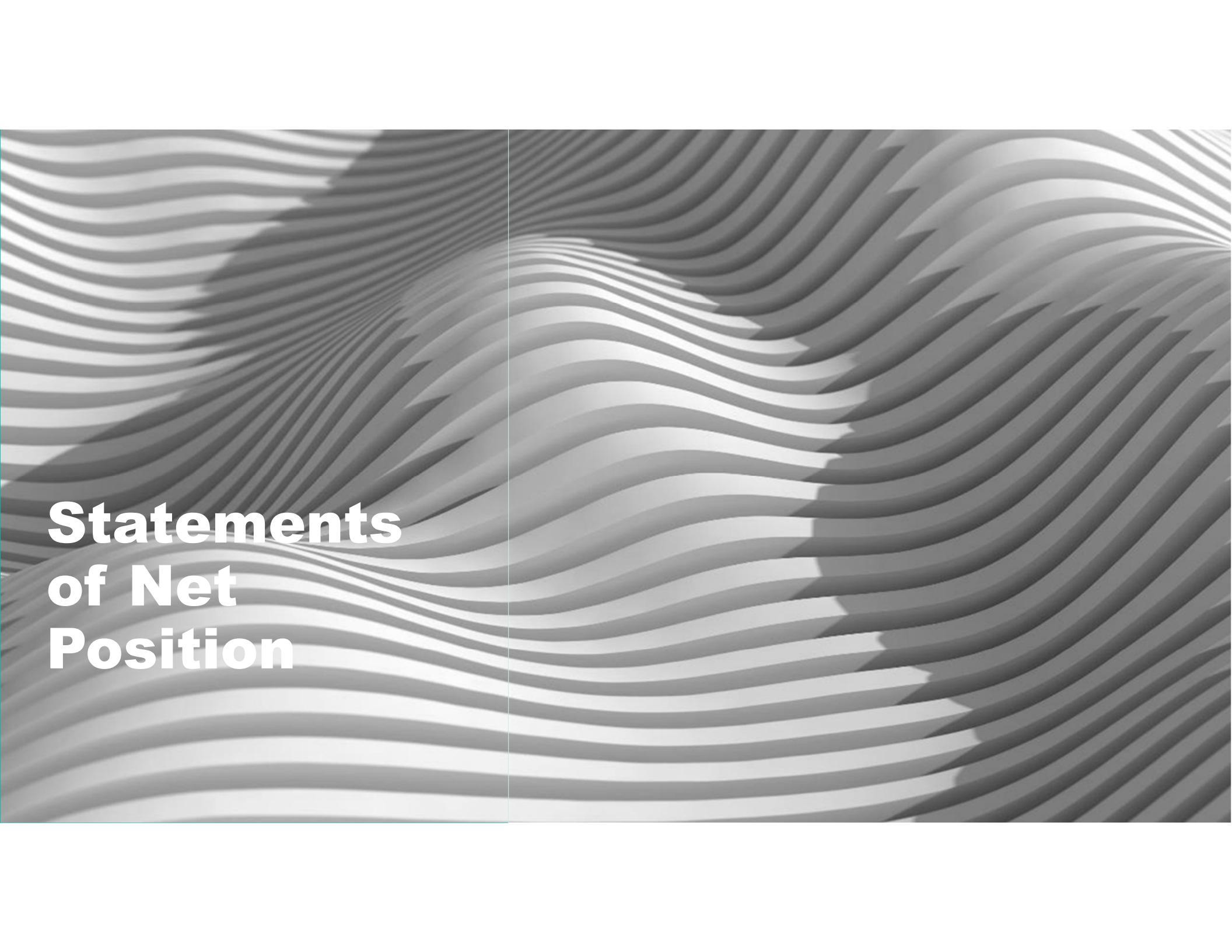


Report of Independent Auditors

Unmodified Opinion

- Financial statements are fairly presented in accordance with generally accepted accounting principles.

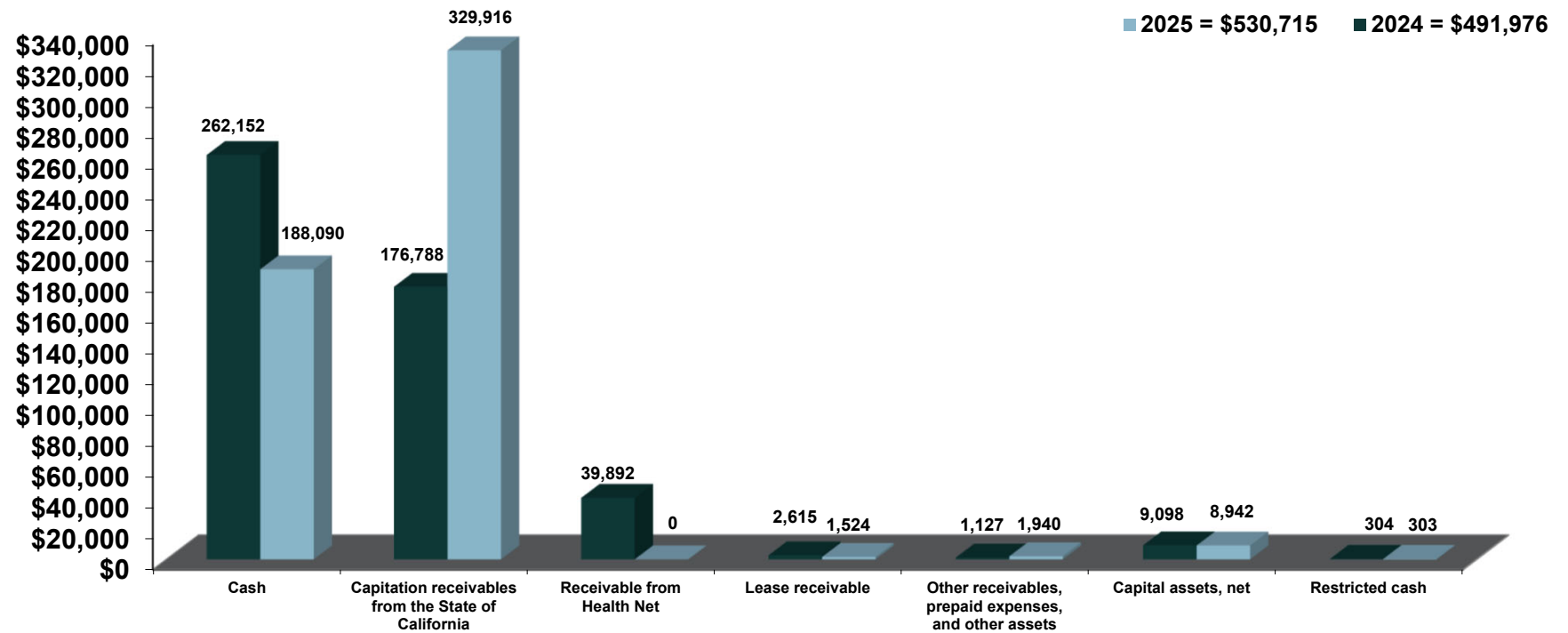




Statements of Net Position

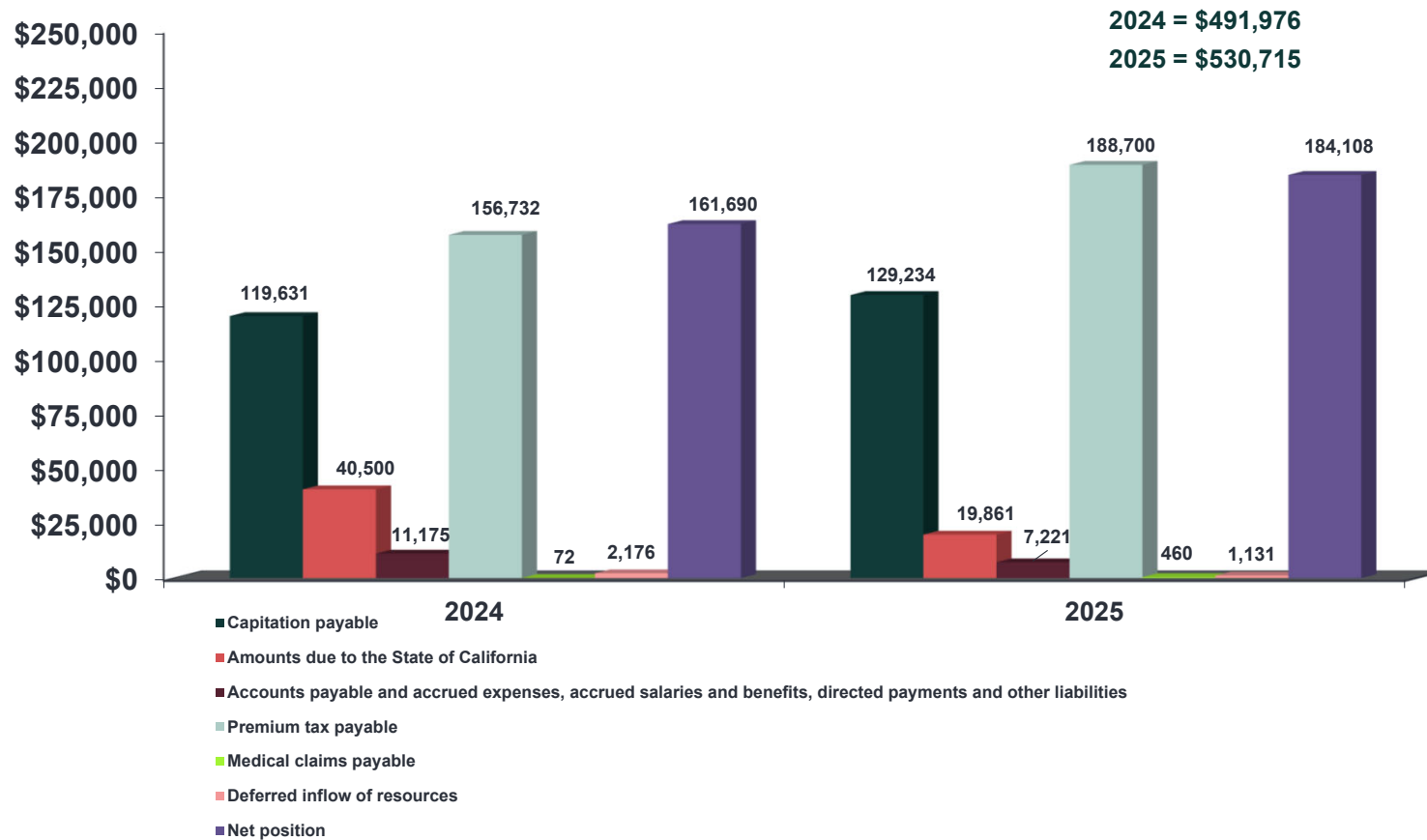
(IN THOUSANDS)

Asset Composition



(IN THOUSANDS)

Liabilities and Net Position Balance



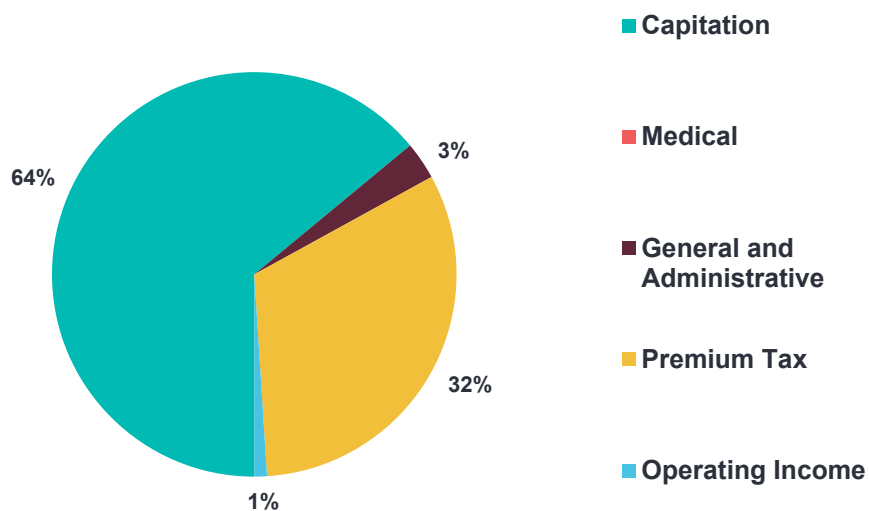


Operations

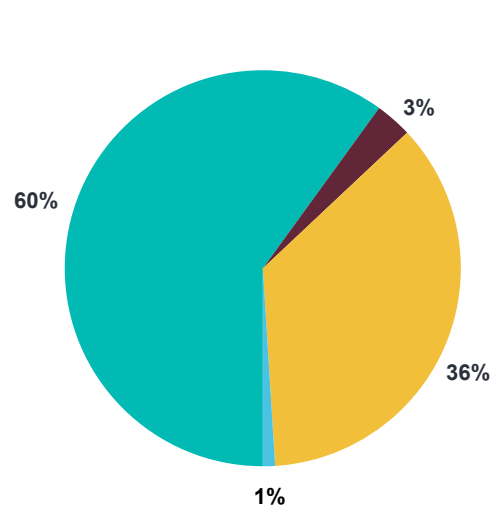
(IN THOUSANDS)

Total Operating Expenses as a % of Total Operating Revenues

June 30, 2024
\$2,048,061
(2024 Revenue)



June 30, 2025
\$2,333,594
(2025 Revenue)



(IN THOUSANDS)

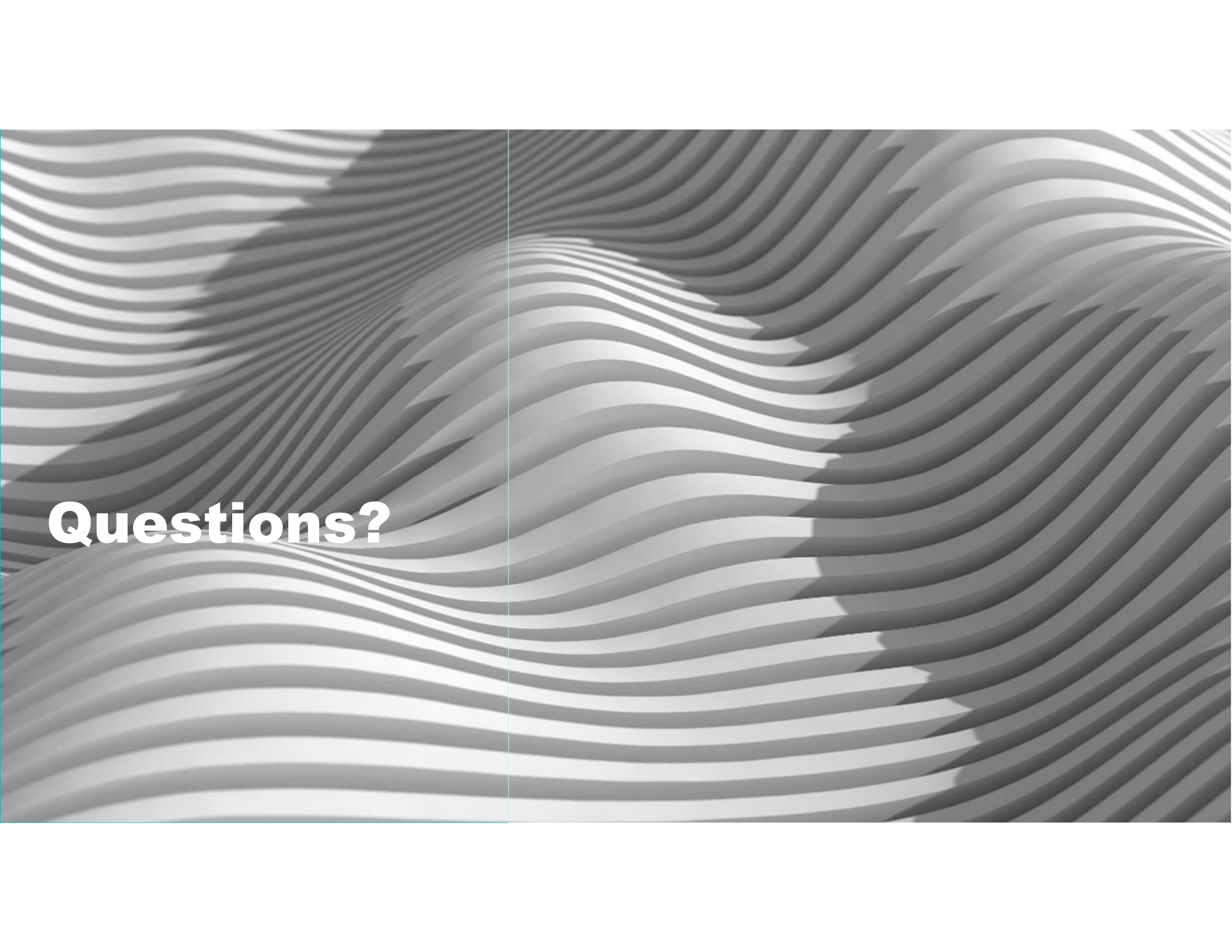
Tangible Net Equity



Important Board Communications

- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of material fraud or noncompliance with laws and regulations





Questions?

**THANK
YOU**

Communications with the Commissioners

**The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health**

June 30, 2025

Communications with the Commissioners

The Commissioners
The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

We have audited the financial statements of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva) as of and for the year ended June 30, 2025, and have issued our report thereon dated October __, 2025. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated April 17, 2025, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. As part of an audit conducted in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control over financial reporting. Accordingly, we considered The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you, as stated in our engagement letter dated April 17, 2025.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by The Fresno-Kings-Madera Regional Health Authority dba CalViva Health are described in Note 2 to the financial statements. During fiscal year 2025, The Fresno-Kings-Madera Regional Health Authority dba CalViva Health adopted Governmental Accounting Standards Board Statement No. 101, *Compensated Absences* and Statement No. 102, *Certain Risk Disclosures*. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2025. We noted no transactions entered into by CalViva during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transactions occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management recorded estimated capitation receivables from the State of California. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.
- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosure affecting the financial statements was related to capitation revenue and is disclosed in Note 2 to the financial statements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of CalViva's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of CalViva's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements the effects of which, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October __, 2025.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to CalViva's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health and management of the Commissioners of the Fresno-Kings-Madera Regional Health Authority dba CalViva Health, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October __, 2025

Report of Independent Auditors and
Financial Statements

**The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health**

June 30, 2025 and 2024

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Management's Discussion and Analysis

**The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023**

The Management's Discussion and Analysis of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is intended to provide readers and interested parties with an overview of the Plan's financial activities for the fiscal years ended June 30, 2025, 2024, and 2023. It should be reviewed in conjunction with the Plan's financial statements and accompanying notes to enhance the reader's understanding of the Plan's financial performance.

Overview of CalViva's Financial Statements

The Fresno-Kings-Madera Regional Health Authority, dba CalViva Health (CalViva or the Plan) is a local governmental health insuring organization that operates in the Counties of Fresno, Kings, and Madera (Tri-Counties). The Boards of Supervisors for the Tri-Counties established the Fresno-Kings-Madera Regional Health Authority (the Authority) in March 2009, in accordance with the State of California Welfare and Institutions Code (the Code) Section 14087.38. Through the provisions of the "Joint Exercise of Powers Agreement between the Counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs" agreement, dated March 2009, and pursuant to the Code, CalViva became financially independent of Fresno, Kings, and Madera Counties. In addition, the Code provides that CalViva is a public entity, separate and apart from the Counties of Fresno, Kings, and Madera. CalViva received its Knox-Keene license from the California Department of Managed Health Care (DMHC) on December 30, 2010, and commenced operations on March 1, 2011.

The mission and purpose of CalViva is to improve access to care and provide quality health care to families in the Fresno, Kings, and Madera County areas at the right place and the right time.

CalViva has contracted with the California Department of Health Care Services (DHCS) to receive funding to provide health care services to the Medi-Cal eligible Tri-County area residents who are enrolled as members of CalViva under the two-plan model. The DHCS contract is effective March 1, 2011, through December 31, 2026. The DHCS contract specifies capitation rates based on a per-member, per-month basis, which may be adjusted annually. DHCS revenue is paid monthly and is based upon the contracted capitation rates and actual Medi-Cal enrollment. In addition, DHCS pays CalViva supplemental capitation rates such as a fixed maternity case rate for each eligible birth incurred by a CalViva Medi-Cal member. CalViva, in turn, provides services to Medi-Cal beneficiaries through a contract with Health Net Community Solutions, Inc. (Health Net), a wholly owned subsidiary of Centene Corporation. Further, CalViva has an administrative service agreement with Health Net in which Health Net performs specific administrative functions for CalViva.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023

On September 2, 2009, the California State Legislature ratified Assembly Bill (AB) No. 1422 (AB 1422), which levies a 2.35% gross premium tax (GPT) on all Medi-Cal capitated revenue received. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. This provision was effective retroactively to January 1, 2009. The GPT program was concluded on June 30, 2012. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSPP), as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSPP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. A modification to the Managed Care Organization (MCO) tax, authorized by Assembly Bill (AB) 160 (Chapter 39, Statutes of 2024) with an effective period of January 1, 2024, through December 31, 2026, was approved by the Centers for Medicare and Medicaid Services (CMS) on December 20, 2024. This modification establishes tax amounts in addition to the MCO tax originally authorized by AB 119 (Chapter 13, Statutes of 2023) approved by CMS on December 15, 2023. Under the Tax Uniformity Requirements enacted July 4, 2025, health care related taxes, including MCO taxes, must apply a uniform 1:1 rate and cannot tax Medicaid business at a higher rate than non-Medicaid business. As a result, the current MCO tax ceases as of the enactment date, however, there is a discretionary allowance of up to a three-year transition period which the State of California is applying for with the federal government.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023

On September 8, 2010, the California State Legislature ratified AB No. 1653 (AB 1653), which established a Quality Assurance Fee (QAF) program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions (W&I) Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding:

Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services," and Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass-through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the QAF program through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. In October of 2013, California approved SB 239, which extended the QAF program for an additional 36 months from January 1, 2014, through December 31, 2016. In November of 2016, the voters of California passed Proposition 52, which permanently extended the QAF program.

Beginning with the July 1, 2017, rating period, DHCS implemented the following managed care Directed Payment programs: (1) Private Hospital Directed Payment (PHDP), (2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP), and (3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, this program provides supplemental reimbursement to participating Network Provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The PHDP program was created to maintain access and improve the quality of care for Medi-Cal beneficiaries. (2) For EPP-FFS and EPP-CAP, this program provides supplemental reimbursement to Network Provider designated public hospitals through either a uniform dollar or percentage increase based on actual utilization of network contracted qualifying services. (3) For QIP, DHCS has directed the Medi-Cal managed care health plans (MCPs) to make QIP payments to designated public hospitals and University of California hospitals which are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments will be linked to delivery of services and increase the amount of funding tied to quality outcomes.

Beginning with the calendar year 2023 rating period, DHCS implemented the District and Municipal Public Hospital Directed Payment (DHDP) program which directed MCPs to reimburse California's District and Municipal Public Hospitals for network contracted services, based on actual utilization of contracted services. The goal of this program is to improve preventative care for children, maternity care, and birth equity through increasing access to care. The payments will be enhanced by either a uniform percentage or dollar increment.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023

Beginning with January 1, 2023, date of service, DHCS implemented the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) to provide performance-based directed payments to eligible network provider SNFs to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP is authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB)186 (Chapter 46, Statutes of 2022)) for dates of service from January 1, 2023, through December 31, 2026. DHCS has directed Medi-Cal managed care plans to make SNF WQIP payments to eligible SNFs according to utilization and performance on designated WQIP metrics. Based on the State of California's Enacted Budget for State fiscal year 2025-2026, the SNF WQIP will end on December 31, 2025.

CalAIM Implementation – Beginning January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. This requires managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. Components that began on January 1, 2022, include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. In addition, institutional Long-Term Care (LTC) benefit including skilled nursing facilities transitioned to Medi-Cal managed care plans effective January 1, 2023. Effective January 1, 2024, all Medi-Cal managed care plans became responsible for the full LTC benefit at facility types such as Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, Pediatric Subacute Care Facility and Subacute Care Facility.

Using this annual report – CalViva's financial statements consist of three statements: Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows.

Fiscal Year 2025 Compared to Fiscal Years 2024 and 2023

On June 30, 2025, CalViva had assets of \$530.7 million, liabilities of \$345.5 million and deferred inflow of resources of \$1.1 million. On June 30, 2024, CalViva had assets of \$492.0 million, liabilities of \$328.1 million and deferred inflow of resources of \$2.2 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by \$22.4 million to \$184.1 million from \$161.7 million at June 30, 2024.

On June 30, 2024, CalViva had assets of \$492.0 million, liabilities of \$328.1 million and deferred inflow of resources of \$2.2 million. On June 30, 2023, CalViva had assets of \$314.1 million, liabilities of \$170.0 million and deferred inflow of resources of \$2.8 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by \$20.4 million to \$161.7 million from \$141.3 million at June 30, 2023.

On June 30, 2023, CalViva had assets of \$314.1 million, liabilities of \$170.0 million and deferred inflow of resources of \$2.8 million. On June 30, 2022, CalViva had assets of \$292.5 million, liabilities of \$160.6 million and deferred inflow of resources of \$3.9 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by \$13.3 million to \$141.3 million from \$128.0 million at June 30, 2022.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023

Assets

Cash and cash equivalents – Cash and cash equivalents decreased \$74.1 million from \$262.2 million at June 30, 2024, to \$188.1 million at June 30, 2025. The decrease is primarily due to net cash used in operating activities.

Cash and cash equivalents increased \$116.0 million from \$146.2 million at June 30, 2023, to \$262.2 million at June 30, 2024. The increase is primarily due to net cash provided by operating activities.

Cash and cash equivalents decreased \$15.0 million from \$161.2 million at June 30, 2022, to \$146.2 million at June 30, 2023. The decrease is primarily due to net cash used in operating activities.

Capitation receivables from the State of California – Capitation receivables from the State of California increased \$153.1 million from \$176.8 million at June 30, 2024, to \$329.9 million at June 30, 2025. The increase is primarily due to the increase in capitation rates and MCO tax revenue from DHCS, in addition to the timing of receipts of MCO tax payments from DHCS.

Capitation receivables from the State of California increased \$53.7 million from \$123.1 million at June 30, 2023, to \$176.8 million at June 30, 2024. The increase is primarily due to the increase in capitation rates, and accrued MCO tax revenue from DHCS, as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

Capitation receivables from the State of California increased \$7.1 million from \$116.0 million at June 30, 2022, to \$123.1 million at June 30, 2023. The increase is primarily due to an increase in membership and capitation rates paid by DHCS, offset by the decrease in accrued MCO tax revenue from DHCS due to its expiration on December 31, 2022.

Receivable from Health Net – Receivable from Health Net decreased \$39.9 million from \$39.9 million at June 30, 2024, to \$0 at June 30, 2025. The decrease is attributable to full collection of the receivable balance from Health Net during the fiscal year ended June 30, 2025.

Receivable from Health Net increased \$9.8 million from \$30.1 million at June 30, 2023, to \$39.9 million at June 30, 2024. The increase is attributable to the accrual of \$39.9 million capitation overpayments made to Health Net during the current fiscal year as a result of DHCS' retroactive capitation rate reduction covering the time period of January 2023 through December 2023, offset by full collection of \$30.1 million receivable balance from Health Net during the current fiscal year, related to the Proposition 56 directed payment program two-sided risk corridor recoupment.

Receivable from Health Net increased \$30.1 million from \$0 at June 30, 2022, to \$30.1 million at June 30, 2023. The increase is attributable to accrued capitation recoupment from Health Net as a result of the DHCS Proposition 56 directed payment program two-sided risk corridor recoupment from the Plan. This risk corridor is subject to a certain threshold of medical expenses compared to premium revenues. Medical expenditures not meeting a minimum threshold as a percentage of revenue paid by DHCS requires CalViva to refund the premium revenue to the State of California. As CalViva pays a percent of premium revenue received from DHCS to Health Net, any recoupment from DHCS results in a receivable from Health Net to CalViva.

Other receivables – Other receivables decreased \$348,949 from \$876,877 at June 30, 2024, to \$527,928 at June 30, 2025. The decrease is primarily due to the decrease of interest rates and the timing of receipts of interest payments from various investment accounts.

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Other receivables increased \$380,115 from \$496,762 at June 30, 2023, to \$876,877 at June 30, 2024. The increase is primarily due to the timing of receipts of interest payments from various investment accounts and increase in interest rates.

Other receivables increased \$411,624 from \$85,138 at June 30, 2022, to \$496,762 at June 30, 2023. The increase is primarily due to the timing of receipts of interest payments from various investment accounts and increase in interest rates.

Prepaid expenses – Prepaid expenses increased \$1,161,829 from \$249,953 at June 30, 2024, to \$1,411,782 at June 30, 2025. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2025.

Prepaid expenses decreased \$1,119,274 from \$1,369,227 at June 30, 2023, to \$249,953 at June 30, 2024. The decrease is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2024.

Prepaid expenses increased \$105,494 from \$1,263,733 at June 30, 2022, to \$1,369,227 at June 30, 2023. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2023. Furthermore, the increase in prepaid expenses is also attributable to the increase in prepaid license fees assessed by DMHC.

Other assets – Other assets remained a balance of \$0 as of June 30, 2025.

Other assets decreased \$23,662 from \$23,662 at June 30, 2023, to \$0 at June 30, 2024. The decrease is due to the security deposits being applied to construction in progress for the office building improvement project during the year ended June 30, 2024.

Other assets increased \$23,662 from \$0 at June 30, 2022, to \$23,662 at June 30, 2023. The increase is due to security deposits that were made during the year ended June 30, 2023, to secure the office building improvement project.

Capital assets, net of accumulated depreciation and amortization – Capital assets, net of accumulated depreciation and amortization, decreased \$155,461 from \$9.1 million at June 30, 2024, to \$8.9 million at June 30, 2025. The decrease is primarily due to the depreciation and amortization expense of \$340,523 recorded, offset by the purchase of \$186,144 capital assets during the year ended June 30, 2025.

Capital assets, net of accumulated depreciation and amortization, decreased \$205,506 from \$9.3 million at June 30, 2023, to \$9.1 million at June 30, 2024. The decrease is primarily due to the depreciation and amortization expense of \$327,624 recorded, offset by the purchase of \$122,118 capital assets during the year ended June 30, 2024.

Capital assets, net of accumulated depreciation and amortization, decreased \$117,152 from \$9.4 million at June 30, 2022, to \$9.3 million at June 30, 2023. The decrease is primarily due to the depreciation and amortization expense of \$299,109 recorded, offset by the purchase of \$196,556 capital assets during the year ended June 30, 2023.

Lease receivable – The Plan as a lessor, recognized a lease receivable, which represents the present value of future lease payments expected to be received by the Plan during the lease term.

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The lease receivable balance decreased \$1.1 million from \$2.6 million at June 30, 2024, to \$1.5 million at June 30, 2025. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2025.

The lease receivable balance decreased \$605,142 from \$3.2 million at June 30, 2023, to \$2.6 million at June 30, 2024. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2024.

The lease receivable balance decreased \$1.0 million from \$4.2 million at June 30, 2022, to \$3.2 million at June 30, 2023. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2023.

Assets restricted as to use – Restricted assets balance decreased \$1,439 from \$304,185 at June 30, 2024, to \$302,746 at June 30, 2025. The decrease is due to distribution of accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2025 and 2024.

Restricted assets balance increased \$2,364 from \$301,821 at June 30, 2023, to \$304,185 at June 30, 2024. The increase is due to accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2024 and 2023.

Restricted assets balance decreased \$323 from \$302,144 at June 30, 2022, to \$301,821 at June 30, 2023. The decrease is due to distribution of accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2023 and 2022.

Liabilities and Deferred Inflow of Resources

Capitation payable – The capitation payable balance increased \$9.6 million from \$119.6 million at June 30, 2024, to \$129.2 million at June 30, 2025. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in capitation rates paid by DHCS.

The capitation payable balance increased \$2.1 million from \$117.5 million at June 30, 2023, to \$119.6 million at June 30, 2024. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in capitation rates paid by DHCS.

The capitation payable balance increased \$22.8 million from \$94.7 million at June 30, 2022, to \$117.5 million at June 30, 2023. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in membership and capitation rates paid by DHCS.

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Amounts due to the State of California – The amounts due to the State of California decreased \$20.6 million from \$40.5 million at June 30, 2024, to \$19.9 million at June 30, 2025. The decrease is attributable to full payment of \$40.5 million payable balance to the State of California during the current fiscal year, as a result of DHCS' retroactive capitation rate recoupment covering the time period of January 2023 through December 2023, offset by the Plan accruing for \$19.9 million payable balance to the State of California as a result of DHCS' potential future recoupment of the MCO tax gain relating to the time period of January 2024 through June 2025.

The amounts due to the State of California decreased \$1.8 million from \$42.3 million at June 30, 2023, to \$40.5 million at June 30, 2024. The decrease is attributable to full payment of \$42.3 million payable balance to the State of California during the current fiscal year, related to DHCS' recoupment of the MCO tax gain and Proposition 56 premium revenue risk corridor, offset by the Plan accruing for \$40.5 million payable balance to the State of California as a result of DHCS' retroactive capitation rate reduction covering the time period of January 2023 through December 2023.

The amounts due to the State of California increased \$33.8 million from \$8.5 million at June 30, 2022, to \$42.3 million at June 30, 2023. The increase is a result of the Plan accruing for DHCS' future recoupment of the MCO tax gain relating to the time period of July 2022 through December 2022 and Proposition 56 premium revenue risk corridor recoupment.

Accounts payable and accrued expenses – Accounts payable and accrued expenses consist of the cost of services received in the current period for which payment has yet to be made. The accounts payable and accrued expenses balance decreased by \$31,773 from \$6.0 million at June 30, 2024, to \$6.0 million at June 30, 2025. The decrease is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

The accounts payable and accrued expenses balance decreased by \$59,406 from \$6.1 million at June 30, 2023, to \$6.0 million at June 30, 2024. The decrease is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

The accounts payable and accrued expenses balance increased by \$380,874 from \$5.7 million at June 30, 2022, to \$6.1 million at June 30, 2023. The increase is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

Accrued salaries and benefits – The accrued salaries and benefits balance increased \$88,542 from \$403,714 at June 30, 2024, to \$492,256 at June 30, 2025. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off (PTO). The increase is primarily due to additional PTO accrued by employees and an increase in payroll expenses during the fiscal year ended June 30, 2025.

The accrued salaries and benefits balance increased \$51,515 from \$352,199 at June 30, 2023, to \$403,714 at June 30, 2024. The accrued salaries and benefits balance consists of accrued payroll and accrued PTO. The increase is primarily due to additional PTO accrued by employees and an increase in payroll expenses during the fiscal year ended June 30, 2024.

The accrued salaries and benefits balance increased \$37,791 from \$314,408 at June 30, 2022, to \$352,199 at June 30, 2023. The accrued salaries and benefits balance consists of accrued payroll and accrued PTO. The increase is primarily due to additional PTO accrued by employees and the timing of the pay period end date in relation to the Plan's fiscal year end date of June 30, 2023.

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Premium tax payable – The premium tax payable balance increased \$32.0 million from \$156.7 million at June 30, 2024, to \$188.7 million at June 30, 2025. The premium tax payable balance primarily represents the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis, and the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues. The increase is primarily due to the increase in the MCO taxes as a result of AB 160 which substantially increased the MCO tax amount during the fiscal year ended June 30, 2025.

The premium tax payable balance increased \$155.3 million from \$1.4 million at June 30, 2023, to \$156.7 million at June 30, 2024. The premium tax payable balance primarily represents the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis, and the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues. The increase is primarily due to the increase in the MCO tax amount for the fiscal year ended June 30, 2024, as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

The premium tax payable balance decreased \$46.2 million from \$47.6 million at June 30, 2022, to \$1.4 million at June 30, 2023. The premium tax payable balance primarily represents the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues, and the MCO tax, which imposes a per enrollee tax amount on a per member, per month basis. The decrease is primarily attributable to SB 78 premium tax payments made to the State of California during the current fiscal year ended June 30, 2023, and the decrease in accrued MCO taxes as a result of the MCO tax expiring on December 31, 2022.

Medical claims payable – The medical claims payable balance represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed and reported but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but not yet reported to the Plan.

The medical claims payable balance increased \$387,618 from \$71,883 at June 30, 2024, to \$459,501 at June 30, 2025. The balance at June 30, 2025, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2025.

The medical claims payable balance decreased \$48,806 from \$120,689 at June 30, 2023, to \$71,883 at June 30, 2024. The balance at June 30, 2024, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2024.

The medical claims payable balance increased \$24,356 from \$96,333 at June 30, 2022, to \$120,689 at June 30, 2023. The balance at June 30, 2023, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2023.

Directed payment payable – The directed payment payable balance represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

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The directed payment payable balance decreased \$4.0 million from \$4.8 million at June 30, 2024, to \$742,751 at June 30, 2025. The decrease is primarily due to DHCS' recoupment of directed payments as a result of DHCS' retroactive directed payment rate reduction covering the time period of July 2019 through December 2021, and the timing of directed payments to the network hospitals and skilled nursing facilities.

The directed payment payable balance increased \$2.6 million from \$2.2 million at June 30, 2023, to \$4.8 million at June 30, 2024. The increase is primarily due to the timing of directed payments to the network hospitals and skilled nursing facilities.

The directed payment payable balance decreased \$1.5 million from \$3.7 million at June 30, 2022, to \$2.2 million at June 30, 2023. The decrease is primarily due to the timing of directed payments to the network hospitals.

Other liabilities – Other liabilities remained a balance of \$25,907 during the years ended June 30, 2025, 2024, and 2023.

Deferred inflow of resources – The Plan as a lessor, recognized a deferred inflow of resources corresponding to the lease receivable amount, and it is defined as an acquisition of net position by the Plan that is applicable to future reporting periods.

Deferred inflow of resources balance decreased \$1.1 million from \$2.2 million at June 30, 2024, to \$1.1 million at June 30, 2025. The decrease is due to recognition of lease revenue corresponding to collection of lease payments from tenants by the Plan during the fiscal year ended June 30, 2025.

Deferred inflow of resources balance decreased \$632,410 from \$2.8 million at June 30, 2023, to \$2.2 million at June 30, 2024. The decrease is due to recognition of lease revenue corresponding to collection of lease payments from tenants by the Plan during the fiscal year ended June 30, 2024.

Deferred inflow of resources balance decreased \$1.1 million from \$3.9 million at June 30, 2022, to \$2.8 million at June 30, 2023. The decrease is due to recognition of lease revenue corresponding to collection of lease payments from tenants by the Plan during the fiscal year ended June 30, 2023.

Statements of Revenues, Expenses, and Changes in Net Position

The Statements of Revenues, Expenses, and Changes in Net Position are a presentation of the Plan's operating results for the fiscal years ended June 30, 2025, 2024, and 2023. In accordance with Governmental Accounting Standards Board (GASB) requirements, certain significant revenues are mandated to be recorded as nonoperating revenues, including investment income. The following is a summary of the operating results for fiscal years ended June 30, 2025, 2024, and 2023.

Capitation revenue – The capitation revenue balance increased \$285.5 million from \$2,048.1 million at June 30, 2024, to \$2,333.6 million at June 30, 2025. The increase is primarily due to the increase in capitation rates from DHCS and the MCO tax revenue, offset by the decrease in membership.

The capitation revenue balance increased \$758.6 million from \$1,289.5 million at June 30, 2023, to \$2,048.1 million at June 30, 2024. The increase is primarily due to the increase in capitation rates from DHCS, membership, and the MCO tax revenue as a result of the CMS' approval of the new MCO tax, effective retroactively to April 1, 2023.

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The capitation revenue balance decreased \$49.0 million from \$1,338.5 million at June 30, 2022, to \$1,289.5 million at June 30, 2023. The decrease is primarily due to the expiration of the MCO tax related revenues on December 31, 2022, and the Proposition 56 premium revenue recoupment by DHCS, offset by the increase in membership and capitation rates from DHCS.

Nonoperating revenue – The nonoperating revenue balance increased \$2.6 million from \$9.1 million at June 30, 2024, to \$11.7 million at June 30, 2025. The increase is due to the increase in investment income, offset by the decrease in rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

The nonoperating revenue balance increased \$3.2 million from \$5.9 million at June 30, 2023, to \$9.1 million at June 30, 2024. The increase is due to the increase in investment income and rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

The nonoperating revenue balance increased \$5.0 million from \$897,393 at June 30, 2022, to \$5.9 million at June 30, 2023. The increase is due to the increase in investment income and rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

Health care expenses – Overall health care expenses consist of the capitation payment that the Plan pays to its subcontracting entities for health care services provided to CalViva members and for the direct payment of medical claims, including claims which have been incurred but not yet reported.

Overall health care expenses increased \$95.6 million from \$1,309.9 million at June 30, 2024, to \$1,405.5 million at June 30, 2025. The increase is primarily due to the increase in capitation rates from DHCS which increases the capitation revenue and capitation expenses, offset by the decrease in membership.

Overall health care expenses increased \$186.0 million from \$1,123.9 million at June 30, 2023, to \$1,309.9 million at June 30, 2024. The increase is primarily due to the increase in capitation rates from DHCS and membership.

Overall health care expenses increased \$21.4 million from \$1,102.5 million at June 30, 2022, to \$1,123.9 million at June 30, 2023. The increase is primarily due to the increase in membership and capitation rates from DHCS, offset by Proposition 56 capitation recoupment from Health Net.

General and administrative expenses – Overall general and administrative expenses increased \$447,874 from \$68.6 million at June 30, 2024, to \$69.0 million at June 30, 2025. The increase is primarily attributable to the increase in expenditures related to license, and salary and benefits, offset by the decrease in administrative service agreement fees and consulting fees. General and administrative expenses as a percentage of revenue totaled 2.9% and 3.3% for the fiscal years ended June 30, 2025 and 2024, respectively.

Overall general and administrative expenses increased \$1.9 million from \$66.7 million at June 30, 2023, to \$68.6 million at June 30, 2024. The increase is primarily attributable to the increase in expenditures related to administrative service agreement fees, insurance, and salary and benefits, offset by the decrease in grants. General and administrative expenses as a percentage of revenue totaled 3.3% and 5.1% for the fiscal years ended June 30, 2024 and 2023, respectively.

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Overall general and administrative expenses increased \$4.8 million from \$61.9 million at June 30, 2022, to \$66.7 million at June 30, 2023. The increase is primarily attributable to the increase in expenditures related to administrative service agreement fees, license, and grants. General and administrative expenses as a percentage of revenue totaled 5.1% and 4.6% for the fiscal years ended June 30, 2023 and 2022, respectively.

Premium tax – In 2009, AB 1422 was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal managed care plans would be subject to a gross premium tax (GPT). CalViva is required to pay 2.35% on gross Medi-Cal capitation revenues to the State of California. The GPT program concluded on June 30, 2012. In June 2013, SB 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. The collected taxes are matched by federal dollars and are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. The State of California calculates the gross premium tax amount in CalViva's capitation rates; as such, the premium tax has no financial impact on the Plan.

On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCS), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCS enrollees, and all other enrollees, as defined.

On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare and Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. A modification to the Managed Care Organization (MCO) tax, authorized by Assembly Bill (AB) 160 (Chapter 39, Statutes of 2024) with an effective period of January 1, 2024, through December 31, 2026, was approved by the Centers for Medicare and Medicaid Services (CMS) on December 20, 2024. This modification establishes tax amounts in addition to the MCO tax originally authorized by AB 119 (Chapter 13, Statutes of 2023) approved by CMS on December 15, 2023. The premium tax recorded was \$848.4 million, \$658.3 million, and \$91.4 million for the fiscal years ended June 30, 2025, 2024, and 2023, respectively.

Report of Independent Auditors

The Commissioners
The Fresno-Kings-Madera Regional Authority
dba CalViva Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of The Fresno-Kings-Madera Regional Authority dba CalViva Health, which comprise the statements of net position as of June 30, 2025 and 2024, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of The Fresno-Kings-Madera Regional Authority dba CalViva Health as of June 30, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of The Fresno-Kings-Madera Regional Authority dba CalViva Health and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Authority dba CalViva Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 12 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of The Fresno-Kings-Madera Regional Authority dba CalViva Health's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
October __, 2025

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upon for any purpose

Financial Statements

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position
June 30, 2025 and 2024

	<u>2025</u>	<u>2024</u>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 188,090,716	\$ 262,152,446
Capitation receivables from the State of California	329,916,083	176,787,742
Receivable from Health Net	-	39,892,500
Other receivables	527,928	876,877
Prepaid expenses	1,411,782	249,953
Lease receivable - current portion	<u>390,921</u>	<u>675,406</u>
Total current assets	<u>520,337,430</u>	<u>480,634,924</u>
CAPITAL ASSETS		
Nondepreciable	3,161,419	3,273,089
Depreciable, net of accumulated depreciation and amortization	<u>5,780,903</u>	<u>5,824,694</u>
Total capital assets	<u>8,942,322</u>	<u>9,097,783</u>
LEASE RECEIVABLE - NONCURRENT PORTION	1,132,757	1,939,362
ASSETS RESTRICTED AS TO USE	<u>302,746</u>	<u>304,185</u>
Total assets	<u><u>\$ 530,715,255</u></u>	<u><u>\$ 491,976,254</u></u>

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position
June 30, 2025 and 2024

	2025	2024
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Capitation payable	\$ 129,234,051	\$ 119,630,944
Amounts due to the State of California	19,860,831	40,500,000
Accounts payable and accrued expenses	5,959,612	5,991,385
Accrued salaries and benefits	492,256	403,714
Premium tax payable	188,700,404	156,731,654
Medical claims payable	459,501	71,883
Directed payment payable	742,751	4,754,619
Total current liabilities	345,449,406	328,084,199
OTHER LIABILITIES	25,907	25,907
Total liabilities	345,475,313	328,110,106
DEFERRED INFLOWS OF RESOURCES	1,131,484	2,176,214
Total liabilities and deferred inflow of resources	<u>\$ 346,606,797</u>	<u>\$ 330,286,320</u>
NET POSITION		
Invested in capital assets	\$ 8,942,322	\$ 9,097,783
Restricted by legislative authority	302,746	304,185
Unrestricted	174,863,390	152,287,966
Total net position	184,108,458	161,689,934
Total liabilities, deferred inflow of resources, and net position	<u>\$ 530,715,255</u>	<u>\$ 491,976,254</u>

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2025 and 2024

	2025	2024
OPERATING REVENUES		
Capitation revenue	\$ 2,333,594,205	\$ 2,048,060,849
OPERATING EXPENSES		
Health care expenses:		
Capitation expense	1,398,230,816	1,308,574,628
Medical expense	7,253,544	1,349,780
Total health care expenses	1,405,484,360	1,309,924,408
General and administrative expenses:		
Administrative service fees	57,403,720	57,606,857
Other expense	5,319,319	5,171,849
Salaries and benefits	4,209,448	3,677,058
Marketing and promotion	1,393,717	1,392,135
Depreciation and amortization	340,523	327,624
Legal and professional	369,833	413,163
Total general and administrative expenses	69,036,560	68,588,686
Premium tax	848,375,000	658,279,779
Total operating expenses	2,322,895,920	2,036,792,873
Income from operations	10,698,285	11,267,976
NONOPERATING REVENUE		
Other income	471,252	632,410
Interest income	11,248,987	8,450,992
Total nonoperating revenue	11,720,239	9,083,402
CHANGES IN NET POSITION	22,418,524	20,351,378
NET POSITION, beginning of year	161,689,934	141,338,556
NET POSITION, end of year	\$ 184,108,458	\$ 161,689,934

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Cash Flows
Years Ended June 30, 2025 and 2024

	2025	2024
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	\$ 2,220,358,364	\$ 1,984,618,526
Health care expenses paid	(1,420,144,672)	(1,307,090,295)
Administrative expenses paid	(885,858,398)	(570,501,434)
Net cash (used in) provided by operating activities	(85,644,706)	107,026,797
CASH FLOWS FROM NONCAPITAL FINANCING AND RELATED ACTIVITY		
Proceeds from lease receivable	536,604	786,031
Net cash provided by noncapital financing and related activity	536,604	786,031
CASH FLOWS FROM CAPITAL FINANCING AND RELATED ACTIVITY		
Payments for purchase of capital assets	(186,144)	(122,118)
Net cash used in capital financing and related activity	(186,144)	(122,118)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest income, net	11,232,516	8,267,739
Net cash provided by investing activity	11,232,516	8,267,739
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(74,061,730)	115,958,449
CASH AND CASH EQUIVALENTS, beginning of year	262,152,446	146,193,997
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 188,090,716</u>	<u>\$ 262,152,446</u>
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES		
Income from operations	\$ 10,698,285	\$ 11,267,976
Adjustments to reconcile income from operations to net cash (used in) provided by operating activities:		
Depreciation and amortization	340,523	327,624
Changes in operating assets and liabilities:		
Capitation receivables from the State of California	(153,128,341)	(53,659,715)
Receivable from Health Net	39,892,500	(9,782,608)
Other receivables	348,949	(380,115)
Prepaid expenses	(1,161,829)	1,119,274
Other assets	-	23,662
Capitation payable	9,603,107	2,085,282
Amounts due to the State of California	(20,639,169)	(1,791,066)
Accounts payable and accrued expenses	(31,773)	(59,406)
Accrued salaries and benefits	88,542	51,515
Premium tax payable	31,968,750	155,284,477
Medical claims payable	387,618	(48,806)
Directed payment payable	(4,011,868)	2,588,703
Net cash (used in) provided by operating activities	<u>\$ (85,644,706)</u>	<u>\$ 107,026,797</u>

See accompanying notes.

**The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Notes to Financial Statements**

Note 1 – Organization

The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is a local governmental health insuring organization that operates in the counties of Fresno, Kings, and Madera (Tri-Counties). The Boards of Supervisors for the Tri-Counties established The Fresno-Kings-Madera Regional Health Authority (the Authority) in March 2009, in accordance with the State of California Welfare and Institutions Code (the Code) Section 14087.38. Through the provisions of the “Joint Exercise of Powers Agreement between the counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs” agreement, dated March 2009, and pursuant to the Code, CalViva became financially independent of Fresno, Kings, and Madera counties. In addition, the Code provides that CalViva is a public entity, separate and apart from the counties of Fresno, Kings, and Madera. CalViva received its Knox-Keene license from the California Department of Managed Health Care (DMHC) on December 30, 2010, and commenced operations on March 1, 2011.

The mission and purpose of CalViva is to improve access to care and provide quality health care to families in the Fresno, Kings, and Madera County areas at the right place and the right time.

CalViva has contracted with the California Department of Health Care Services (DHCS) to receive funding to provide health care services to the Medi-Cal eligible Tri-County area residents who are enrolled as members of CalViva under the two-plan model. The DHCS contract is effective March 1, 2011, through December 31, 2026. The DHCS contract specifies capitation rates based on a per-member, per-month basis, which may be adjusted annually. DHCS revenue is paid monthly and is based upon the contracted capitation rates and actual Medi-Cal enrollment. In addition, DHCS pays CalViva supplemental capitation rates such as a fixed maternity case rate for each eligible birth incurred by a CalViva Medi-Cal member. CalViva, in turn, provides services to Medi-Cal beneficiaries through a contract with Health Net Community Solutions, Inc. (Health Net), a wholly owned subsidiary of Centene Corporation. Further, CalViva has an administrative service agreement with Health Net in which Health Net performs specific administrative functions for CalViva.

The Fresno-Kings-Madera Regional Health Authority
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On September 2, 2009, the California State Legislature ratified Assembly Bill (AB) No. 1422 (AB 1422), which levies a 2.35% gross premium tax (GPT) on all Medi-Cal capitated revenue received. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. This provision was effective retroactively to January 1, 2009. The GPT program was concluded on June 30, 2012. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. A modification to the Managed Care Organization (MCO) tax, authorized by Assembly Bill (AB) 160 (Chapter 39, Statutes of 2024) with an effective period of January 1, 2024, through December 31, 2026, was approved by the Centers for Medicare and Medicaid Services (CMS) on December 20, 2024. This modification establishes tax amounts in addition to the MCO tax originally authorized by AB 119 (Chapter 13, Statutes of 2023) approved by CMS on December 15, 2023. Under the Tax Uniformity Requirements enacted July 4, 2025, health care related taxes, including MCO taxes, must apply a uniform 1:1 rate and cannot tax Medicaid business at a higher rate than non-Medicaid business. As a result, the current MCO tax ceases as of the enactment date, however, there is a discretionary allowance of up to a three-year transition period which the State of California is applying for with the federal government.

The Fresno-Kings-Madera Regional Health Authority
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On September 8, 2010, the California State Legislature ratified AB No. 1653 (AB 1653), which established a Quality Assurance Fee (QAF) program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions (W&I) Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding:

Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services," and Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass-through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the QAF program through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. In October of 2013, California approved SB 239, which extended the QAF program for an additional 36 months from January 1, 2014, through December 31, 2016. In November of 2016, the voters of California passed Proposition 52, which permanently extended the QAF program.

Beginning with the July 1, 2017, rating period, DHCS implemented the following managed care Directed Payment programs: (1) Private Hospital Directed Payment (PHDP), (2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP), and (3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, this program provides supplemental reimbursement to participating Network Provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The PHDP program was created to maintain access and improve the quality of care for Medi-Cal beneficiaries. (2) For EPP-FFS and EPP-CAP, this program provides supplemental reimbursement to Network Provider designated public hospitals through either a uniform dollar or percentage increase based on actual utilization of network contracted qualifying services. (3) For QIP, DHCS has directed the Medi-Cal managed care health plans (MCPs) to make QIP payments to designated public hospitals and University of California hospitals that are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments will be linked to delivery of services and increase the amount of funding tied to quality outcomes.

Beginning with the calendar year 2023 rating period, DHCS implemented the District and Municipal Public Hospital Directed Payment (DHDP) program which directed MCPs to reimburse California's District and Municipal Public Hospitals for network contracted services, based on actual utilization of contracted services. The goal of this program is to improve preventative care for children, maternity care, and birth equity through increasing access to care. The payments will be enhanced by either a uniform percentage or dollar increment.

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Beginning with January 1, 2023, date of service, DHCS implemented the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) to provide performance-based directed payments to eligible network provider SNFs to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP is authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB)186 (Chapter 46, Statutes of 2022)) for dates of service from January 1, 2023, through December 31, 2026. DHCS has directed Medi-Cal managed care plans to make SNF WQIP payments to eligible SNFs according to utilization and performance on designated WQIP metrics. Based on the State of California's Enacted Budget for State fiscal year 2025-2026, the SNF WQIP will end on December 31, 2025.

CalAIM implementation – Beginning January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. This requires managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. Components that began on January 1, 2022, include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. In addition, institutional Long-Term Care (LTC) benefit including skilled nursing facilities transitioned to Medi-Cal managed care plans effective January 1, 2023. Effective January 1, 2024, all Medi-Cal managed care plans became responsible for the full LTC benefit at facility types such as Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, Pediatric Subacute Care Facility and Subacute Care Facility.

Note 2 – Summary of Significant Accounting Policies

Accounting standards – Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements, as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts, and the State Controller's Office prescribed reporting guidelines.

Proprietary fund accounting – The Plan utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Use of estimates – The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates used in preparing the financial statements include capitation receivables from the State of California, receivable from Health Net, medical claims payable such as liability for incurred but not reported claims expense, useful lives of capital assets, lease receivable, and deferred inflow of resources.

The Fresno-Kings-Madera Regional Health Authority
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Risks and uncertainties – The Plan's business could be impacted by external price pressure on new and renewal business; additional competitors entering the Plan's markets; federal and state legislation; and governmental licensing regulations of Health Maintenance Organizations (HMOs) and insurance companies. External influences in these areas could have the potential to adversely impact the Plan's operations in the future.

Income taxes – The Plan operates under the purview of the Internal Revenue Code (IRC) Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, the Plan is not subject to federal or state income taxes.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits and other short-term, highly liquid securities with original maturities of three months or less.

Concentration of risk – Financial instruments potentially subjecting the Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (FDIC) insurance thresholds. If any of the financial institutions with whom the Plan does business were placed into receivership, the Plan may be unable to access the cash on deposit with such institutions in order to operate its business without adverse effect. As of June 30, 2025 and 2024, the Plan's uninsured cash and cash equivalent balance totaled \$187,711,364 and \$261,761,773, respectively. The uninsured balances are collateralized in accordance with state law, which requires qualifying securities to be pledged at 110% of the uninsured balances. To date, the Plan has not experienced any losses on these accounts.

The Plan is highly dependent upon the State of California for its revenues. All capitation receivable and capitation revenues are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Plan.

The Plan has a contract with Health Net whereby Health Net provides virtually all administrative services vital to the Plan's successful daily operation. In addition, the Plan has a capitation agreement with Health Net whereby the Plan utilizes Health Net's network of contracted providers to furnish care for most of the Plan's members. The inability of Health Net to meet its obligations under these contracts could significantly impact the Plan's ability to operate in the short term until alternative arrangements could be made.

Capital assets – Capital assets are recorded at cost. The capitalization threshold of such assets is \$10,000. Depreciation of capital assets is based on the straight-line method over the estimated useful lives of the assets, estimated to be three to 30 years. Expenditures for maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized.

The Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

The Fresno-Kings-Madera Regional Health Authority
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Lease receivable and deferred inflow of resources – Pursuant to GASB Statement No. 87, *Leases*, the Plan as a lessor recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Plan during the lease term. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Plan that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Plan recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative future receipts on the contract exceed \$100,000 that meet the definition of an other than short-term lease. The Plan uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Assets restricted as to use – The Plan is required by the DMHC to restrict cash having a fair value of at least \$300,000 for the payment of member claims in the event of its insolvency. The amount recorded was \$302,746 and \$304,185 at June 30, 2025 and 2024, respectively. Restricted cash comprises certificates of deposit and is stated at fair value.

Medical claims payable – Medical claims payable balance of \$459,501 and \$71,883 at June 30, 2025 and 2024, respectively, represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but not yet reported to the Plan. The balances at June 30, 2025 and 2024, were determined by factors such as cost of services and enrollment for providers paid on a fee-for-service basis.

Net position – Net position is classified as invested in capital assets and restricted or unrestricted net position. Invested in capital assets represents investments in land, building, furniture and fixtures, and computer equipment and software, net of depreciation and amortization. Restricted net position is noncapital assets that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Plan. Unrestricted net position consists of net position that does not meet the definition of invested in capital assets or restricted net position.

Operating revenues and expenses – The Plan's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. The primary operating revenue is derived from capitation in support of providing health care services to its members. Operating expenses are all expenses incurred to provide such health care services. Nonoperating revenues and expenses consist of those revenues and expenses that are related to investing and financing activities.

The Fresno-Kings-Madera Regional Health Authority
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Capitation revenue – Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. The State of California pays the Plan capitation revenue on a monthly basis based on initial membership, which is adjusted monthly for retroactivity. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by the Fresno County Department of Social Services, the Madera County Department of Social Services, and the Kings County Human Services Agency, and validated by the State of California. The State of California provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

Premium deficiencies – The Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2025 and 2024.

Capitation expense and medical expenses – CalViva contracts with providers to furnish health care services to enrolled members. The expenses related to these provisions for covered services to enrolled CalViva members are recognized on an accrual basis.

Premium tax – The Plan paid the State of California a gross premium tax (AB 1422), which was levied in September 2009 pursuant to Section 28 of Article XIII of the California Constitution and is effective retroactively from January 1, 2009, to June 30, 2012. The payment amount is determined by multiplying the Plan's capitation revenue by 2.35%. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans, as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016--2017, 2017--2018, and 2018--2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSPP enrollees, and all other enrollees, as defined. On September 2019, Assembly Bill 115 authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115. The new MCO tax was effective retroactively from April 1, 2023, through December 31, 2026. Assembly Bill 160 authorized a modification to the MCO tax, and established tax amounts in addition to the MCO tax originally authorized by AB 119, with an effective period of January 1, 2024, through December 31, 2026. The premium tax equaled \$848,375,000 and \$658,279,779 for the years ended June 30, 2025 and 2024, respectively. Premium tax is recognized in the period the related capitation revenue is recognized.

Insurance coverage – The Plan maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the "claims-made" policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the term of the "claims-made" policies but reported subsequent to the termination of the insurance contract may be uninsured.

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New accounting pronouncements – In June 2022, the GASB issued Statement No. 101, *Compensated Absences*. The Statement updates the recognition and measurement guidance for compensated absences. This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. This statement is effective for fiscal years beginning after December 15, 2023. The Plan adopted the Statement effective July 1, 2024, and the adoption had no material impact on the financial statements.

In December 2023, the GASB issued Statement 102, *Certain Risk Disclosures*. This Statement requires disclosure of vulnerabilities arising from concentrations or constraints when such conditions could subject the entity to a substantial impact and when related events are known or likely to occur within 12 months of the financial statement issuance date. The Plan adopted the Statement effective July 1, 2024, and the adoption had no material impact on the financial statements.

In May 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements*. This statement modifies the basic financial statements and MD&A to enhance governmental financial reports. Changes include revisions to MD&A, modifications to proprietary fund statements, elimination of separate extraordinary and special item presentations, and changes to budgetary comparison information. This statement is effective for fiscal years beginning after June 15, 2025. The Plan is currently evaluating the impact of the adoption of this Statement on its financial statements.

In September 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*. This statement requires separate disclosure of certain capital assets in the notes, such as lease, intangible right-to-use, and subscription assets, each by major class. It also establishes new disclosure requirements for capital assets that a government has decided to sell and for which a sale is probable within one year. This Statement is effective for fiscal years beginning after June 15, 2025, with retroactive application required upon adoption. The Plan is currently evaluating the impact of the adoption of this Statement on its financial statements.

Note 3 – Investments

The Plan held investments as of June 30 as follows:

	2025	2024
Assets restricted as to use	\$ 302,746	\$ 304,185
	<u>\$ 302,746</u>	<u>\$ 304,185</u>

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Investments authorized by the Plan's investment policy – Investments may only be made as authorized by the Plan's investment policy. The objective of the policy is to ensure the Plan's funds are prudently invested to preserve capital and provide necessary liquidity.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, an entity will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, an entity will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code requires that a financial institution secure deposit made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit).

As of June 30, 2025 and 2024, none of the Plan's deposits with financial institutions in excess of federal depository insurance limits were held in uncollateralized accounts and none of the Plan's investments were subject to custodial credit risk.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Plan did not have any investments that were considered highly sensitive to changes in interest rates as of June 30, 2025 and 2024.

Information about the sensitivity of the fair values of the Plan's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the Plan's investments by maturity:

Remaining Maturity (in Months) as of June 30, 2025				
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	\$ 302,746	\$ -	\$ 302,746	\$ -
Total	<u>\$ 302,746</u>	<u>\$ -</u>	<u>\$ 302,746</u>	<u>\$ -</u>
Remaining Maturity (in Months) as of June 30, 2024				
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	\$ 304,185	\$ 304,185	\$ -	\$ -
Total	<u>\$ 304,185</u>	<u>\$ 304,185</u>	<u>\$ -</u>	<u>\$ -</u>

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Investments made by the Plan are not rated by Standard & Poor's, but are fully FDIC insured.

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Concentration of credit risk – The investment policy of the Plan contains no limitation on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code. More than 5% of the Plan's investments are in certificates of deposit issued by the United Security Bank and the South State Bank as of June 30, 2025. These investments were 83.31% and 16.69%, respectively, of the Plan's total investments as of June 30, 2025. More than 5% of the Plan's investments are in certificates of deposit issued by the United Security Bank and the First Federal Savings and Loan Association as of June 30, 2024. These investments were 83.45% and 16.55%, respectively, of the Plan's total investments as of June 30, 2024.

Note 4 – Capital Assets, Net

A summary of changes in capital assets, net for the years ended June 30, 2025 and 2024, is as follows:

	Balance at July 1, 2024	Additions	Retirements	Transfers	Balance at June 30, 2025
Land	\$ 3,161,419	\$ -	\$ -	\$ -	\$ 3,161,419
Construction in progress	111,670	-	-	(111,670)	-
Building	7,993,729	124,496	-	111,670	8,229,895
Furniture and fixtures	238,934	61,648	(14,430)	-	286,152
Computer equipment and software	71,723	-	(15,723)	-	56,000
Total assets	11,577,475	186,144	(30,153)	-	11,733,466
Less: depreciation expense and accumulated depreciation related to retirements	(2,479,692)	(340,523)	29,071	-	(2,791,144)
Capital assets, net	\$ 9,097,783	\$ (154,379)	\$ (1,082)	\$ -	\$ 8,942,322

	Balance at July 1, 2023	Additions	Retirements	Transfers	Balance at June 30, 2024
Land	\$ 3,161,419	\$ -	\$ -	\$ -	\$ 3,161,419
Construction in progress	-	111,670	-	-	111,670
Building	7,993,729	-	-	-	7,993,729
Furniture and fixtures	228,486	10,448	-	-	238,934
Computer equipment and software	91,982	-	(20,259)	-	71,723
Total assets	11,475,616	122,118	(20,259)	-	11,577,475
Less: depreciation expense and accumulated depreciation related to retirements	(2,172,327)	(327,624)	20,259	-	(2,479,692)
Capital assets, net	\$ 9,303,289	\$ (205,506)	\$ -	\$ -	\$ 9,097,783

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Note 5 – Capitation Receivables from the State of California

CalViva receives capitation from the State of California based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State of California makes monthly payments based on actual members for the current month and retroactive adjustments related to prior months. The capitation receivable represents amounts due from the State of California under the Medi-Cal program. CalViva had capitation receivable of \$329,916,083 and \$176,787,742 due from the State of California as of June 30, 2025 and 2024, respectively.

Note 6 – Receivable from Health Net

CalViva recoups capitation from Health Net based upon premium revenue CalViva repays DHCS. Due to changes in DHCS' actuarial assumptions such as but not limited to the difference between the actual enrollment data and DHCS' original enrollment projections for the period of January 1, 2023, through December 31, 2023, DHCS actuarially determined there would be lower costs and utilization for this period and therefore retroactively reduced the calendar year 2023 capitation rates for capitation premium previously paid to the Plan. This has resulted in CalViva needing to recoup from Health Net a portion of the capitation payments it previously overpaid to Health Net. The Plan recorded a receivable from Health Net of \$39,892,500 as of June 30, 2024. This capitation receivable balance was fully collected from Health Net during the fiscal year ended June 30, 2025.

Note 7 – Capitation Payable

CalViva contracts with providers to furnish certain health care services to enrolled members. The cost of health care services provided or contracted for is accrued in the period in which it is provided to an enrolled member. The Plan recorded capitation payable of \$129,234,051 and \$119,630,944 as of June 30, 2025 and 2024, respectively.

Note 8 – Amounts Due to the State of California

The initial Medi-Cal managed care rates for the period of January 1, 2023, through December 31, 2023, were developed assuming the start of the unwinding of Medicaid enrollment to be April 1, 2023, which was postponed to be July 1, 2023, in actuality. In addition, the implementation date of the Intermediate Care Facility for Developmentally Disabled (ICF/DD) and Subacute Long-Term Care (LTC) member transition was delayed from July 1, 2023, to January 1, 2024. Considering the difference between the actual enrollment data and the original enrollment projections, including the delayed implementation of the ICF/DD and Subacute LTC services, DHCS anticipated lower costs and utilization for this period. As a result, DHCS amended the calendar year 2023 rates which results in retroactive rate reductions to capitation premiums previously paid to the Plan, and, consequently, will be recouping funds accordingly. As such, CalViva recorded amounts due to the State of California of \$40,500,000 as of June 30, 2024. This payable balance was fully paid to DHCS during the fiscal year ended June 30, 2025.

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For the period of January 1, 2024, through June 30, 2025, CalViva recorded amounts due to the State of California of \$19,860,831 as of June 30, 2025, related to DHCS' potential future recoupment of the MCO tax gain.

Note 9 – Directed Payment Payable

CalViva is under the direction of the DHCS to implement the directed payment program for enhanced reimbursements to eligible and participating network hospitals and skilled nursing facilities for qualifying contracted services. Directed payment payable balance of \$742,751 and \$4,754,619 as of June 30, 2025 and 2024, respectively, represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

Note 10 – Retirement and Deferred Compensation Plans

Retirement plan – Effective January 1, 2010, the Plan established a defined contribution money purchase pension plan, 401(a), for its executive employees. The contribution requirement is established by the Plan. Employees do not make contributions to the Plan. Furthermore, employer contributions are immediately vested. The amounts are not available to employees until termination, retirement, death, disability, and other specific conditions. The Plan's contributions to the retirement plan totaled \$242,379 and \$226,938 for the years ended June 30, 2025 and 2024, respectively.

Deferred compensation plan – The Plan offers its employees a deferred compensation plan created in accordance with IRC Section 457. The 457b deferred compensation plan is available to all employees and permits them to defer a portion of their salary. An employer match is also provided and is vested at the rate of 33% per year. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency. The Plan's contributions to the deferred compensation plan totaled \$117,911 and \$112,517 for the years ended June 30, 2025 and 2024, respectively.

The market value of the investments held equals the amounts due to plan participants under both deferred compensation plans. The assets in both deferred compensation plans referenced above are not available to pay the liabilities of CalViva. CalViva is not controlling the assets in both deferred compensation plans, and employees who participate in these plans are responsible for the direction, use, exchange, or employment of the assets. Therefore, the respective assets and liabilities are not reflected in the statements of net position.

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Note 11 – Lessor Lease Arrangements

The Plan is a lessor for noncancelable leases of office space with lease terms through 2029. Lease revenue from the lease arrangements was \$471,252 and \$632,410 for the years ended June 30, 2025 and 2024, and is included in other income in the statements of revenues, expenses, and changes in net position. Interest revenue from the lease arrangements was \$148,495 and \$243,260 for the years ended June 30, 2025 and 2024, respectively, and is included in interest income in the statements of revenues, expenses, and changes in net position.

Note 12 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity was \$24,835,942 and \$21,980,608 at June 30, 2025 and 2024, respectively. The Plan's tangible net equity was \$184,108,458 and \$161,689,934 at June 30, 2025 and 2024, respectively.

Note 13 – Risk Management

The Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Plan's commercial coverage.

Note 14 – Commitments and Contingencies

Litigation – In the ordinary course of business, the Plan is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the Plan's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Plan.

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Note 15 – Federal and State Health Care Policy and Budget Cuts

Health Plan is subject to risks and uncertainties arising from potential changes in federal health care policy, grants, and budgetary adjustments affecting Medicare and Medicaid programs. Proposed and potential cuts to Medicaid could indirectly impact Medicare beneficiaries by straining state budgets. Cuts to Medicaid, including elimination of the enhanced federal match rate for expansion enrollees or the imposition of work requirements, could lead to significant coverage losses, particularly among low-income individuals, those with disabilities, or chronic conditions. States may respond to reduced federal funding by raising taxes or cutting other essential programs. Potential policy changes under consideration include reductions in the federal Medicaid matching rate, imposition of work requirements, more frequent eligibility redeterminations leading to disenrollments, implementation of per-capita caps on federal funding, and elimination of provider taxes used to offset Medicaid costs. If implemented, such changes could force states to reduce benefits, lower payments to providers, and increase financial pressures on state budgets, which may, in turn, adversely affect Health Plan's operations. However, the timing, likelihood, and specific impact of these policy changes remain uncertain.

Item #7

Attachment 7.A

2025 Health Equity

7.A Executive Summary

7.A.1 Work Plan Mid-Year Evaluation



REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Pao Houa Lee, MBA, Senior Health Equity Specialist
Sia Xiong-Lopez, MA, Health Equity Officer

COMMITTEE DATE: October 16, 2025

SUBJECT: Health Equity 2025 Work Plan Mid-Year Evaluation – Summary Report

Summary:

This report provides information on the Health Equity Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The Health Equity Work Plan is broken down into the following four sections: 1) Language Assistance Program (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of June 30, 2025, all work plan activities are on target to be completed by the end of the year with some already completed.

Purpose of Activity:

To evaluate the mid-year progress against the work plan activities and identify changes to be made to meet end of year goals. CalViva Health (CVH) has delegated all language services to Health Net's Health Equity Department.

Data/Results (include applicable benchmarks/thresholds):

Below is a high-level summary of the activities completed during the first six months of 2025. For complete report and details per activity, please refer to the attached 2025 Health Equity Work Plan Mid-Year Evaluation Report.

a. Language Assistance Services

- a. Completed audit requirements for Behavioral Health and Health Equity Oversight.
- b. Amended 3 language vendors' contracts, amendment includes DEI training for interpreters and updates on rates.
- c. Updated tagline to include traditional Chinese.
- d. Fifty-two staff completed their bilingual assessment or were re-assessed.
- e. Seven translation reviews were completed.
- f. Completed annual report of the LAP assessment results for the Timely Access Reporting.
- g. Four health education material field tests were completed.

b. Compliance Monitoring

- a. Health Equity reviewed 15 grievance cases with one intervention identified and 5 interpreter complaints.
- b. Completed, presented and received approval for the 2024 End of Year Language Assistant Program, 2024 End of Year Work Plan reports, the 2025 Program Description, and 2025 Work Plan.
- c. Attended all Public Policy Committee meetings.
- d. Completed one findhelp training for staff with 222 attendees and one provider training to be conducted at the end of the year.
- e. 1,279 referrals were made in findhelp with 157 closed loop referrals, 37 members got help, and 375 new programs were added to the platform.

c. *Communication, Training and Education*

- a. Annual coding and resolution of grievance to new hires and current A&G staff on track to complete in Q3.
- b. Provider's newsletter on track to complete in Q3.
- c. Provider's materials available on provider's library, materials include LAP program and findhelp How-to guide.

d. *Health Literacy, Cultural Competency and Health Equity*

- a. English material review completed for a total of 31 materials.
- b. Completed Health Literacy Toolkit in Q2.
- c. Hosted two Readability and EMR Database trainings.
- d. National Health Literacy Month on track to complete in Q4.
- e. Hosted 2 plain language trainings for staff with 7 attendees.
- f. LAP and the use of plain language training for providers to be on track for Q4.
- g. Cultural Competency (344 attendees) and Implicit Bias (no attendees) Training for providers completed in Q1 and staff training is on track to complete in Q4.
- h. W30-6+ Project: 23 (15.54%) members self-reported taking their babies to their IWC visit. CDC's Milestone Tracker App scan for BIH members: 50 Apple Store, 28 Google Play. Members incentives up to June 2025 includes 287 \$25 gift cards and 36 gift baskets.
- i. SUD/MH Project: Interventions included using Smart Phrases to capture provider (SAMC) notification, included Resiliency Center as a partnered CBO, and trained providers on serving the Latino/Hispanic members.

e. *CalViva Health Equity*

- a. DEI training is on track to be completed by the end of the year.
- b. Collaborated with Fresno Superintendent Schools and Cradle to Career in Fresno Network Improvement Committee, 89% (32) of the total identified students were tested and are reading at grade level.
- c. Stakeholders such as Kings County Public Health and Behavior Health, Pear Suite- Valley Voices, Kings Community Action Organization (KCAO) and CVH developed a flyer, survey, and pre-screening assessment and will launch the Perimenopause and Menopause Awareness Campaign on September 1. KCAO will host the first focus groups at their facility in early October.

Analysis/Findings/Outcomes:

All activities are on target to be completed by the end of the year with some already completed. The Health Equity Department will continue to implement, monitor, and track C&L related services and activities.

Next Steps:

Continue to implement the remaining six months of the Health Equity 2025 CalViva Health Work Plan and report to the QI/UM Committee.



2025 Health Equity Mid-Year Work Plan

Submitted by:

Patrick Marabella, MD, Chief Medical Officer

Amy Schneider, RN, BSN, Senior Director Medical Management

Mission:

CalViva Health's Health Equity mission is to be an industry leader in ensuring health equity for all members and their communities.

Goals:

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:

1. To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
2. To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
3. To advance and sustain cultural and linguistic innovations.

Objectives:

To meet these goals, the following objectives have been developed:

- A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).
- B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.
- C. To be champions of cultural and linguistic services in the communities CalViva Health serves.
- D. To promote and be champions for diversity of CalViva Health members, providers and Plan staff.

Selection of the Cultural and Linguistics Activities and Projects:

The Cultural and Linguistics Work Plan activities and projects are selected based on the results from the CalViva 2022 Population Needs Assessment Report (PNA) (i.e., demographics, health status, risk factors, and surveys), regulatory requirements, department evaluation report from the previous year, HEDIS results, contractual requirements, and strategic corporate goals and objectives. After review and input from senior management staff, projects and new departmental activities are identified and incorporated into this work plan. Programs and services are developed with special attention to the cultural and linguistic needs of our membership. This work plan addresses the needs of our Medi-Cal (MC) members.

Strategies:

The Health Equity Work Plan supports and maintains excellence in the cultural and linguistics activities through the following strategies:

- A. Goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities;
- B. Work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements;
- C. Support information-gathering and addressing needs through Population Needs Assessment (PNA), data analysis, and participation in the CalViva Health Public Policy Committee (PPC);
- D. Interacting with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The Health Equity Work plan is divided into the following areas in support of the Principal CLAS Standard (To provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs): 1) Language Assistance Program Activities, 2) Compliance Monitoring, 3) Communication, Training and Education and 4) Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity.

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	Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/25 - 6/30/25)	Year-End Update (7/1/25 - 12/31/25)
	Language Assistance Program Activities					
1	Rationale	The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members. ¹				
2	Responsible Staff:	Primary: P. Lee, I. Diaz	Secondary: D. Fang, L. Espinoza			
3	Audit	Assure Health Equity/C&L audit readiness to support DMHC and DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: review of TAG to identify risk areas, collecting requested documentation, submitting documents to regulator as requested, preparing all supporting documents for on-site visit by regulator, fill out DHCS C&L questionnaire Conduct internal audit to ensure compliance with Medi-Cal and LAP requirements (ensure systems are capturing provider and office language capabilities per SB137 for HN)	Vary by year	4 audits completed: CalViva Behavioral Health Oversight CalViva Health Equity Oversight CalViva QM Oversight CalViva DHCS	
4	Contracted Vendors	Conduct language assistance vendor management oversight. Review and update vendor contracts to ensure alignment with requirements; participate in vendor oversight calls; align and submit reports as needed. Ensure risk assessments are completed, annually.	Number of vendor contracts updated or amended; date of JOC meetings; number of risk assessment completed	Ongoing	Amended contracts to include TGI and DEI trainings for 3 vendors. Updated rates for 1 vendor. Renew contracts for 1 vendor. Completed annual risk assessment for 11 vendors.	

5	Data	Collect and conduct analysis of language utilization and demographic data to identify emerging language needs and threshold languages.	Updated LAP utilization report to contain: monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log. Production of report showing emerging language need and threshold languages.	Semi-annual	Ongoing; data received and input on a monthly basis. Data used to analyze findings for LAP reports.	
6	Operational	Document emerging and threshold language for fiscal year and deploy process and timeline for incorporation of languages into member materials. Specifically identify whether new languages meet threshold criteria and write on document that threshold analysis was completed.	Documentation of notification to impacted departments; documented process and timeline for incorporation of emerging and threshold languages	March	Completed in March. Ongoing deliverables for 8/1 (Q3) implementation date.	
7	Data	Conduct membership data pulls. Facilitate alignment and collection of demographic data. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly	Ongoing; data received and input on a monthly basis.	
8	Operational	Gather and upload reports to the Member Preferred Written Format SharePoint site. Upload files to Unified Member View (UMV) through the PREFAPI Wrapper Tool.	Weekly reports posted on SharePoint site. Monthly upload to UMV.	Weekly	These reports were uploaded and posted weekly for a total of 25 weeks.	
9	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing	Four criteria were reviewed with the following providers who were audit and their respective compliance rate 29 audits at 97% (Office Mgmt. D_1), 26 audits at 100% (Office Mgmt. D_2), 29 audits at 97% (Format F), and 23 audits at 77% (Format G).	

10	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials.	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint. Also maintain inventory and organization of public and working files.	June and December	Updated tagline to include traditional Chinese	
11	Member Communication	Write/review articles for LAP, Findhelp, Privacy, and other content as needed to assure Cultural and Linguistic appropriateness and to meet NCQA HEA Plus requirements for members' newsletter Annual LAP mailing to survey REAL and SOGI.	The member newsletters are mailed to members once a year for each LOB.	Annual	Newsletters are on track to be mailed to members in Q4.	
12	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified or recertified annually	Annual	52 staff completed a bilingual assessment	
13	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis	Report to summarize utilization of LAP services, number of bilingual staff and provide year over year trends for the utilization of LAP services	Q2 & Q3	2024 EOY Work Plan, 2024 EOY LAP report, 2025 Program Description, 2025 Work Plan were completed accepted by committee in April 2025.	
14	Operational	Coordinate Health Net LAP Oversight operational meetings with Centralized Unit and Behavioral Health.	Quarterly meetings and review of metrics, interpreter and translation issues, grievances discussion, billing and invoice changes and system upgrades	Quarterly	Completed Q1 (1/28/25) and Q2 (4/21/25) quarterly oversight meetings. One additional ad hoc meeting (6/18/25).	

15	Operational	Request interpreter service complaint/exempt grievance logs from call center and conduct trend analysis. Provide complaint information to impacted area for resolution, e.g., vendor, internal process.	Monitor interpreter service vendors through service complaints.	Biannual (trend)	Ongoing collection of logs. On track for trend analysis.	
16	Operational	Coordinate and facilitate quarterly Health Equity Department/LAP meetings to review requirements and department procedures for language and health literacy services	Minutes of meetings	Quarterly	Completed Q1 (3/6/25) and Q2 (6/26/25) meetings. On track for Q3 and Q4.	
17	Operational	Support Population Health Management (PHM) with completing the PNA report every three years in collaboration with Local Health Departments (LHD) and community stakeholders. Support PNA data collection and report writing as well as action plan update. Provide Population Analysis Report with demographic and social needs data for presentation by PHM.	PNA report/updates completed according to DHCS requirements. Submit to compliance for filling. Data provided to PHM. Next PNA Report is in 2025.	May	N/A for Mid-Year.	
18	Access and Availability	Implement activities to meet the 2025 PNA and Geo Access action plans.	Report on PNA and Geo Access action plan activities and metrics	May	N/A for Mid-Year.	
19	Member Experience	Provide consultation and support on reasonable accommodation requests.	Number of reasonable accommodation requests supported	Ongoing	No reasonable requests were received during this timeframe.	
20	Operational	Develop, update and maintain translation, alternate formats, interpreter services, bilingual assessment, and all Health Equity policies and procedures (P&Ps)	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual and as needed	Completed in March. Ongoing revisions for select P&Ps per DHCS feedback through June.	
21	Operational	Collect and review LAP P&Ps from other departments to assure compliance with use of tagline, NDN, translation process and interpreter coordination	P&Ps will be reviewed and placed in Health Equity LAP compliance folder	Annual	N/A for mid-year	
22	Operational	Complete Health Equity Geo Access report including cultural analysis to meet NCQA requirements. To be completed every two years	Data collection and data analysis for Health Equity GeoAccess report.	Q3 2025	Geo Access report is on track to be completed in November 2025.	

23	Operational	Attend workgroup meetings and contribute to solutions for improving Access and Availability, produce annual or quarterly (as needed) and annual TAR reports	Annual TAR report completed and Access and Availability meetings attended	Quarterly/Annually	Completed, presented, and committee accepted report in June 2025.	
24	Operational	Manage the translation review process and resources	Number of translation reviews completed	Ongoing	1 translation reviews requested in Q1 and 6 were received in Q2 of 2025. Translation review requests were completed in Arabic, Hmong, Chinese and Spanish.	
25	Training	Review, update and/or assign LAP online training	Number of staff who are assigned training and percentage of completion	Annual	On track to be completed in Q4.	
26	Operational	Lead IT projects related to language assistance services such as standing request and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories.	Successful implementation of IT projects	Ongoing	Ongoing participation and contributions to REAL/SOGI/DOH Leads meetings.	
27	Operational	Participate in CAHPS Action Plan Meeting with Health Equity to identify potential actions to improve member experience	CAHPS Action Plan Meetings attended and action plan/activities implemented	Quarterly	Completed. CAHPS action plan meeting occurred on 03/31/2025 and in June 2025 to review Q2 findings.	

28	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Monitor strategic partners and specialty plans for compliance with LAP program. Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing	Specialty plan oversight monitoring checklist received in Q2.	
29	Translation and Alternate Format Management	Vital documents management inclusive of annual reminders to dept. managers, confirm placement of vital docs info on TAFT master spreadsheet, request annually from departments which vital documents they produce (including adverse benefit determination notices) and request desktop/policy from departments (when appropriate) on vital document process. Use information obtained from business unit to update the vital document spreadsheet and glossary. Oversee implementation and management of TAFT master spreadsheet.	Master spreadsheet of Vital Documents	Ongoing	Completed collecting updated spreadsheets in Q1.	
30	Compliance and Accreditation	Manage the Health Education material field testing process and resources for the Field Testing Workgroup.	Number of materials field tested completed annually	Ongoing	There were a total of 4 Health Education material field tests completed. There was 1 completed in Q1 and 3 completed in Q2.	
31	Compliance and Accreditation	Provide oversight to translation projects and coordinate ad hoc multi department requests and provide overall coordination support between the vendor and internal departments	Number of materials translated	Ongoing	2 materials coordinated and translated/remediated, this includes taglines and a provider training	
	Compliance Monitoring					

32	Rationale	Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.				
33	Responsible Staff:	Primary: P. Lee, A. Said	Secondary: I. Diaz			
34	Complaints and Grievances	Oversight of complaints received on LAP or C&L services, including monitoring and responding to C&L grievances. Develop and maintain desktop for grievance resolution process. Collect grievance and call center reports. Maintain quarterly contact with the call center to ensure they monitor C&L complaints. Conduct monthly reconciliation meetings with A&G.	Number of grievances, complaints, and interventions.	Quarterly	A total of 15 cases were referred to C&L (14 medical and 1 behavior health). These included 1 Cultural: Non-Discrimination (ND), 9 Cultural: Perceived Discrimination (PD), 5 Linguistic: ND Of all cases, 1 required corrective action and/or provider intervention. Tailored information, tools, and resources were provided to the respective providers through targeted engagement. Reviewed and responded to 5 complaints.	
35	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers to gauge the effectiveness of the LAP program	Production of trend analysis report	August	MY 2024 grievance trend analysis completed in Q2.	
36	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December	Made updates to the grievance desktop in Q2.	

37	Oversight	Complete all CalViva required Health Equity/C&L reports	Develop Health Equity CalViva work plan, write/revise and submit Health Equity CalViva Program Description. Prepare and submit work plan, LAP mid-year and end of year reports	Ongoing	2024 EOY Work Plan, 2024 EOY LAP report, 2025 Program Description, and 2025 Work Plan were completed and accepted by committee in April 2025.	
38	Oversight	Participate in CalViva required work groups and committees	Participate in the ACCESS workgroup, QI/UM workgroup, QI/UM committee, monthly operations management meetings. Provide support for Regional Health Authority meetings as needed or requested.	Ongoing	Attend weekly QI/UM meetings and quarterly Access Workgroup meetings. Attended annual provider visits.	
39	Member Support	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings with presentations and/or materials as needed.	Quarterly	Attended both PPC meetings in March and June. Developed PPT for committee meeting in Q2.	
40	SDoH/Community Resources	Work with Marketing to develop new/rebrand findhelp materials for member and findhelp website, as needed	Rebranding findhelp materials and websites	Ongoing	Completed member flyers. On track to finish member how to guide.	
41	Operational	Collaborate with community and health plan partners on SDoH and social needs support programs, including biweekly meetings with findhelp.	Attend meetings, conduct presentations and support activities	Biweekly As needed	Attended bi-weekly meeting and supported the testing and launch of findhelp Cozeva integration.	

42	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal departments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Update training to align with Cozeva integration by creating an online findhelp course for staff and an on-demand recording for providers. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within Findhelp to address social risks within each month.	Ongoing	Conducted 1 staff training in April where 222 staff members attended. Providers' training is on track to be completed in Q3 and Q4. 136 SNA completed 1,279 referrals 157 closed loops 37 members got help 375 programs were added.	
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43	Collaboration-External	HN collaboration and consultation to external forums such as DHCS HECL workgroup, AHIP health equity workgroup, NCQA expert workgroup on health equity and other SDoH collaborative forums, as needed.	Minutes of meetings that reflect HN consultation and shared learning	Quarterly	Attended collaborative meetings with various stakeholders and workgroups, which includes: San Joaquin, Stanislaus, El Dorado, Alpine Counties DEI Workgroup Central and Imperial Counties DEI Workgroup California Association of Health Plans for TGI training HICE SB923 ad hoc AIDS Healthcare Foundation AHIP Health Equity Workgroup QTI/QAMS Governance Meeting slides/presentation	
	Communication, Training and Education					
44	Rationale	To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.				
45	Responsible Staff:	Primary: P. Lee, S. Rushing	Secondary: L. Espinoza, M. Quan			
46	Training and Support	Train and provide support to A&G on coding and resolution of grievances; re-align coding per 1557 non-discrimination reporting	Development of scripted responses and/or training for A&G associates regarding grievance responses, coding, when to send to Health Equity	Annually	On track for Q3.	

47	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations). Update training deck with specific data slides at mid-year and EOY. Update interpreter and translation quick reference guides with any system updates or process changes and collect the reference guides from the call center.	Create and post to share drive: curriculum, power point, list of participants from Call Center and Provider Relations who attended the in-service. Ensure material is shared with attendees post trainings. Update and collect interpreter and translation quick reference guides with any system updates or process changes	Ongoing	Ongoing; hosted a training in Q1 with no new hires and in Q2 a total of 24 staff received the training.	
48	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing	Ongoing	
49	Provider Communication	Provider Update to cover the following required topics: 1. LAP services 2. Race/ethnicity and language diversity of members 3. Culture and health care topic 4. Promote on-line cultural competence/OMH training 5. Health literacy	Provider Updates distributed and fax/email distribution proof from Marketing	Ongoing	1. LAP Provider Update pending for Q3. 2. LAP Provider Update pending for Q3. 3. Culture and Health Care N/A 4. LAP Provider Update pending for Q3. 5. Health Literacy pending for Q4.	
50	Provider Communication and Training	Promote C&L flyer and provider material about Health Equity Department consultation and resources available, inclusive of LAP program and interpreter services.	Provider material made available on provider's library.	Ongoing	Flyers updated on provider library	
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
51	Rationale	To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.				

52	Responsible Staff:	Primary: A. Kelechian	Secondary: A. Schoepf			
53	English Material Review	Conduct English Material Review (EMR). Include: review content and layout of materials for reading grade level and cultural and linguistic appropriateness.	All EMRs are completed within a 5 business day turnaround as tracked through Workfront. Exception: Content heavy and high-volume requests are completed within 7 business days.	Ongoing	7 EMRs were completed in Q1 and 24 completed in Q2.	
54	Training	Review and update of Health Literacy Toolkit. Implement provider plain language materials and resources through webinars and online platforms when requested.	Production and distribution of toolkit. Distribution of provider plain language resources.	Q3	Toolkit completed in Q2. Providers' materials are scheduled for Q4.	
55	Operational	Review and update Health Literacy materials as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials.	Update and post materials on Health Literacy SharePoint	Ongoing	Materials completed in Q2.	
56	Training	Quarterly training and resources for staff on how to use the C&L database and write in plain language, including online training.	Number of staff trained. Quarterly training and resources production.	Quarterly	7 staff members joined the Q1 training. In Q2, training was not completed because no one registered.	
57	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities completed.	October	On track for Q4.	
	Cultural Competency Training Program					
58	Rationale	To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.				
59	Responsible Staff:	Primary: P. Lee, S. Rushing	Secondary: L. Espinoza, I. Diaz			

60	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) external workgroup. Attend ad hoc/subgroups on training requirements and shared resources (where applicable) per APLs (SB923; DEI)	Minutes of meetings that reflect consultation and shared learning	Ongoing	Participation in HICE C&L Workgroup (and SB923) meetings (1/6; 1/13; 1/21; 2/3; 2/24; 3/10, 3/24; 4/7, 4/22, 5/5, 5/19)	
61	Provider Training	Conduct cultural competency, implicit bias, and gender identity training/workshops for contracted providers and provider groups upon request. Training content to include access to care needs for all members from various cultural and ethnic backgrounds, with limited English proficiency, disabilities, and regardless of their gender, sexual orientation or gender identity (TGI training APL 24-017/SB923). Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented. Work with provider communication to implement ICE for Health computer based training through provider update(s) and/or provider newsletters and/or medical directors, promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates. Work with provider engagement to publish invites for trainings and as warranted create on-demand trainings. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	Output number of providers who received cultural competency training by type of training received. Number of attendees/participants and training evaluation and meeting minutes	Annual	Language Assistance Programs and the Use of Plain Language for Health Literacy (OnDemand 1/1/25) 112 attendees Strengthening Cultural Humility, Dismantling Implicit Bias in the Healthcare Setting (Implicit Bias) (OnDemand 1/1/25) no attendees Special Needs and Cultural Competency (OnDemand 1/1/25) 344 attendees Transgender, Gender Diverse, & Intersex Affirming Care & Equity 1/22/25: 6/30/25 33% of PPGs have attended/completed training 6/30/25 100% of Vendors have attended/completed training	

62	Provider Training	Coordinate with HE team lead SME to track implementation of Language Assistance Programs and the Use of Plain Language for Health Literacy training for providers. Topics: Language Assistance Program, health literacy, plain language communication, health literacy/plan language resources	Number of attendees/participants and training evaluation	Q4	Expecting training in Q4	
63	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles/webinars that educate staff on culture, linguistics and the needs of special populations. Deploy online Cultural Humility and Health Equity training during August's CLAS month celebration.	Attendance record and online tracking. Event summary and activity specific participation totals	Q3	CLAS Month Kickoff meeting took place on June 3rd and 5th 2025, with an additional QI Engagement Committee meeting taking place on 07/17 2025	
64	Accreditation	Obtain NCQA Health Equity Accreditation and HEA Plus	Procurement of Health Equity Accreditation and Health Equity Accreditation Plus and lead collection and preparation of materials during non-renewal years	Ongoing	Assisted in accreditation submissions with document delivery. N/A for HEA Plus in 2025 (in lookback period).	
65	Report	Complete reports for NCQA Health Equity Accreditation and HEA Plus. Reports includes Defining the Community, Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis.	Timely completion of reports. Submitted to NCQA HEA Plus.	Q1	Completed Q1 2025.	
	Health Equity					

66	Rationale	To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.				
67	Responsible Staff:	Primary: P. Lee, D. Fang,	Secondary: A. Schoepf			
68	Operational	Lead quarterly Health Equity Collaborative Workgroup. Workgroup aligns QI, population health, SDoH, cultural competency and disparity initiatives across departments. It is inclusive of reporting out and supporting disparity reduction projects, Health Equity updates and reporting to support NCQA and other regulatory requirements.	Facilitate at a minimum quarterly meetings and intra departmental collaboration on Health disparities. Take minutes and attendance and share out workgroup presentation decks.	Quarterly	Health Equity Collaborative Workgroup 4/21, 7/14 Provide consult for data request from HE Strategic Dept Provide consult for Disability grant	
69	Operational	Implement disparity model for PIP projects (W30-6+) include formative research, community, member and provider interventions. Partner with Fresno Black Infant Health to improve compliance rate among Black infants 0-30 months. By 12/31/2025, use targeted interventions for CalViva Health Black or African American members in Fresno County: 1. To improve the rate of at least six infant well care visits by 15 months of life from a baseline rate of 27.98%* to a goal rate of 38.99%. 2. To improve the rate of three or more infant well care visits within 120 days of life from a baseline rate of 26.60%* to a goal rate of 37.23%.	Development of modules; Support with barrier analysis and interventions to help meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing	Data Reconciliation: 49 Black/African American members engaged BIH enrollment rate of 16.55%. 23 (15.54%) members self-reported taking their babies to their IWC visit. CDC's Milestone Tracker App scan, BIH members: 50 Apple Store, 28 Google Play Member incentives:- up to June 2025 cohort includes 287 gift cards, 36 gift baskets.	

70	Operational	Provide support for SUD/MH non-clinical PIP project. Partner with hospitals to ensure timely notification for providers. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage of provider notifications for members with SUD/MH diagnoses following or within 7 days of an emergency department visit in Fresno and Madera Counties.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Support with barrier analysis and interventions such as cultural competency training. Attend bi-weekly meetings.	Ongoing	Interventions included using Smart Phrases to capture provider (SAMC) notification, referring members to a CBO (Resiliency Center), and training providers on serving the Latino/Hispanic members.	
71	Operational	Provide support for Madera Lean FUA/FUM QMIP project. Partner with local hospitals to improve rates among members' follow up care after 30 days of an emergency visit. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage (from MY2023 9.84% to 24.51% for FUA and 40.59% for FUM) of members who receive follow up services after an ED Visit for SUD/MH diagnoses following or within 7 days of an emergency department visit for Madera County members.	Support with barrier analysis and interventions such as cultural competency training. Development of modules; meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing	Onboarded Camarena Health as a provider to support project. Will use Lanes Data to measure performance.	
72	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project to improve W30-6+ rates. The CVH/CSV IHI Collaborative Team will use targeted interventions to improve the W30-6+ rate at the combined CSV-Elm St. clinics for Hispanic children 0-15 months by 20% (from 41% to 61%) by March 2025.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Attend internal meetings and IHI/DHCS learner bi-weekly calls.	Ongoing	Phase 1 concluded in March, Phase 2 to resume in September. CSV's current rate is 40.24%, (11/27) while for Fresno County overall, the rate is 56.68% (1485/2620).	

73	Operational	Provide consultation to departments on cultural competency and improving health care outcomes (including enrollment) for key demographics and key metrics to support health equity	Consultation and /or trainings provided	Ongoing	Ongoing. Provide consultation in QI POD meetings and disparity project meetings.	
74	Report	Conduct annual disparities analysis for each county.	Conduct disparities analysis for NCQA and DHCS measures by REL and share with internal stakeholders.	Q4	Annual analysis completed and presented in Q1.	
75	Report	Complete Disparity Project Report. Report is inclusive of disparity reduction projects annual write ups. Report is completed annually or bi-annually.	Report for NCQA including annual disparity gap analysis and prioritized opportunities for intervention. Disparity reduction project write-ups demonstrating implementation of member, community and provider level initiatives and evaluation.	Q3	On track to be completed in July.	
76	Responsible Staff:	Primary: S. Xiong-Lopez	Secondary: J. Nkansah			
77	HEQ Project/ Activity	Distribute DEI survey to CVH Leadership, and Staff Members to identify opportunities/ improvement needed surrounding DEI	Survey completed 8/2024 - 61.05% of staff and leadership Disagreed/Strongly Disagreed that CVH took time to celebrate/ acknowledge most celebrated cultures. Goal: Decrease the percentage of staff disagreement (CVH takes time to acknowledge/ celebrate most celebrated cultures) to below 50% by Q3 2025 Implement Cultural celebration and heritage month 2x a year Rearrange settings of staff meeting with ice breakers and team activities to promote inclusiveness.	Annually	On track to be completed in Q4.	
78	HEQ Project/ Activity	Distribute DEI survey to CVH Board, Committee, to identify opportunities/ improvement needed surrounding DEI	Survey Completed- No major concerns as it relates to DEI. Action: Review of CVH Bylaws to account for changes such as equity, inclusion, or cultural humility for governance bodies. Goal: Implementation of new Bylaws to include HEQ initiatives Q3 2024	Annually	On track to be completed in Q4.	

79	HEQ Project/ Activity	Assist and/or serve as consultant with Fresno County Network Improvement Committee Pilot to address leading health indicators focusing on upstream measures such as risk factors and behaviors, rather than disease outcomes (focusing on pregnant moms, families with children ages 0-9)	Data: 39% of the 53 identified students are reading grade level. Identified impact of reading level influenced by, poverty, socioeconomically disadvantage, access to health care. Goal: 100% of the 53 identified students are reading at grade level by 6/2025 Action: Children and families are set up with trained CHW to assist in community navigation. School liaison, Social workers, representative will receive training to become CHW. CBOs, and policy makers to identify strategies to help with SoDH, improve health, wellness and academics outcomes	Ongoing	Closing Activity: In May 2025, data showed that 89% of the total identified students, or 32 students, were tested and are reading at their grade level. **CVH Contribution:** CVH participated in the NIC pilot as a community and strategy partner to identify more effective ways to assist families. They initiated a gathering of 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 Enhanced Case Management, Community Supports, and Community Health Workers (CHWs). The pilot cohort proved to be effective. By providing families with resources to tackle these key challenges, school staff could focus solely on meeting the reading level goals for each student. There were many trials and errors throughout the year. For future initiatives, it would be beneficial for all stakeholders to clearly identify their community partners and define their roles with the schools to ensure better quality support. No new project launches have been identified yet.	
80	HEQ Project/ Activity	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations	Q3	DEI training has been scheduled for all staff December 5, 2025	

81	HEQ Project/ Activity	HE Project Pilot- (Kings County) Focused on perimenopause and menopause in women ages 40-60	Data: Kings County has 4,079 CVH members who identify as a woman between the ages of 40-60. Kings County has a total of 8 providers with specialty in OB/GYN in network with CVH. Of the 8 providers only 4 of have an assessment in place for perimenopause and menopause, however members have to specifically ask for an assessment or have symptoms present. Goal: Bring perimenopause/menopause awareness to women ages 40-60, through health education. Action: A work group has been established in Kings County Q1, 2025 to identify champion provider and group to provide health education and promote awareness by end of Q2.	Q3	The workgroup has identified Pear Suite as the community health worker (CHW) provider to deliver health education for members interested in perimenopause and menopause. Additionally, they will assist in streamlining the referral system for those who meet the criteria for these conditions. The Department of Behavioral Health and Department of Public Health Pear Suite, and CVH, developed a flyer, survey, and pre-screening assessment, and will be launching the Perimenopause and Menopause Awareness Campaign on September 1. Kings Community Action Organization (KCAO) will also be supporting the project by hosting three focus groups at their facility in late September and October.	
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¹ National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^ Indicates revision.

* Indicates new.

Fresno-Kings-Madera Regional Health Authority Commission Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description

David Hodge, MD
Regional Health Authority Commission Chairperson

Date

Patrick Marabella, MD, Chief Medical Officer
Chair, CalViva Health QI/UM Committee

Date

Item #8

Attachment 8.A

2025 Quality Improvement Health Equity
Transformation Program



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**QUALITY IMPROVEMENT AND
HEALTH EQUITY
TRANSFORMATION PROGRAM (QIHETP)**

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1.0 **Executive Summary**

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera in California. Under California's Medi-Cal Managed care program, the RHA dba CalViva Health is designated as the Local Initiative. CalViva Health is contracting with Health Net Community Solutions (HNCS) to provide cultural and linguistic services and programs for CalViva Health membership. CalViva Health ("CalViva" or "Plan") may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva Health. CalViva Health, in collaboration with HNCS, is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, provider networks, and CalViva Health and HNCS.

The HNCS Health Equity Department, on behalf of CalViva Health, develops programs and services to facilitate understanding, communication and cultural responsiveness between members, providers, and Plan staff. The Quality Improvement Utilization Management Committee (QIUMC) reviews and adopts these programs.

CalViva Health is committed to developing and implementing a comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions.

2.0 **Staff Resources and Accountability**

2.1 Quality Improvement (QI) and Health Equity Governance Structure.

The CalViva Health Quality Improvement Utilization Management Committee (QIUMC) has responsibility for the Quality Improvement and the Health Equity Transformation activities of CalViva Health according to the responsibilities given to them by the Regional Health Authority Commissioners. This responsibility includes reviewing, analyzing, evaluating, and acting on the results of QI and Health Equity activities and ensuring appropriate follow-up on performance deficiencies and gaps in care. The QIUMC is chaired by the Chief Medical ~~Officer~~Officer, and the CalViva Health Equity Officer is a member of the QIUM Committee in an advisory capacity. The UM Committee meets seven times per year. External practitioners from Primary Care and a variety of specialties reflecting an appropriate geographic and specialty mix participate on this committee including a Behavioral Health provider, along with representatives from Compliance and Medical Management which includes Utilization Management, Care Management, and Quality Improvement.

2.2 QIUMC oversight activities include but are not limited to:

- Annually assess Utilization Management (UM), QI, and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program at the regional and/or county level.
- Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities.
- Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP), including QI/UM participation in informing the

Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan.

- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
- Institute actions to address performance deficiencies, including policy recommendations.
- Ensure follow-up of identified performance deficiencies or gaps in care.
- Shall provide input and advice on a non-exclusive list of topics including Population Health Management; Coordination of Care Clinical quality of physical and behavioral health care; Access to primary and specialty health care providers and services; member experience with respect to clinical quality, access, and availability, culturally and linguistically competent health care and services, and continuity and coordination of care.

2.3 CalViva Health has enhanced the Quality Improvement and Utilization Management Committee to support health equity projects and collaboration across the Plan.

- As part of the Committee support, the QIUM Work Group will meet weekly to prepare and drive content for the upstream Committee. This supports a focused and meaningful discussion for decision making.
- The CalViva Health Equity Officer will consolidate the data & recommendations received from QIUM Work Group, Public Policy Committee (PPC), Community Advisory Groups (CAGs) and the PHM annual assessment and recommend strategies and interventions that will inspire actionable recommendations and discussions at the QIUM Committee.
- Key outcomes include identification of discussion topics or decision points for discussion during the QIUM Committee, informing or engaging social & community partners, and implementing with or evaluating the success of local partners, for example Community Advisory Groups (CAGs) and targeted projects or pilots.

3.0 MISSION, GOALS AND OBJECTIVES

3.1 Mission

CalViva Health's Health Equity mission is to:

- Improve structural determinants of health equity, by working within and across societal institutions and systems.
- Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities.
- Improve institutional drivers of health equity, by working within our institution, ~~all-~~ **lines of business**, with providers, and with other key stakeholders.
- Improve individual & household-level social needs & networks, by improving

access, quality, and value of services for our members.

3.2 Goals

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:

- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services for members and providers.
- To promote and support active participation of our members and potential members in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

3.3 Objectives

To meet these goals, the following objectives have been developed:

- CalViva Health's QIHETP will monitor, evaluate, and require timely action to address necessary improvement in the quality of care delivered and to improve upon health equity and address health disparities. The QIHETP will be accomplished and maintained through cross-functional participation, engagement, and prioritization, and through a collaborative governance structure.

4.0 Program Activities

4.1 Quality Improvement Activities

- A. CalViva Health annually assesses the overall effectiveness of its Quality Improvement (QI) Program at improving clinical and service practices. Interventions are monitored through the QI Work Plan and an annual evaluation is provided to measure the effectiveness of the Quality Program.
- B. The Quality Improvement Work Plan includes eight categories to determine CalViva Health's success in achieving specified goals. The plan calculates the number and percentage of activities completed and objectives met per category and outlines performance against goals. Categories include:
 1. Behavioral Health
 2. Chronic Conditions
 3. Pharmacy & Related Measures
 4. Member Engagement and Experience

-
5. Hospital Quality/ Patient Safety
 6. Pediatric/ Perinatal/ Dental
 7. Preventive Health
 8. Provider Engagement/ Communication

- C. Quality goals vary according to regulatory and accreditation standards which can change annually. [See Annual and Mid-Year Quality Improvement, Health Education and Wellness Work Plan and Work Plan Evaluations.](#)

4.2 Health Equity Activities

- A. The Health Equity Department provides an annual overview of activities, achievements, and barriers. All activities described in the Year End Report are reflective of our commitment to providing culturally competent services to our membership. The Department presents and requires approval of the Program Description, Year End Report, Work Plan, and biannual Work Plan Evaluations.
- B. The Health Equity Work Plan is divided into **6 content areas**. Each workplan activity is assigned a lead and support. These are aligned with the subject matter experts. The activities are tracked with mid-year and year-end updates to discuss at the QIUMC biannually.
1. [Language Assistance Program Activities](#)
 2. [Compliance Monitoring](#)
 3. [Communication, Training, and Education](#)
 4. [Health Literacy](#)
 5. [Cultural Competency](#)
 6. [Health Equity](#)
- ~~Content area 1 outlines activities and deliverables related to Language Assistance Services~~
- ~~• Content area 2 outlines activities and deliverables related to Compliance Monitoring~~
 - ~~• Content area 3 outlines activities and deliverables related to Communication, Training, and Education~~
 - ~~• Content area 4 outlines activities and deliverables related to Health Literacy~~
 - ~~• Content area 5 outlines activities and deliverables related to Cultural Competency~~
 - ~~• Content area 6 outlines activities and deliverables related to Health Equity.~~

4.3 Population Health Management Activities

- A. Annually, CalViva Health evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. CalViva examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records (EHRs), data from health plan UM and/or CM programs, and advanced data sources such as claims databases or regional health information.

-
- B. Evaluation is conducted based on the characteristics and needs of the member population (including social determinants of health), health status and health risks broken down by ages birth to 65 and over and needs of child members with Special Health Care Needs (SHCN), disabilities, and severe and persistent mental illness. Data is analyzed to determine changes to the PHM programs or resources. Modifications to program design and resources are made based on findings.
 - C. CalViva Health obtained Health Plan Accreditation (HPA) with the National Committee for Quality Assurance (NCQA) in May 2024 to ensure PHM standards are maintained.

5.0 Delegated Subcontractors & Downstream Delegated Subcontractors

- A. CalViva Health delegates utilization management, credentialing, case management and complex care management, claims processing and payment to Health Net Community Solutions, an NCQA accredited organization, who may sub-delegate these functions to designated practitioners, provider groups, contracted vendors or ancillary organizations. Comprehensive delegation policies and processes have been established to address oversight of these entities.
- B. Annually, delegated organizations must demonstrate the willingness, capability, proficiency and experience to manage the delegated responsibilities. The Plan will institute corrective action and/or may revoke delegation when it determines the delegate is unable or unwilling to carry out the delegated responsibilities.
- C. Delegates that are certified or NCQA accredited are not required to undergo an annual on-site review for elements included in the accreditation; however, the Plan will conduct reviews for all other elements not included in the NCQA accreditation.

5.1 External Quality Review (EQR) Technical Report

- A. CalViva Health follows the PIP approach as provided by the Department of Health Care Services (DHCS) and its designated External Quality Review Organization (EQRO).
- B. CalViva Health's EQRO is Health Services Advisory Group (HSAG).
- B-C. Annually CalViva conducts an analysis of actions taken to address recommendations provided in the annual External Quality Review (EQR) technical report and based upon the results of this analysis identifies priorities and plans for future opportunities and areas for improvement.

6. Delivery of Services and Quality of Care Analysis

- A. CalViva Health leadership and the QIUMC is charged with monitoring the health equity activities, medical management, and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions.

B. The Quality Program impacts the following:

- CalViva Health Members in all demographic groups and in all counties for which CalViva Health is licensed.
- Network Providers include practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- Aspects of Care including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by CalViva Health.
- Health Disparities by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- Communication to meet the cultural and linguistic needs of all members.
- Behavioral Health Aspects of Care integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- Practitioner/Provider Performance relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- Services Covered by CalViva Health including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), [Subacute Long-Term Care, Intermediate Care Facilities for Members with Developmental Disabilities](#), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS), and Multi-purpose Senior Services Program (MSSP) that meets the special, cultural and linguistic, complex or chronic needs of all members.
- Internal Administrative Processes which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

C. Encounter Data

- Provider Engagement and Provider Performance & Analytics departments provide oversight and capabilities in support of improving and maintaining performance with providers and their membership. Collaboration between the departments involves the Provider Relations, Practice Transformation, Encounters, RAF, and Data Analytics and Solutions teams.

-
- Encounter data is integrated in the Operational Data Warehouse (ODW) and TruCare. Data collection improvement projects include deploying contracts with health information exchanges and vendors that receive or process claims, encounters, member demographics or clinical data to improve efficiency of operations.
 - The data is utilized for Incentive Programs for Providers and the PHM program. Finally, encounter data is used to prioritize interventions along the strategic tracks, under Data, Analytics, & Technology.

C.D. Grievances and Appeals

- The Appeals & Grievances (A&G) Department will regularly conduct aggregate analysis of appeals and grievances to track and trend potential issues and barriers to care. The QIUMC will annually review appeals and grievances system policies and procedures.
- CalViva Health leadership will monitor compliance with regulations, policies and procedures as well as conduct analysis to track potential issues and barriers to care.
- The system will allow monitoring of appeals and grievances to include the number received, pending and resolved for all levels of the system, disposition of resolution in favor of the member or Plan, number of cases pending over 30 calendar days, and member by eligibility category.
- An analysis of the Grievance System will be included in the annual QI Program Evaluation. The QI Program shall define that the monitoring and tracking of the grievance submitted is reported to an appropriate level (i.e.: medical vs. care delivery issues). The QI Program shall monitor outcomes that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance or an appeal that involves clinical issues shall be resolved by an appropriate clinical health care professional.
- The Appeals and Grievances Department works with the Credentialing and the Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recertified every three years. All practitioners and providers are monitored monthly for Medicare/Medicaid sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions.
- The Peer Review Committee (PRC) is an independent review body established to achieve an effective mechanism for continuous review and evaluation of the quality of care and service delivered to enrollees. This includes monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies, deliberating corrective actions, and when

necessary, initiating remedial actions with follow up monitoring. The overall goal is to ensure that CalViva Health members receive comparable appropriate quality of care and services.

- Analysis and evaluation of results of focused audits, studies, quality of care and safety issues and quality of service issues are presented to the QIUMC.

~~D.E.~~ D.E. Utilization Review

- The Utilization Management (UM) program involves pre-service, concurrent and post-service evaluation of the utilization of services provided to members and management of member appeals.
- The UM program requires cooperative participation of practitioners, delegates, hospitals and other providers to ensure a timely, effective and medically sound program. The program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence of the Plan's management or concerns for the plan's fiscal performance.

~~E.F.~~ E.F. Consumer Satisfaction Surveys

- CalViva Health continuously monitors member experience throughout the year using the CAHPS survey results, and monitoring member pain points including member appeals and grievances, and Call Center drivers.
- CAHPS goals are ~~based on~~ aligned with contributions to the Quality Rating Programs. ~~The goal for Medi-Cal CalViva, the objective is to achieve is-~~ year-over-year improvement, aiming to meet or exceed -with a target goal of- the 25th percentile Quality Compass percentile benchmark.

7. Equity-Focused Interventions

7.1 Health Equity Model

- Disparity reduction efforts are implemented through a model that integrates departments across Quality Improvement, Provider Engagement, Health Equity, Community Engagement, Health Education, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach and media, provider interventions and system level initiatives. The following highlights the core components of the disparity reduction model:
- Planning inclusive of key informant interviews, focus groups, literature reviews and data analysis (spatial and descriptive).
- The Health Disparity model gives the Plan a unique ability to understand target population(s) and implement tailored disparity reductions efforts to improve the quality of health care. Race/ethnicity, language, gender identity, and sexual orientation are analyzed to develop targets for disparity reduction

efforts and specific interventions to address the disparities and the barriers associated with that.

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- The CAHPS Survey is deployed annually for CalViva to fulfill accreditation and regulatory requirements.
- The survey ~~requests-asks~~ members ~~for~~ feedback on ~~their~~ health plan (call center, claims), ~~as well as their experience with~~ providers (doctor communication, access, care coordination), ~~and It also includes~~ overall rating of health plan and health care quality. Supplemental questions may be added to ~~gain additional insights around the better understand member - experiences, such as with the health plan including (but not limited to)~~ interpreter services, call center ~~drivers~~interactions, ~~and~~ access ~~standards to~~ care.
- Due to the anonymous nature of the survey, the CAHPS Program Managers conduct a quarterly root cause analysis of member pain points by reviewing grievances, appeals, and call center data.
- The Health Equity ~~Department~~ and the CAHPS ~~Department teams hold have~~ ~~established a bi-monthly~~quarterly meetings to review results, identify areas ~~of opportunity for improvement~~, and discuss a ~~joint shared a~~Action pPlan. These ~~Health Equity CAHPS~~ meetings ~~include a breakdown of review-~~CAHPS results ~~and stratification of the results~~ by race/ethnicity, sex assigned at birth (gender), age, and other ~~member characteristics~~demographics. This ~~review analysis~~ is based on self-reported member data.

B. Performance Improvement Projects (PIPs)

- CalViva Health's overall aim is to provide equitable, high-quality care services to its culturally and linguistically diverse population no matter the individual's personal characteristics. The purpose of the organization's HE program is to reduce health care inequities and disparities by implementing interventions for identified individuals who are likely to experience or are experiencing obstacles to health care services due to their race/ethnicity, language preference, gender identity, and/or sexual orientation.
- By working to eliminate bias and discrimination within communities and the healthcare industry, the goal is to improve care.
- Performance Improvement Projects (PIPs) are two-year projects required of each Medi-Cal health plan by the California Department of Health Care Services (DHCS). DHCS requires two PIPs of each health plan during the two-year PIP process. Health Plans may ~~be assigned a PIP topic by DHCS~~ ~~or~~ choose their PIP topic from the categories provided by DHCS.
- The plan follows the PIP approach as provided by the Department of Health Care Services (DHCS) and its designated External Quality Review Organization (EQRO). This approach guides the Plan through a process for

conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. The EQRO provides technical assistance throughout the process with frequent contact and feedback to ensure that PIP projects are well-designed at the onset and provide opportunities for mid-course corrections.

- Summary of progress and outcomes of PIP's are reported to the QIUMC. A summary of each PIP is also documented in the Annual QI Program Evaluation. Upon completion of each PIP, the EQRO provides a confidence level on the validity and reliability of the results.

C.G. Population Needs Assessment (PNA)

- Under the PHM Program, CalViva will fulfill the PNA requirement by meaningfully participating in the Community Health Assessments (CHAs)/ and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs).
- As part of Health Plan Accreditation, CalViva will continue to develop a "PHM Strategy" describing how CalViva meets the needs of our members over the continuum of care. To inform the PHM Strategy for NCQA, CalViva will annually complete an assessment of member needs and characteristics, including identification of subpopulations based on characteristics and needs.
- The Health Education and Health Equity Departments conduct a Population Needs Assessment (PNA) every three years to improve health outcomes for members. The PNA is conducted through an analysis of CAHPS survey data and follows the DHCS guidance provided in APL 23-021-]
- Participants in CalViva Health's Public Policy Committee (PPC) provide input to the PNA and review the PNA results.
- The results of the PNA are used to identify C&L/health equity program strategies to improve health outcomes and to reduce health disparities.
- CalViva will work with other MCPs in the region to develop a unified planning process, including staffing, funding, data sharing, and communications with the LHJs.
- CalViva will share the data agreed upon with the LHJs and Plan partners in a timely manner.
- As part of meaningful participation in LHJs' CHAs/CHIPs, CalViva will contribute resources to support LHJs' CHAs/CHIPs in the form of funding and/or in-kind staffing.
- In addition, CalViva will continue involvement in Community Reinvestment as appropriate.
- CalViva will publish the CHA/CHIP on our public-facing website with a brief paragraph on how CalViva meaningfully participated.
- CalViva will submit our annual DHCS PHM Strategy Deliverable using the DHCS template.

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- ~~• The Health Equity work plan is adjusted to include all strategies that have been identified to improve health outcomes and reduce health disparities for members. The Health Equity work plan serves as the PNA action plan that is submitted to DHCS.~~

8. Engagement Strategy

A. CalViva Health has a policy to provide CalViva Health ~~associates~~ staff with guidelines in developing health equity practices and engagement of members, their family members, and communities. CalViva Health is committed to supporting the health of our members and promoting the reduction of health disparities across our membership. To accomplish this, Health Equity collaborates across departments and with external partners in order to analyze, design, implement and evaluate health disparity interventions.

B. Public Policy Committee (PPC)

- Information provided by the PPC participants is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for CalViva to understand that perception, experience and satisfaction of services.
- As part of their involvement, the group's focus is to serve meaningful community and consumer advisory functions that includes taking part in identifying and prioritizing CLAS opportunities for improvement, as well as identifying and prioritizing social risks and needs of individuals for the program to address.
- CalViva will engage the PPC as part of our participation in the LHJ's LHJ's CHA/CHIP process. CalViva will regularly report on our involvement in the findings from LHJ's CHAs/CHIPs to the PPC and obtain input/advice from the PPC on how to use findings from the CHAs/CHIPs to influence CalViva's strategies and workstreams related to the Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- ~~• The PPC also reviews the Population Needs Assessment. Through this review and feedback process, the PPC members are able to provide their views and preferences for our strategies and projects. Feedback is incorporated into the project plans and cultural and linguistic services programs. Additional PPC and PNA process details are in Public Program and Health Education P&Ps, respectively.~~

C. Member & Family Engagement

- The Health Equity department completes community assessments that include key informant interviews and focus groups. The community assessments identify community, member, and provider level barriers that contribute to identified disparities.

- Community assessments are completed by inviting members, their family members, and caregivers to participate in focus groups and/or key informant interviews. Feedback from members and their family is used to design interventions to address disparities.

D. Community-Based Organizations

- CalViva Health draws data from community and individual social needs and risks ~~data~~ to determine partnerships with community partners. Engaging with partner organizations that share ~~in~~ the same goal to reduce the negative effects of social risks and improve outcomes for individuals within communities provides more effective ways to address social needs. Cross ~~-~~ collaboration is mutually beneficial and enables partners to support each other in providing resources and interventions.
- CalViva Health and the Health Equity Department are active in the community through participation in local community workgroups and collaboratives, and other CBO activities.
- Creating and maintaining a community network allows for input and guidance on member services and programs and assures that the Health Equity work reflects the needs of CalViva Health members. Social needs and social risks all play into determining the appropriate partners, selecting and engaging in initiatives with community-based organizations.

9. Communication and Ongoing Commitment

A. CalViva Health has obtained NCQA's Health Plan Accreditation and ~~is committed to obtaining~~ Health Equity Accreditation ~~by 2026~~.

- CalViva Health will be able to provide annual copies of Accreditation status, survey type, and level (as applicable).
- CalViva Health will share results, recommended actions, and any Corrective Action Plans (as applicable).
- CalViva Health will share expiration date of accreditation.

B. As applicable, CalViva Health will develop and submit to DHCS a QI and Health Equity plan annually which will include the following:

- A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions identified through activities in Section 2. Quality Improvement Activities, above.
- A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities and actions to address deficiencies identified through activities in Section 5. Fully Delegated Subcontractors & Downstream Fully Delegated Subcontractors, above.
- An analysis of actions taken to address any Contractor-specific recommendations in the ERQ Technical Report and CalViva Health's

specific evaluation reports identified through activities in Section 6. External Quality Review (EQR) Technical Report, above.

- An analysis of the delivery of services and quality of care of CalViva Health and its fully delegated subcontractor, based on data from a variety of sources included, but not limited to, those outlined in Section 7. Equity-focused Interventions, above.
- Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services.
- A description of CalViva Health's commitment to member and/or family focused care through the activities outlined in Section 9. Engagement Strategy, above, and how CalViva Health utilizes this information from this engagement to inform CalViva Health policies and decision making.
- PHM activities and findings as outlined in CalViva Health's contract with DHCS which will be derived from activities in Section 4. Population Health Management Activities, above; and
- Outcomes and findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

C. CalViva Health is committed to making the QI and Health Equity plan publicly available on its website on an annual basis. CalViva Health will also publicly post the DHCS-approved NSMHS Member and PCP Outreach & Education Plan on an annual basis.

STAFF RESOURCES AND ACCOUNTABILITY

1. CalViva Health Committees

A. Governing Body/RHA Commission

The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of CalViva Health.

B. QI/UM Committee

The QI/UM Committee monitors the quality and safety of care and services rendered to CalViva Health members. This Committee identifies opportunities for improvement, recommends policy decisions, evaluates the results of activities, institutes needed actions, and ensures follow-up as appropriate. The Health Equity program description, work plan, language assistance utilization report and end of year reports are all submitted to the CalViva Health QI/UM committee for review and approval. The QI/UM committee provides regular reports to the RHA Commission.

C. Public Policy Committee

The Public Policy Committee includes CalViva Health members, member advocates (supporters), an RHA Commissioner, and a health care provider. Committee responsibilities include obtaining feedback and guidance in the delivery of culturally and linguistically appropriate health care services and establishing and maintaining community linkages. The Health Equity program description, work plan, language assistance utilization report and end of year reports are shared as information to the Public Policy Committee. The Public Policy Committee provides regular reports to the QI/UM Committee and the RHA Commission.

2. CalViva Health Staff Roles and Responsibilities

A. Chief Medical Officer

CalViva Health's Chief Medical Officer's responsibilities include assuring that CalViva Health's programs are compatible and interface appropriately with the provider network_

and the overall scope of CalViva Health's QI program. A medical management team is under the direction of the Chief Medical Officer.

B. Chief Compliance Officer

CalViva Health's Chief Compliance Officer's responsibilities include assuring that CalViva Health's programs are compliant with the DHCS contract, regulatory standards and reporting requirements. A compliance team is under the direction of the Chief Compliance Officer.

C. Health Equity Officer

CalViva's Health's Health Equity Officer reports to the Chief Executive Officer and is responsible for providing leadership and health equity services across the organization.

3. HNCS Health Equity Department Staff Roles and Responsibilities

The Health Equity Department is unique in its cross-functional support structure. The Department's function is to fulfill all cultural and linguistic contractual and regulatory requirements and serve as a resource and support for all health equity and C&L services. The Health Equity Department is staffed by the Director of Program Accreditation, a Manager of Health Equity Department, a Program Manager III, five Senior Health Equity Specialists, ~~one~~ two Health Equity Specialists, ~~a Project Coordinator II~~, and one supplemental staff.

A. HNCS Leadership Team

HNCS is a subsidiary of Health Net LLC. Through a dedicated and qualified staff, important cultural and linguistic services are developed and coordinated within the CalViva Health service area by HNCS. HNCS, as a subsidiary of Health Net LLC., continues to maintain their internal reporting responsibilities (e.g. Chief Executive Officer (CEO), Vice Presidents, Officers, Directors, etc.) however, activities conducted within the CalViva Health service area are subject to oversight by CalViva Health's staff and respective committees.

The Chief Health Equity Officer, under the Chief Medical Officer, is responsible for providing leadership in Health Equity efforts across the organization. Under the Chief Health Equity Officer, the Health Equity Department contributes to planning the program structure for Health Net. The Chief Health Equity Officer ensures the plan's health equity structure is aligned with Corporate and other state plans, as appropriate.

A. Fresno-Kings-Madera Regional Health Authority Commission Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Program Description



~~October 17, 2024~~

David Hodge, MD

Date

Regional Health Authority Commission Chairperson



~~October 17, 2024~~

Patrick Marabella, MD, Chief Medical Officer

Date

Chair, CalViva Health QI/UM Committee

Item #9

Attachment 9.A

Skilled Nursing Facility Quality Assurance
Performance Improvement Dashboard
Report Q2 2025



REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners
CalViva Health QI/UM Committee

FROM: Patrick C. Marabella, MD Chief Medical Officer
Amy R. Schneider, RN Senior Director Medical Management

COMMITTEE DATE: October 16, 2025

SUBJECT: Skilled Nursing Facility (SNF) Quality Assurance Performance Improvement (QAPI) Program – Q2 2025 Summary Report

Summary:

Skilled Nursing Facilities (SNFs) in CalViva Health region perform better than the state and national averages on avoidable trips to the emergency department and in-patient readmissions. SNFs in CalViva Health region have lower state enforcement actions and have lower than the state average rates of UTIs. SNFs in the CalViva Health region have higher rates than the state average of Falls and Use of Anti-Psychotic Medications.

There are 36 licensed SNFs in the CalViva Health designated service area. In the last 12 months, CalViva Health Members admitted to 90 different nursing homes statewide.

Table 1 – Long Term Care Unique Member Utilization by County: 2025

	Jan	Feb	March	April	May	June	July	August
Fresno	870	844	825	806	825	819	822	826
Kings	104	99	99	101	104	111	108	113
Madera	95	88	100	98	96	93	98	97
Other*	62	58	47	47	47	42	42	41
Total	1,131	1,089	1,071	1,052	1,072	1,065	1,070	1,077

**Other refers to Counties outside the CalViva Health service region*

Table 2 - Top 10 SNFs in CalViva Health Service Region by Unique Member Utilization

SNF	Unique Members	SNF	Unique Members
1. Madera Rehabilitation & Nursing	70	6. Centerpointe Care Center	53
2. Community Subacute	66	7. Hanford Post Acute	52
3. Healthcare Centre of Fresno	60	8. Cornerstone Care Center	50
4. Sunnyside Convalescent	54	9. Fresno Post Acute Care	46
5. Manning Gardens	54	10. Orchard Post Acute	38

Table 3 - The Top 5 Performing SNFs

The top 5 performing SNFs serving CalViva Health members are:

Q1 2025	Q2 2025
1. Selma Convalescent Hospital	1. California Home for the Aged
2. California Home for the Aged	2. Selma Convalescent Hospital
3. Oakwood Gardens Care Center	3. The Terraces
4. Willow Creek Healthcare Center	4. Valley Healthcare Center
5. The Terraces	5. Dycora Transitional Health - Sanger

Table 4 - The Bottom 5 Performing SNFs

Overall, the bottom 5 performing SNFs serving CalViva Health members are:

Q1 2025	Q2 2025
1. Healthcare Centre of Fresno	1. Madera Rehabilitation & Nursing Center
2. Kingsburg Center	2. Manning Gardens Care Center
3. Manning Gardens Care Center	3. Healthcare Centre of Fresno
4. Rolling Hills Care Center	4. Kingsburg Center
5. Madera Rehabilitation & Nursing Center	5. Sunnyside Convalescent Hospital

Avoidable Emergency Department Visits in Q2 2025

In Q2 2025, CalViva had 543 unique members in the top 10 utilizing SNFs, up from 399 in Q1 2025. In Q2 2025, the 543 members had 23 avoidable Emergency Department Visits.

- California Average: 11.1%
- National Average: 12%
- CalViva Health Average: 9.5%

Avoidable Acute In-patient Admissions in Q2 2025

In Q2 2025, CalViva had 543 unique members in the top 10 utilizing SNFs. There were 39 avoidable Acute In-patient admissions during that same time.

- California Average: 22.7%
- National Average: 23.4%
- CalViva Health Average: 18%

On a quarterly basis, this report will be updated to identify and trend quality outcomes and allow for directed referrals to quality SNFs and to identify SNFs for quality improvement.

Purpose of Activity:

The purpose of this report is to provide the CalViva QI/UM Committee with a summary of key quality, regulatory, satisfaction and performance measures for Skilled Nursing Facilities serving CalViva Health Members in Fresno, Kings, Madera and multiple other counties for the purpose of oversight monitoring and identification of opportunities for improvement. Once opportunities for improvement have been identified and addressed, the QI/UM Committee will utilize this report to monitor the success and challenge of improvement activities to ensure goals are met and compliance sustained. The ultimate goal of this report is to improve the overall quality of outcomes and care for CalViva Members.

Methodology

CalViva is responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for the LTC services provided. The Health Plan has a system in place to collect quality assurance and improvement findings from CDPH and CMS, which includes survey deficiency results, citation results, annual certification survey site visits, financial penalties and complaint findings.

CalViva Health's comprehensive QAPI program incorporates the following:

- Claims data for SNF residents, including emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data
- Mechanism to assess the quality and appropriateness of care furnished to Members
- Member community integration
- DHCS, CDPH and CMS efforts to prevent, detect and remediate critical incidents

The QAPI program utilizes internal claims and publically available data from CDPH and CMS to help identify overall quality of care and outcomes in skilled nursing facilities. Metrics used to identify and trend the quality of providers include the following categories:

- Use of Anti-Psychotic Medications
- Rate of Falls with Injury
- Pneumococcal Vaccine Rate
- Pressure Ulcers
- UTI Rates
- Staffing
- Number of State Enforcement Actions
- Infection Control Deficiencies
- Quality of Care Deficiencies
- Freedom from Abuse Deficiencies
- Overall CMS Star Rating
- Preventable Emergency Department Utilization
- Preventable Inpatient Admission to Acute Care

Data/Results (include applicable benchmarks/thresholds – updated quarterly):

Table 5 – Q2 2025 Overall Top Performing SNFs in CalViva Health Region based on a weighted 5-point scale using metrics in Summary

Overall Quality Score - Top Ranked	
Skilled Nursing Facility	Quality Score
California Home for the Aged	4.53
Selma Convalescent Hospital	4.51
The Terraces	4.46
Valley Healthcare Center	4.43
Dycora Transitional Health - Sanger	4.23
North Pointe Healthcare Centre	4.20
Dycora Transitional health - Clovis	4.14
Community Subacute & Transitional Care	4.04
Kings Nursing & Rehabilitation	4.02
Oakwood Gardens Care Center	3.96

Source: Publically available data, claims data

Table 6 – Q2 2025 Overall Bottom Performing SNFs in CalViva Health Region based on a weighted 5-point scale using metrics in Summary

Overall Quality Score - Bottom Ranked	
Skilled Nursing Facility	Quality Score
Coalinga Regional Medical Center D/P	3.14
Sierra Vista Healthcare	3.06
Oakhurst Healthcare Center	2.95
Hanford Post Acute	2.88
Evergreen Care Center	2.88
Sunnyside Convalescent Hospital	2.76
Kingsburg Center	2.63
Healthcare Centre of Fresno	2.44
Manning Gardens Care Center	2.41
Madera Rehabilitation & Nursing Center	2.20

Source: Publically available data, claims data

Table 7 – SNFs with lowest rate of preventable Emergency Department visits per CalViva Health member Q1 2025 compared to Q2 2025

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q1 2025 ER Avoidable	Q2 2025 ER Avoidable
Centerpointe Care Center	53	53	1	0
Brighton Post Acute	45	46	0	0
Willow Creek Healthcare Center	40	38	1	0
Kingsburg Center	37	37	3	0
Kings Healthcare & Wellness Center	26	26	0	0

Source: claims data

Table 8 – SNFs with the highest rate of preventable Emergency Department visits per CalViva Health member Q1 2025 compared to Q2 2025

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q1 2025 ER Avoidable	Q2 2025 ER Avoidable
Manning Gardens Care Center	52	54	8	6
Madera Rehabilitation & Nursing	73	70	4	4
Community Subacute & Transitional	59	66	2	4
Cornerstone Care Center	38	50	0	4
Sierra Vista Healthcare	32	33	2	4

Source: claims data

Table 9 – SNFs with the lowest rate of preventable Acute Inpatient Admissions per CalViva Health member Q1 2025 compared to Q2 2025

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q1 2025 IP Avoidable	Q2 2025 IP Avoidable
Fresno Post Acute Care	46	46	0	0
Palm Village Retirement Center	33	33	1	0
Vineyard Care Center	22	20	1	0
Gateway Care Center	21	19	0	0
GHC of Fresno	3	18	0	0

Source: claims data

Table 10 – SNFs with the highest rate of preventable Acute Inpatient Admissions per CalViva Health member Q1 2025 compared to Q2 2025

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q1 2025 IP Avoidable	Q2 2025 IP Avoidable
Community Subacute & Transitional	59	66	3	8
Manning Gardens Care Center	52	54	16	8
Cornerstone Care Center	38	50	2	5
Healthcare Center of Fresno	52	60	5	4
Oakwood Gardens Care Center	35	37	7	4

Source: claims data

Table 11 – 2024 SNF Workforce Quality Incentive Program (WQIP) Quality Score

SNF Name	SNF Score	Member Days
MANNING GARDENS CARE CENTER, INC.	72.15%	7,597
HORIZON HEALTH & SUBACUTE CENTER	64.39%	12,321
CALIFORNIA HOME FOR THE AGED, INC.	63.36%	11,447
BETHEL LUTHERAN HOME, INC.	60.78%	9,443
FOWLER CARE CENTER	60.10%	7,687
SIERRA VISTA HEALTHCARE	59.75%	9,998
PACIFIC GARDENS NURSING & REHABILITATION	48.86%	12,817
MADERA REHABILITATION & NURSING CENTER	45.01%	13,828
EVERGREEN CARE CENTER	43.83%	6,721
FRESNO POST ACUTE CARE	41.55%	4,514

Source: DHCS Scoring Report

The SNF WQIP scoring system uses a combination of metrics across workforce, clinical quality and equity domains to determine incentive payments for skilled nursing facilities. Facilities are scored based on their performance across all managed care plans they serve, and the scores are aggregated to calculate a per diem incentive amount.

Higher SNF score, calculated by DHCS, results in higher per diem incentive payment for each CalViva Health member day in the SNF.

Analysis/Findings/Outcomes:

The following 3 SNFs have the highest rates of preventable ED utilization and Acute Inpatient Admissions:

- Manning Gardens Care Center (managed by Cambridge Health)
- Madera Rehabilitation & Nursing Center
- Community Subacute & Transitional

Manning Gardens Care Center

Analysis of the publically available data shows this SNF continues to have higher rates than the State average rates of Anti-Psychotic Medication use and Falls. However, they've shown improvement in their rate of UTIs. The SNF is implementing the following to improve their quality outcomes:

- Hydration Rounds – Daily, starting 9/1/25, dedicated staff will monitor availability and consumption of water.
- Pharmacy Education – Anti-Psychotic Utilization education scheduled in Q4.
- Physical Therapy Team making rounds to ensure all Walkers are properly measured – Starting 9/1/25.

Madera Rehabilitation & Nursing Center

Analysis of the publically available data shows this SNF has higher than the State average rates of Anti-Psychotic Medication use and Falls. This SNF has shown improvement in their prevalence of Pressure Ulcers. The Health Plan has shared with Madera Rehabilitation member-level detail for additional investigation and targeted training. The SNF is implementing the following to improve their quality outcomes:

- Staffing challenges prevent SNF from implementing Emergency Department Companion Program in Q3. Will attempt in Q4.
- Pharmacy Education – Anti-Psychotic Utilization education scheduled in Q4.
- Physical Therapy Team making rounds to ensure all Walkers are properly measured – Starting 9/1/25.

Community Subacute & Transitional

Analysis of the publically available data shows this SNF has better than average rates of Fall and Anti-Psychotic Medication use. However, rates of UTI and Pressure Ulcers are higher than the state average, resulting in higher-than-expected emergency department utilization and inpatient admissions. The SNF is implementing the following to improve their quality outcomes:

- Hydration Rounds – Daily, starting 9/1/25, dedicated staff will monitor availability and consumption of water.
- Physical Therapy Team to provide staff caregiver training on safe patient repositioning skills - Starting 9/1/25.

Barrier Analysis:

- Staffing Challenges in Central Valley
 - Multiple SNFs reporting challenges with recruiting and retention of Certified Nursing Assistants – Immigration enforcement in the community caused fear. Immigrant CNAs stopped showing up for work. Additionally, Fresno Adult School and Pacific Health Education have reported a drop in enrollment in their CNA programs. Nursing Homes and their associations are working to develop strategies to train staff for certified nursing assistant positions.
- Unreported Falls – “Nursing Homes Failed to Report 43% of Falls”
 - [Nursing Homes Failed To Report 43 Percent of Falls With Major Injury and Hospitalization Among Their Medicare-Enrolled Residents | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

- MDS 3.0 assessments are used to capture patient changes in conditions. These assessments impact SNF quality ratings, inspections and reimbursement. Publically available data will only capture what is reported by the SNF. Failing to report accurate fall metrics during the assessment will impact our ability to properly capture quality.

Actions Taken/Next Steps:

Manning Gardens

- Education on *Psychotropic Medication Use* for licensed staff to ensure safe and effective treatment, understanding risks, benefits, proper administration and monitoring of side effects. Training will include obtaining informed consent, establishing clear treatment goals, regular monitoring and review, open communication with families, providers and staff, avoiding abrupt discontinuation and recognizing the need for comprehensive mental health care. Scheduled for Q4.

Madera Rehabilitation

- Starting on 9/1, Madera Rehabilitation began to evaluate all walkers and wheelchairs for safety and mobility to reduce falls. To use walkers safely, Physical Therapy staff will ensure they are at the correct height, patients wear proper shoes or non-skid socks and maintain proper posture by keeping arms bent and looking straight ahead. All caregiver staff will receive training by end of Q4, and all new hires will receive training during orientation.

Community Subacute & Transitional

- Ongoing Hydration Rounds, starting 9/1/25. Hydration programs are essential in nursing homes to prevent serious health consequences like falls and infections. Additionally, hydration programs improve resident well-being, cognitive function and physical independence. Regular, targeted fluid intake is crucial because seniors often experience a reduced sense of thirst and may be at higher risk for dehydration due to factors like immobility, fear of incontinence and certain medications. A good hydration program involves identifying risk factors, creating personalized care plans with measurable goals and using various interventions, such as providing fluids with meals, offering water-rich foods and placing drinks in convenient locations.

Item #10

Attachment 10.A

Financials as of August 31, 2025

	Fresno-Kings-Madera Regional Health Authority dba CalViva Health	
	Balance Sheet	
	As of August 31, 2025	
		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	259,560,523.53
5	Total Bank Accounts	\$ 259,560,523.53
6	Accounts Receivable	
7	Accounts Receivable	263,359,774.52
8	Total Accounts Receivable	\$ 263,359,774.52
9	Other Current Assets	
10	Interest Receivable	677,720.37
11	Investments - CDs	0.00
12	Prepaid Expenses	1,499,311.25
13	Security Deposit	0.00
14	Total Other Current Assets	\$ 2,177,031.62
15	Total Current Assets	\$ 525,097,329.67
16	Fixed Assets	
17	Buildings	5,599,905.19
18	Computers & Software	13,999.94
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	109,986.17
22	Total Fixed Assets	\$ 8,885,310.40
23	Other Assets	
24	Investment -Restricted	303,142.48
25	Lease Receivable	1,847,932.49
26	Total Other Assets	\$ 2,151,074.97
27	TOTAL ASSETS	\$ 536,133,715.04
28	LIABILITIES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	81,035.30
33	Accrued Admin Service Fee	4,746,544.00
34	Capitation Payable	128,172,687.77
35	Claims Payable	71,587.70
36	Directed Payment Payable	127,870,640.15
37	Total Accounts Payable	\$ 260,942,494.92
38	Other Current Liabilities	
39	Accrued Expenses	1,234,702.91
40	Accrued Payroll	136,147.96
41	Accrued Vacation Pay	412,240.66
42	Amt Due to DHCS	21,628,399.54
43	IBNR	414,406.37
44	Loan Payable-Current	0.00
45	Premium Tax Payable	0.00
46	Premium Tax Payable to BOE	325,404.28
47	Premium Tax Payable to DHCS	62,791,666.67
48	Total Other Current Liabilities	\$ 86,942,968.39
49	Total Current Liabilities	\$ 347,885,463.31
50	Long-Term Liabilities	
51	Renters' Security Deposit	25,906.79
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	\$ 25,906.79
54	Total Liabilities	347,911,370.10
55	Deferred Inflow of Resources	1,448,331.45
56	Equity	
57	Retained Earnings	184,108,458.37
58	Net Income	2,665,555.12
59	Total Equity	\$ 186,774,013.49
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	\$ 536,133,715.04

	Fresno-Kings-Madera Regional Health Authority dba CalViva Health			
	Budget vs. Actuals: Income Statement			
	July 2025 - August 2025 Income Statement			
		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	1,356,168.42	1,250,000.00	106,168.42
3	Premium/Capitation Income	321,127,201.71	346,251,687.00	(25,124,485.29)
4	Total Income	322,483,370.13	347,501,687.00	(25,018,316.87)
5	Cost of Medical Care			
6	Capitation - Medical Costs	243,793,725.77	207,012,708.00	36,781,017.77
7	Medical Claim Costs	945,253.53	1,100,000.00	(154,746.47)
8	Total Costs of Medical Care	244,738,979.30	208,112,708.00	36,626,271.30
9	Gross Margin	77,744,390.83	139,388,979.00	(61,644,588.17)
10	Expenses			
11	Admin Service Agreement Fees	9,532,259.00	9,130,704.00	401,555.00
12	Bank Charges	0.00	1,200.00	(1,200.00)
13	Computer & IT Services	44,211.38	45,186.00	(974.62)
14	Consulting & Accreditation Fees	5,460.00	90,830.00	(85,370.00)
15	Depreciation Expense	57,012.04	62,000.00	(4,987.96)
16	Dues & Subscriptions	42,559.54	54,000.00	(11,440.46)
17	Grants	1,527,335.35	1,529,820.00	(2,484.65)
18	Insurance	63,509.95	80,973.00	(17,463.05)
19	Labor	671,530.19	839,858.00	(168,327.81)
20	Legal & Professional Fees	27,481.97	62,420.00	(34,938.03)
21	License Expense	214,521.14	296,808.00	(82,286.86)
22	Marketing	180,181.68	250,000.00	(69,818.32)
23	Meals and Entertainment	1,377.31	3,600.00	(2,222.69)
24	Office Expenses	15,349.94	20,830.00	(5,480.06)
25	Parking	20.00	260.00	(240.00)
26	Postage & Delivery	481.90	820.00	(338.10)
27	Printing & Reproduction	0.00	920.00	(920.00)
28	Recruitment Expense	222.06	28,750.00	(28,527.94)
29	Rent	0.00	2,000.00	(2,000.00)
30	Seminars & Training	150.99	6,600.00	(6,449.01)
31	Supplies	2,567.26	2,500.00	67.26
32	Taxes	62,791,666.67	125,583,333.34	(62,791,666.67)
33	Telephone & Internet	3,937.56	8,000.00	(4,062.44)
34	Travel	2,472.85	4,600.00	(2,127.15)
35	Total Expenses	75,184,308.78	138,106,012.34	(62,921,703.56)
36	Net Operating Income	2,560,082.05	1,282,966.66	1,277,115.39
37	Other Income			
38	Other Income	105,473.07	59,249.00	46,224.07
39	Total Other Income	105,473.07	59,249.00	46,224.07
40	Net Other Income	105,473.07	59,249.00	46,224.07
41	Net Income	2,665,555.12	1,342,215.66	1,323,339.46

Fresno-Kings-Madera Regional Health Authority dba CalViva Health			
Income Statement: Current Year vs Prior Year			
July 2025 - August 2025 vs July 2024 - August 2024 Income Statement			
	Total		
	July 2025 - August 2025 (CY)	July 2024 - Aug 2024 (PY)	
1	Income		
2	Interest Income	1,356,168.42	1,862,681.05
3	Premium/Capitation Income	321,127,201.71	335,729,546.64
4	Total Income	\$ 322,483,370.13	\$ 337,592,227.69
5	Cost of Medical Care		
6	Capitation - Medical Costs	243,793,725.77	228,339,325.79
7	Medical Claim Costs	945,253.53	213,755.66
8	Total Costs of Medical Care	\$ 244,738,979.30	\$ 228,553,081.45
9	Gross Margin	\$ 77,744,390.83	\$ 109,039,146.24
10	Expenses		
11	Admin Service Agreement Fees	9,532,259.00	9,632,326.00
12	Computer & IT Services	44,211.38	20,735.28
13	Consulting & Accreditation Fees	5,460.00	7,710.00
14	Depreciation Expense	57,012.04	55,419.54
15	Dues & Subscriptions	42,559.54	40,568.86
16	Grants	1,527,335.35	1,496,072.59
17	Insurance	63,509.95	55,727.26
18	Labor	671,530.19	658,008.67
19	Legal & Professional Fees	27,481.97	15,105.32
20	License Expense	214,521.14	248,815.12
21	Marketing	180,181.68	159,329.09
22	Meals and Entertainment	1,377.31	2,647.89
23	Office Expenses	15,349.94	13,450.11
24	Parking	20.00	10.49
25	Postage & Delivery	481.90	260.55
26	Printing & Reproduction	0.00	737.86
27	Recruitment Expense	222.06	-549.00
28	Rent	0.00	0.00
29	Seminars & Training	150.99	5,747.24
30	Supplies	2,567.26	2,018.83
31	Taxes	62,791,666.67	93,958,333.34
32	Telephone & Internet	3,937.56	8,330.40
33	Travel	2,472.85	1,110.45
34	Total Expenses	\$ 75,184,308.78	\$ 106,381,915.89
35	Net Operating Income	\$ 2,560,082.05	\$ 2,657,230.35
36	Other Income		
37	Other Income	105,473.07	94,951.45
38	Total Other Income	\$ 105,473.07	\$ 94,951.45
39	Net Other Income	\$ 105,473.07	\$ 94,951.45
40	Net Income	\$ 2,665,555.12	\$ 2,752,181.80

Item #10

Attachment 10.B

Medical Management

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2025

Current as of End of the Month: August
Revised Date: 09/15/2025

Attachment

CalViva - 2025																		2025 YTD	2024
Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4			
Expedited Grievances Received	7	6	8	21	5	9	12	26	16	9	0	25	0	0	0	0		72	126
Standard Grievances Received	184	202	217	603	187	174	159	520	199	195	0	394	0	0	0	0		1517	1761
Total Grievances Received	191	208	225	624	192	183	171	546	215	204	0	419	0	0	0	0		1589	1887
Grievance Ack Letters Sent Noncompliant	1	2	2	5	1	0	0	1	0	1	0	1	0	0	0	0		7	10
Grievance Ack Letter Compliance Rate	99.5%	99.0%	99.1%	99.2%	99.5%	100.0%	100.0%	99.8%	100.0%	99.5%	0.0%	99.7%	0.0%	0.0%	0.0%	0.0%		99.54%	99.4%
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0		1	0
Expedited Grievances Resolved Compliant	7	5	9	21	4	9	12	25	15	10	0	25	0	0	0	0		71	126
Expedited Grievance Compliance rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	0.0%	96.0%	0.0%	0.0%	0.0%	0.0%		98.6%	100.0%
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	1
Standard Grievances Resolved Compliant	138	165	212	515	221	193	169	583	171	188	0	359	0	0	0	0		1457	1702
Standard Grievance Compliance rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%		100.0%	99.9%
Total Grievances Resolved	145	170	221	536	225	202	181	608	187	198	0	385	0	0	0	0		1529	1829
Grievance Descriptions - Resolved Cases																		2025 YTD	2024
Quality of Service Grievances	130	161	208	499	210	184	171	565	181	192	0	373	0	0	0	0			
Access - Other - DMHC	28	22	18	68	29	39	40	108	36	34	0	70	0	0	0	0		246	270
Access - PCP - DHCS	5	18	13	36	18	17	8	43	13	12	0	25	0	0	0	0		104	118
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0		1	0
Access - Spec - DHCS	2	9	7	18	6	5	7	18	11	6	0	17	0	0	0	0		53	78
Administrative	21	30	52	103	41	36	24	101	36	31	0	67	0	0	0	0		271	186
Balance Billing	23	22	34	79	45	30	25	100	18	22	0	40	0	0	0	0		219	0
Community Supports	4	6	1	11	4	11	6	21	2	5	0	7	0	0	0	0		39	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Interpersonal	6	16	14	36	18	14	11	43	22	20	0	42	0	0	0	0		121	122
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Other	9	7	33	49	13	7	13	33	14	17	0	31	0	0	0	0		113	339
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0		1	1
SNF-Long Term Care	1	1	3	5	2	0	2	4	3	2	0	5	0	0	0	0		14	0
Transportation - Access	15	13	5	33	7	8	11	26	9	16	0	25	0	0	0	0		84	175
Transportation - Behavior	5	3	2	10	3	3	5	11	4	10	0	14	0	0	0	0		35	89
Transportation - Other	11	14	26	51	24	14	19	57	12	16	0	28	0	0	0	0		136	86
Quality Of Care Grievances	15	9	13	37	15	18	10	43	6	6	0	12	0	0	0	0		92	361
Access - Other - DMHC	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0		1	3
Access - PCP - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0		1	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Access - Spec - DHCS	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	4
Behavioral Health	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0		2	0
Other	4	2	1	7	0	3	2	5	3	1	0	4	0	0	0	0		16	60
PCP Care	5	1	7	13	8	7	7	22	2	2	0	4	0	0	0	0		39	94
PCP Delay	2	1	3	6	1	3	0	4	1	1	0	2	0	0	0	0		12	116
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Specialist Care	3	2	1	6	2	3	0	5	0	1	0	1	0	0	0	0		12	60
Specialist Delay	1	2	0	3	2	1	0	3	0	0	0	0	0	0	0	0		6	24
SNF-Long Term Care	0	0	0	0	0	1	0	1	0	1	0	1	0	0	0	0		2	0
Exempt Grievances Received	183	214	201	598	116	155	129	400	157	170	0	327	0	0	0	0		1325	1885
Access - Avail of Appt w/ PCP	1	1	4	6	2	5	4	11	3	1	0	4	0	0	0	0		21	15
Access - Avail of Appt w/ Specialist	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0		2	0
Access - Avail of Appt w/ Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0		3	0
Access - Wait Time - wait too long on telephone	1	0	1	2	2	0	0	2	1	0	0	1	0	0	0	0		5	7
Access - Wait Time - in office for appt	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	2
Access - Panel Disruption	3	3	5	11	3	5	0	8	1	4	0	5	0	0	0	0		24	15
Access - Shortage of Providers	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0		1	0
Access - Geographic/Distance Access Other	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0		2	0
Access - Geographic/Distance Access PCP	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0		2	3
Access - Geographic/Distance Access Specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Access - Interpreter Service Requested	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	0		2	0
Benefit Issue - Specific Benefit not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Attitude/Service - Health Plan Staff	2	2	1	5	0	2	1	3	1	1	0	2	0	0	0	0		10	14
Attitude/Service - Provider	10	9	15	34	10	6	3	19	12	8	0	20	0	0	0	0		73	43
Attitude/Service - Office Staff	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	5
Attitude/Service - Vendor	0	0	0	0	10	6	0	16	7	6	0	13	0	0	0	0		29	4
Attitude/Service - Health Plan	0	0	1	1	0	0	0	0	0	1	0	1	0	0	0	0		2	12
Authorization - Authorization Related	1	2	1	4	2	2	1	5	2	2	0	4	0	0	0	0		13	6
Eligibility Issue - Member not eligible per Health Plan	0	32	2	34	0	0	0	0	0	0	0	0	0	0	0	0		34	4
Eligibility Issue - Member not eligible per Provider	3	29	5	37	10	6	10	26	7	7	0	14	0	0	0	0		77	48
Health Plan Materials - ID Cards-Not Received	27	23	20	70	14	26	17	57	28	16	0	44	0	0	0	0		171	210
Health Plan Materials - ID Cards-Incorrect Information on Card	1	1	2	4	0	2	0	2	1	2	0	3	0	0	0	0		9	2
Health Plan Materials - Other	2	0	0	2	1	0	2	3	1	0	0	1	0	0	0	0		6	4
Behavioral Health Related	0	0	0	0	1	2	3	6	2	3	0	5	0	0	0	0		11	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	58	60	72	190	31	45	37	113	38	64	0	102	0	0	0	0		405	652
PCP Assignment/Transfer - HCO Assignment - Change Request	19	15	17	51	3	11	12	26	13	15	0	28	0	0	0	0		105	301
PCP Assignment/Transfer - PCP effective date	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
PCP Assignment/Transfer - PCP Transfer not Processed	2	1	2	5	1	2	1	4	6	1	0	7	0	0	0	0		16	37
PCP Assignment/Transfer - Rollout of PPG	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	7
PCP Assignment/Transfer - Mileage Inconvenience	2	0	6	8	2	1	3	6	2	0	0	2	0	0	0	0		16	14

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	2	6	3	11	5	3	8	16	5	1	0	6	0	0	0	0	33	34
Standard Appeals Received	59	38	43	140	42	47	61	150	53	44	0	97	0	0	0	0	387	331
Total Appeals Received	61	44	46	151	47	50	69	166	58	45	0	103	0	0	0	0	420	365
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Appeals Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.00%	99.4%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	3	6	11	5	3	6	14	7	1	0	8	0	0	0	0	33	35
Expedited Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.00%	100.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Resolved Compliant	42	52	39	133	45	45	52	142	55	49	0	104	0	0	0	0	379	325
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	99.8%
Total Appeals Resolved	44	55	45	144	50	48	58	156	62	50	0	112	0	0	0	0	412	361
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	42	55	45	142	50	47	56	153	61	50	0	111	0	0	0	0	406	353
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	2	3	2	0	2	4	2	1	0	3	0	0	0	0	10	9
Community Supports	5	6	5	16	8	7	11	26	6	16	0	22	0	0	0	0	64	0
DME	10	11	8	29	11	12	7	30	17	9	0	26	0	0	0	0	85	37
Experimental/Investigational	1	5	5	11	6	0	2	8	6	0	0	6	0	0	0	0	25	0
Mental Health	0	1	0	1	0	3	0	3	1	0	0	1	0	0	0	0	5	1
Advanced Imaging	7	20	1	28	11	13	16	40	12	12	0	24	0	0	0	0	92	162
Other	6	2	5	13	4	3	7	14	7	5	0	12	0	0	0	0	39	35
Pharmacy/RX Medical Benefit	3	6	6	15	4	3	5	12	5	5	0	10	0	0	0	0	37	47
Surgery	7	4	9	20	4	5	4	13	4	1	0	5	0	0	0	0	38	62
SNF-Long Term Care	1	0	4	5	0	1	2	3	1	1	0	2	0	0	0	0	10	0
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Post Service Appeals	2	0	0	2	0	1	2	3	1	0	0	1	0	0	0	0	6	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Community Supports	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Other	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	2	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	2	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	22	22	19	63	23	18	34	75	29	19	0	48	0	0	0	0	186	156
Uphold Rate	50.0%	40.0%	42.2%	43.8%	46.0%	37.5%	58.6%	48.1%	46.8%	38.0%	0.0%	42.9%	0.0%	0.0%	0.0%	0.0%	45.1%	43.2%
Overturns - Full	18	28	22	68	25	26	18	69	25	24	0	49	0	0	0	0	186	194
Overturn Rate - Full	40.9%	50.9%	48.9%	47.2%	50.0%	54.2%	31.0%	44.2%	40.3%	48.0%	0.0%	43.8%	0.0%	0.0%	0.0%	0.0%	45.1%	53.7%
Overturns - Partial	0	2	4	6	1	2	3	6	7	6	0	13	0	0	0	0	25	10
Overturn Rate - Partial	0.0%	3.6%	8.9%	4.2%	2.0%	4.2%	5.2%	3.8%	11.3%	12.0%	0.0%	11.6%	0.0%	0.0%	0.0%	0.00%	6.1%	2.8%
Withdrawal	4	3	0	7	1	2	3	6	1	1	0	2	0	0	0	0	15	1
Withdrawal Rate	9.1%	5.5%	0.0%	4.9%	2.0%	4.2%	5.2%	3.8%	1.6%	2.0%	0.0%	1.8%	0.0%	0.0%	0.0%	0.0%	3.6%	0.3%
Membership	428,829	430,593	431,030		430,849	432,549	432,886		433,612	430,032	0		0	0	0	0		
Appeals - PTMPM	0.10	0.13	0.10	0.33	0.12	0.11	0.13	0.36	0.14	0.12	0	0.39	0	0	0	-	0.36	0.09
Grievances - PTMPM	0.34	0.39	0.51	1.25	0.52	0.47	0.42	1.41	0.43	0.46	0	1.34	0	0	0	-	1.33	0.24

CalViva Health Appeals and Grievances Dashboard (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	2	6	2	10	5	2	6	13	4	1	0	5	0	0	0	0	28	22
Standard Appeals Received	43	26	35	104	36	35	53	124	41	38	0	79	0	0	0	0	307	375
Total Appeals Received	45	32	37	114	41	37	59	137	45	39	0	84	0	0	0	0	335	397
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	3	5	10	5	2	6	13	4	1	0	5	0	0	0	0	28	22
Expedited Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	35	37	27	99	38	38	37	113	49	39	0	88	0	0	0	0	300	346
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total Appeals Resolved	37	40	32	109	43	40	43	126	53	40	0	93	0	0	0	0	328	368
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	35	40	32	107	43	39	41	123	52	40	0	92	0	0	0	0	322	366
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	2	3	2	0	2	4	2	1	0	3	0	0	0	0	10	28
Community Supports	5	3	2	10	6	6	6	18	6	13	0	19	0	0	0	0	47	0
DME	8	7	7	22	10	10	7	27	15	6	0	21	0	0	0	0	70	63
Experimental/Investigational	1	5	3	9	5	0	2	7	4	0	0	4	0	0	0	0	20	9
Behavioral Health	0	1	0	1	0	3	0	3	1	0	0	1	0	0	0	0	5	1
Advanced Imaging	5	17	1	23	11	12	10	33	11	10	0	21	0	0	0	0	77	130
Other	5	1	3	9	4	1	7	12	5	4	0	9	0	0	0	0	30	65
Pharmacy/RX Medical Benefit	3	3	4	10	4	2	4	10	5	4	0	9	0	0	0	0	29	30
Surgery	5	3	7	15	1	5	1	7	2	1	0	3	0	0	0	0	25	40
SNF-Long Term Care	1	0	3	4	0	0	2	2	1	1	0	2	0	0	0	0	8	0
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Post Service Appeals	2	0	0	2	0	1	2	3	1	0	0	1	0	0	0	0	6	3
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Other	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	2	3
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	2	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	19	18	11	48	18	13	23	54	27	14	0	41	0	0	0	0	143	134
Uphold Rate	51.4%	45.0%	34.4%	44.0%	41.9%	32.5%	53.5%	42.9%	50.9%	35.0%	0.0%	44.1%	0.0%	0.0%	0.0%	0.0%	43.6%	36.4%
Overturns - Full	14	21	17	52	23	23	15	61	21	20	0	41	0	0	0	0	154	213
Overturn Rate - Full	37.8%	52.5%	53.1%	47.7%	53.5%	57.5%	34.9%	48.4%	39.6%	50.0%	0.0%	44.1%	0.0%	0.0%	0.0%	0.0%	47.0%	57.9%
Overturns - Partial	0	1	4	5	1	2	2	5	4	5	0	9	0	0	0	0	19	15
Overturn Rate - Partial	0.0%	2.5%	12.5%	4.6%	2.3%	5.0%	4.7%	4.0%	7.5%	12.5%	0.0%	9.7%	0.0%	0.0%	0.0%	0.0%	5.8%	4.1%
Withdrawal	4	0	0	4	1	2	3	6	1	1	0	2	0	0	0	0	12	6
Withdrawal Rate	10.8%	0.0%	0.0%	3.7%	2.3%	5.0%	7.0%	4.8%	1.9%	2.5%	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	3.7%	1.6%
Membership	340,965	342,423	342,628		342,378	343,598	343,733		343,931	340,499	0		0	0	0			
Appeals - PTMPM	0.11	0.12	0.09	0.32	0.13	0.12	0.13	0.37	0.15	0.12	0	0.09	0	0	0	0.00	0.19	0.06
Grievances - PTMPM	0.33	0.40	0.56	1.29	0.54	0.48	0.44	1.46	0.44	0.47	0	0.30	0	0	0	0.00	0.76	0.32

	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
	2	0	0	0	0	6	8
	42	0	0	0	0	132	143
	44	0	0	0	0	138	151
	0	0	0	0	0	0	0
	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	1
	0	0	0	0	0	0	0
	2	0	0	0	0	6	8
	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
	0	0	0	0	0	0	0
	36	0	0	0	0	123	144
	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
	38	0	0	0	0	129	152
	37	0	0	0	0	122	137
	5	0	0	0	0	19	18
	1	0	0	0	0	8	8
	0	0	0	0	0	0	0
	2	0	0	0	0	5	2
	5	0	0	0	0	22	33
	4	0	0	0	0	13	16
	1	0	0	0	0	3	0
	0	0	0	0	0	0	0
	7	0	0	0	0	16	11
	0	0	0	0	0	0	0
	4	0	0	0	0	7	9
	1	0	0	0	0	1	2
	0	0	0	0	0	0	0
	2	0	0	0	0	6	11
	3	0	0	0	0	5	5
	2	0	0	0	0	17	22
	1	0	0	0	0	7	15
	0	0	0	0	0	0	1
	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
	0	0	0	0	0	1	0
	0	0	0	0	0	0	0
	0	0	0	0	0	3	2
	1	0	0	0	0	2	4
	0	0	0	0	0	1	4
	0	0	0	0	0	0	0
	0	0	0	0	0	0	3
	0	0	0	0	0	0	1
	0	0	0	0	0	0	0

CalViva Health Appeals and Grievances Dashboard (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	0	0	1	1	0	1	0	1	1	0	0	1	0	0	0	0	3	2
Standard Appeals Received	2	3	2	7	1	4	2	7	8	3	0	11	0	0	0	0	25	21
Total Appeals Received	2	3	3	8	1	5	2	8	9	3	0	12	0	0	0	0	28	23
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	1
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	1	1	0	1	0	1	1	0	0	1	0	0	0	0	3	2
Expedited Appeals Compliance Rate	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	1	2	3	6	2	1	4	7	4	6	0	10	0	0	0	0	23	21
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Total Appeals Resolved	1	2	4	7	2	2	4	8	5	6	0	11	0	0	0	0	26	23
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	1	2	4	7	2	2	4	8	5	6	0	11	0	0	0	0	26	23
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Community Supports	0	2	1	3	1	0	2	3	0	1	0	1	0	0	0	0	7	
DME	0	0	0	0	0	0	0	0	1	2	0	3	0	0	0	0	3	2
Experimental/Investigational	0	0	1	1	1	0	0	1	2	0	0	2	0	0	0	0	4	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	0	0	0	0	0	0	1	1	0	2	0	2	0	0	0	0	3	5
Other	0	0	1	1	0	1	0	1	1	0	0	1	0	0	0	0	3	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Surgery	1	0	0	1	0	0	1	1	1	0	0	1	0	0	0	0	3	5
SNF-Long Term Care	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	0	1	3	4	1	2	4	7	1	1	0	2	0	0	0	0	13	11
Uphold Rate	0.0%	50.0%	75.0%	57.1%	50.0%	100.0%	100.0%	87.5%	20.0%	16.7%	0.0%	18.2%	0.0%	0.0%	0.0%	0.0%	50.0%	47.8%
Overturns - Full	1	1	1	3	1	0	0	1	1	4	0	5	0	0	0	0	9	11
Overturn Rate - Full	100.0%	50.0%	25.0%	42.9%	50.0%	0.0%	0.0%	12.5%	20.0%	66.7%	0.0%	45.5%	0.0%	0.0%	0.0%	0.0%	34.6%	47.8%
Overturns - Partial	0	0	0	0	0	0	0	0	3	1	0	4	0	0	0	0	4	0
Overturn Rate - Partial	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	16.7%	0.0%	36.4%	0.0%	0.0%	0.0%	0.0%	15.4%	0.00%
Withdrawal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Withdrawal Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%
Membership	38,244	38,318	38,427		38,410	38,514	38,498		38,716	38,714	0		0	0	0	0		
Appeals - PTMPM	0.03	0.05	0.10	0.06	0.05	0.05	0.10	0.07	0.13	0.15	0	0.09	0	0	0	0.00	0.06	0.05
Grievances - PTMPM	0.42	0.31	0.34	0.36	0.44	0.42	0.44	0.43	0.46	0.52	0	0.33	0	0	0	0.00	0.28	0.33

CalViva Health Appeals and Grievances Dashboard (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	2	1
Standard Appeals Received	14	9	6	29	5	8	6	19	4	3	0	7	0	0	0	0	55	66
Total Appeals Received	14	9	6	29	5	8	8	21	4	3	0	7	0	0	0	0	57	67
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	2	1
Expedited Appeals Compliance Rate	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	6	13	9	28	5	6	11	22	2	4	0	6	0	0	0	0	56	63
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total Appeals Resolved	6	13	9	28	5	6	11	22	4	4	0	8	0	0	0	0	58	64
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	6	13	9	28	5	6	11	22	4	4	0	8	0	0	0	0	58	64
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Community Supports	0	1	2	3	1	1	3	5	0	2	0	2	0	0	0	0	10	0
DME	2	4	1	7	1	2	0	3	1	1	0	2	0	0	0	0	12	11
Experimental/Investigational	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	3	0	5	0	1	5	6	1	0	0	1	0	0	0	0	12	27
Other	1	1	1	3	0	1	0	1	1	1	0	2	0	0	0	0	6	7
Pharmacy/RX Medical Benefit	0	3	2	5	0	1	1	2	0	0	0	0	0	0	0	0	7	9
Surgery	1	1	2	4	3	0	2	5	1	0	0	1	0	0	0	0	10	4
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	3	3	5	11	4	3	7	14	1	4	0	5	0	0	0	0	30	25
Uphold Rate	50.0%	23.1%	55.6%	39.3%	80.0%	50.0%	63.6%	63.6%	25.0%	100.0%	0.0%	62.5%	0.0%	0.0%	0.0%	0.0%	51.7%	39.1%
Overturns - Full	3	6	4	13	1	3	3	7	3	0	0	3	0	0	0	0	23	35
Overturn Rate - Full	50.0%	46.2%	44.4%	46.4%	20.0%	50.0%	27.3%	31.8%	75.0%	0.0%	0.0%	37.5%	0.0%	0.0%	0.0%	0.00%	39.7%	54.7%
Overturns - Partial	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0	2	4
Overturn Rate - Partial	0.0%	7.7%	0.0%	3.6%	0.0%	0.0%	9.1%	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%	6.3%
Withdrawal	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Withdrawal Rate	0.0%	23.1%	0.0%	10.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.2%	0.0%
Membership	49,620	49,852	49,975		50,061	50,437	50,655		50,965	50,819	0		0	0	0	0.00%		
Appeals - PTMPM	0.12	0.26	0.18	0.56	0.10	0.12	0.22	0.44	0.08	0.078711	0	0.05	0	0	0	0.00	0.26	0.11
Grievances - PTMPM	0.30	0.42	0.34	1.06	0.46	0.44	0.24	1.13	0.31	0.354198	0	0.22	0	0	0	0.00	0.60	0.33

CalViva Health Appeals and Grievances Dashboard (SPD)

Pharmacy - Pharmacy-Retail	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access - Provider No Show	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access - Provider Late	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Behaviour	7	0	0	7	0	0	0	0	1	1	0	2	0	0	0	0	9	0
Transportation - Other	1	7	5	13	1	0	3	4	5	1	0	6	0	0	0	0	23	2
OTHER - Other	0	2	2	4	0	1	1	2	1	0	0	1	0	0	0	0	7	15
Claims Complaint - Balance Billing from Provider	4	4	6	14	5	5	6	16	1	3	0	4	0	0	0	0	34	30

CalViva Health Appeals and Grievances Dashboard (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	0	2	3	5	1	0	2	3	2	1	0	3	0	0	0	0	11	3
Standard Appeals Received	23	8	13	44	13	11	20	44	15	11	0	26	0	0	0	0	114	132
Total Appeals Received	23	10	16	49	14	11	22	47	17	12	0	29	0	0	0	0	125	135
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	1	4	5	1	0	2	3	2	1	0	3	0	0	0	0	11	3
Expedited Appeals Compliance Rate	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	-200.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	13	17	8	38	15	11	15	41	18	13	0	31	0	0	0	0	110	126
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total Appeals Resolved	13	18	12	43	16	11	17	44	20	14	0	34	0	0	0	0	121	129
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	9	18	12	39	0	11	17	28	20	14	0	34	0	0	0	0	101	125
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Consultation	0	0	0	0	0	0	0	0	2	1	0	3	0	0	0	0	3	17
Community Supports	0	2	1	3	0	2	7	9	4	4	0	8	0	0	0	0	20	0
DME	4	5	4	13	0	4	2	6	4	3	0	7	0	0	0	0	26	37
Experimental/Investigational	0	2	1	3	0	0	1	1	1	0	0	1	0	0	0	0	5	1
Behavioral Health	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Advanced Imaging	2	3	0	5	0	4	3	7	4	3	0	7	0	0	0	0	19	29
Other	2	0	4	6	0	0	2	2	2	0	0	2	0	0	0	0	10	25
Pharmacy/RX Medical Benefit	0	4	1	5	0	1	2	3	1	2	0	3	0	0	0	0	11	6
Surgery	1	1	1	3	0	0	0	0	1	0	0	1	0	0	0	0	4	10
SNF-Long Term Care	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0	2	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	8	7	7	22	9	2	12	23	10	6	0	16	0	0	0	0	61	51
Uphold Rate	61.5%	38.9%	58.3%	51.2%	56.3%	18.2%	70.6%	52.3%	50.0%	42.9%	0.0%	47.1%	0.0%	0.0%	0.0%	0.0%	50.4%	39.5%
Overturns - Full	4	7	4	15	7	8	3	18	7	7	0	14	0	0	0	0	47	72
Overturn Rate - Full	30.8%	38.9%	33.3%	34.9%	43.8%	72.7%	17.6%	40.9%	35.0%	50.0%	0.0%	41.2%	0.0%	0.0%	0.0%	0.0%	38.8%	55.81%
Overturns - Partial	0	1	1	2	0	1	1	2	3	1	0	4	0	0	0	0	8	6
Overturn Rate - Partial	0.0%	5.6%	8.3%	4.7%	0.0%	9.1%	5.9%	4.5%	15.0%	7.1%	0.0%	11.8%	0.0%	0.0%	0.0%	0.0%	6.6%	4.7%
Withdrawal	1	3	0	4	0	0	1	1	0	0	0	0	0	0	0	0	5	5
Withdrawal Rate	7.7%	16.7%	0.0%	9.3%	0.0%	0.0%	5.9%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.1%	3.9%
Membership	47,731	47,867	47,918		47,871	48,091	48,307		48,591	48,534	0		0	0	0			
Appeals - PTMPM	0.27	0.38	0.25	0.90	0.33	0.23	0.35	0.91	0.41	0.29	-	0.23	0	0	0	0.00	0.51	0.15
Grievances - PTMPM	1.09	1.09	1.34	3.51	1.38	1.23	1.16	3.76	1.23	1.38	-	0.87	0	0	0	0.00	2.04	0.65

Cal Viva Dashboard Definitions	
Categories	Description
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative	Grievances related to health plan benefit, pain authorization or access issues
Balance Billing	Member billing for Par and Nonpar providers.
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/RX Medical Benefit	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy/RX Medical Benefit	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist
APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.

Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawals	Number of withdrawn appeals
Withdrawal Rate	Percentage of withdrawn appeals
EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).
Exempt Grievance tab key – Calviva Dashboard	
Column Definitions.	
Date Opened	The date the case was received
SF #	The internal HealthNet system ID code for the CCC representative who documented the call
Rep Name	Name of the CCC associate who took the call
Sup Name	Supervisor of the CCC associate who took the call
Mbr ID	The Calviva Health ID number of the member
SPD	Marked "yes" if the member is part of the "Seniors & Persons with Disabilities" population
Date of Birth	Date of birth of the member
Mbr Name	Name of the member
Reason	The case was categorized as a Calviva Exempt Grievance, hence the reason it's on the report
Preventable	Used if an Exempt Grievance was determined to be preventable
Access to Care	Used if determined Exempt Grievance was related to Access to Care
Issue Main Classification	Case is categorized by type of complaint
Issue Sub Classification	Case is subcategorized by type of complaint
DMHC Complaint Category	Case is categorized based on the DMHC TAR template complaint category
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here
Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it's an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligiblty or lackthereof.
Health Care Benefits	When it's an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavior of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavior of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavior of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
The Outlier Tab	
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.
Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #10

Attachment 10.C

Medical Management

Key Indicator Report



Healthcare Solutions Reporting Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 8/01/2025 to 8/31/2025

Report created 9/24/2025

Purpose of Report: Summary report on Inpatient and Outpatient Utilization Metrics by Region, County, PPG entity
Reports show inpatient Rates with and without maternity, readmission, TAT Compliance, Care Management Programs

Exhibits:

[Read Me](#)

[Main Report CalVIVA](#)

[CalVIVA Commission](#)

[CalVIVA Fresno](#)

[CalVIVA Kings](#)

[CalVIVA Madera](#)

[Glossary](#)

Contact Information

Sections

Concurrent Inpatient TAT Metric

TAT Metric

CCS Metric

Case Management Metrics

Authorization Metrics

Contact Person

Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>

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John Gonzalez

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 8/01/2025 to 8/31/2025
Report created 9/24/2025

ER utilization based on Claims data	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-02	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
MEMBERSHIP																Quarterly Averages									
Expansion Mbr Months	122,125	122,163	122,244	121,961	121,430		121,277	121,332	122,118	122,345	123,026	123,322	123,901	122,392		118,378	120,374	122,111	121,878	121,576	122,898		120,685	244,928	
Adult/Family/O TLIC Mbr Mos	265,991	264,882	264,720	263,023	261,420		261,031	262,374	262,053	261,911	262,247	262,070	262,013	259,720		265,833	266,571	265,827	263,054	261,819	262,076		265,321	523,355	
Aged/Disabled Mbr Mos	47,366	47,622	47,822	48,280	48,512		47,624	47,618	47,808	47,837	48,038	48,242	48,532	48,562		47,003	46,643	47,388	48,205	47,683	48,039		47,310	96,065	
COUNTS																Annual Averages									
Admits - Count	2,240	2,191	2,155	2,114	2,143		2,281	2,017	2,067	2,021	2,050	2,032	2,036	2,015		2,188	2,146	2,244	2,137	2,122	2,034		2,179	2,174	
Expansion	784	722	710	707	745		856	728	722	720	745	746	756	751		710	729	758	721	769	737		730	792	
Adult/Family/O TLIC	909	973	912	886	864		921	884	897	853	890	842	880	858		910	900	943	887	901	862		910	929	
Aged/Disabled	547	496	533	521	534		504	405	448	448	415	444	400	406		569	517	542	529	452	436		539	453	
Admits Acute - Count	1,473	1,402	1,392	1,422	1,432		1,545	1,309	1,352	1,385	1,321	1,310	1,277	1,299		1,437	1,428	1,434	1,431	1,474	1,339		1,438	1,421	
Expansion	607	575	548	571	604		687	565	571	583	592	600	579	597		541	576	596	574	608	592		572	627	
Adult/Family/O TLIC	412	418	425	444	387		463	438	433	441	407	379	389	368		470	447	433	419	445	409		442	439	
Aged/Disabled	454	409	419	407	441		395	306	348	361	322	331	309	334		426	407	438	422	350	338		424	355	
Readmit 30 Day - Count	267	238	264	246	258		250	214	228	253	229	225	155	102		247	254	249	256	231	236		251	207	
Expansion	106	84	85	95	108		112	97	106	115	106	111	69	53		94	108	97	96	105	111		99	96	
Adult/Family/O TLIC	43	48	52	40	40		41	38	32	39	29	37	32	21		40	48	43	44	37	35		44	34	
Aged/Disabled	118	106	127	111	110		97	79	90	99	94	77	54	28		112	98	110	116	89	90		109	78	
**ER Visits - Count	14,407	14,758	14,713	13,937	14,841		15,643	14,826	15,421	14,624	15,342	14,025	12,726	5,968		14,087	15,282	14,645	14,497	15,297	14,664		14,628	13,572	
Expansion	4,365	4,330	4,255	3,811	4,104		4,488	4,009	4,358	4,240	4,538	4,404	4,259	2,035		3,707	4,128	4,380	4,057	4,285	4,394		4,068	4,041	
Adult/Family/O TLIC	8,190	8,657	8,717	8,408	8,868		9,304	9,121	9,276	8,557	9,004	7,851	6,832	3,295		8,480	9,108	8,338	8,664	9,234	8,471		8,647	7,905	
Aged/Disabled	1,852	1,771	1,741	1,718	1,869		1,851	1,696	1,787	1,827	1,800	1,770	1,635	638		1,901	2,046	1,928	1,776	1,778	1,799		1,913	1,626	
PER/K																									
Admits Acute - PTMPY	40.6	38.7	38.4	39.4	39.8		43.1	36.4	37.6	38.5	36.6	36.3	35.3	36.2		40.0	39.5	39.5	39.6	41.0	37.1		39.8	39.4	
Expansion	59.6	56.5	53.8	56.2	59.7		68.0	55.9	56.1	57.2	57.7	58.4	56.1	58.5		54.9	57.5	58.5	56.5	60.0	57.8		56.9	30.7	
Adult/Family/O TLIC	18.6	18.9	19.3	20.3	17.8		21.3	20.0	19.8	20.2	18.6	17.4	17.8	17.0		21.2	20.1	19.6	19.1	20.4	18.7		20.0	10.1	
Aged/Disabled	115.0	103.1	105.1	101.2	109.1		99.5	77.1	87.3	90.6	80.4	82.3	76.4	82.5		108.8	104.8	110.9	105.1	88.0	84.4		107.4	44.3	
Bed Days Acute - PTMPY	202.1	189.6	184.2	196.8	210.2		226.4	176.9	195.1	203.5	169.9	175.1	157.4	168.9		217.4	209.0	199.6	197.0	199.5	182.8		205.8	193.9	
Expansion	295.1	291.5	247.9	305.3	341.8		388.0	300.3	321.9	298.2	286.0	289.3	253.3	273.9		329.7	316.2	301.3	298.2	336.7	291.1		311.2	158.4	
Adult/Family/O TLIC	69.3	70.1	75.3	72.9	70.8		83.8	66.3	74.0	94.2	66.3	63.3	67.1	67.0		79.5	74.4	70.8	73.0	74.7	74.6		74.4	38.6	
Aged/Disabled	707.6	592.2	624.3	598.0	631.5		597.2	472.0	535.1	559.7	438.2	490.8	400.3	448.7		714.2	702.2	660.4	617.9	534.8	496.1		673.2	258.1	
ALOS Acute	5.0	4.9	4.8	5.0	5.3		5.3	4.9	5.2	5.3	4.6	4.8	4.5	4.7		5.4	5.3	5.0	5.0	4.9	4.9		5.2	4.9	
Expansion	4.9	5.2	4.6	5.4	5.7		5.7	5.4	5.7	5.2	5.0	5.0	4.5	4.7		6.0	5.5	5.1	5.3	5.6	5.0		5.5	5.2	
Adult/Family/O TLIC	3.7	3.7	3.9	3.6	4.0		3.9	3.3	3.7	4.7	3.6	3.6	3.8	3.9		3.8	3.7	3.6	3.8	3.7	4.0		3.7	3.8	
Aged/Disabled	6.2	5.7	5.9	5.9	5.8		6.0	6.1	6.1	6.2	5.4	6.0	5.2	5.4		6.6	6.7	6.0	5.9	6.1	5.9		6.3	5.8	
Readmit % 30 Day	11.9%	10.9%	12.3%	11.6%	12.0%		11.0%	10.6%	11.0%	12.5%	11.2%	11.1%	7.6%	5.1%		11.3%	11.8%	11.1%	12.0%	10.9%	11.6%		11.5%	9.5%	
Expansion	13.5%	11.6%	12.0%	13.4%	14.5%		13.1%	13.3%	14.7%	16.0%	14.2%	14.9%	9.1%	7.1%		13.2%	14.8%	12.7%	13.3%	13.7%	15.0%		13.5%	12.1%	
Adult/Family/O TLIC	4.7%	4.9%	5.7%	4.5%	4.6%		4.5%	4.3%	3.6%	4.6%	3.3%	4.4%	3.6%	2.4%		4.4%	5.4%	4.5%	5.0%	4.1%	4.1%		4.8%	3.6%	
Aged/Disabled	21.6%	21.4%	23.8%	21.3%	20.6%		19.2%	19.5%	20.1%	22.1%	22.7%	17.3%	13.5%	6.9%		19.8%	19.0%	20.2%	21.9%	19.6%	20.7%		20.2%	17.1%	
**ER Visits - PTMPY	397.0	407.4	406.1	386.0	412.9		436.6	412.5	428.4	406.1	424.9	388.1	351.5	166.3		392.0	423.0	403.7	401.6	425.8	406.4		405.1	376.8	
Expansion	428.9	425.3	417.7	375.0	405.6		444.1	396.5	428.2	415.9	442.6	428.5	412.5	199.5		375.8	411.5	430.4	399.4	422.9	429.0		404.5	198.0	
Adult/Family/O TLIC	369.5	392.2	395.1	383.6	407.1		427.7	417.2	424.8	392.1	412.0	359.5	312.9	152.2		382.8	410.0	376.4	395.2	423.2	387.9		391.1	181.3	
Aged/Disabled	469.2	446.3	436.9	427.0	462.3		466.4	427.4	448.5	458.3	449.6	440.3	404.3	157.7		485.2	526.5	488.2	442.1	447.5	449.4		485.2	203.0	

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024-Trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	2025-Trend	Q1-2024	Q2-2024	Q3-2024	Q4-2024	2024 - Quarters Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	YTD-2024	YTD-2025	Year trends
Perinatal Case Management						Perinatal Case Management						Perinatal Case Management						Perinatal Case Management						Perinatal Case Management				
Total Number Of Referrals	137	203	196	157	134		237	223	317	366	320	221	274	204		686	601	474	487		777	907	478			2,248	2,162	
Pending	-	-	-	1	21		-	-	-	-	-	-	-	6		-	-	-	22		-	-	6			22	6	
Ineligible	13	14	27	17	15		18	15	17	18	22	13	19	12		40	37	44	59		50	53	31			180	134	
Total Outreached	124	189	169	139	98		219	208	300	348	298	208	255	186		646	564	430	406		727	854	441			2,046	2,022	
Engaged	105	87	71	77	51		113	141	187	225	197	122	162	127		466	346	295	199		441	544	289			1,306	1,274	
Engagement Rate	85%	46%	42%	55%	52%		52%	68%	62%	65%	66%	59%	64%	68%		72%	61%	69%	49%		61%	64%	66%			64%	63%	
Total Screened and Declined	9	9	12	13	10		-	3	6	5	6	3	3	1		47	9	25	35		9	14	4			116	27	
Unable to Reach	10	93	86	49	37		106	64	107	118	95	83	90	58		133	209	110	172		277	296	148			624	721	
Total Cases Managed	422	392	383	368	346		307	311	342	374	389	361	363	359		937	809	670	513		477	494	441			1,779	846	
Total Cases Closed	102	68	88	58	82		75	60	50	62	74	85	81	61		471	424	334	228		185	221	142			1,457	548	
Cases Remained Open	295	306	287	291	247		199	231	277	297	310	270	266	289		442	388	306	247		277	270	289			247	289	
Physical Health Case Management						Physical Health Case Management						Physical Health Case Management						Physical Health Case Management						Physical Health Case				
Total Number Of Referrals	272	173	313	177	153		185	185	401	544	516	385	331	402		774	800	669	643		771	1,445	733			2,886	2,949	
Pending	-	1	2	1	12		-	-	-	-	-	-	-	40		-	1	2	15		-	-	40			18	40	
Ineligible	25	14	12	8	4		4	2	4	28	16	10	18	15		81	134	43	24		10	54	33			282	97	
Total Outreached	247	158	299	168	137		181	183	397	516	500	375	313	347		693	665	624	604		761	1,391	660			2,586	2,812	
Engaged	107	67	114	69	82		113	120	180	292	273	215	175	218		339	319	277	265		413	780	393			1,200	1,586	
Engagement Rate	43%	42%	38%	41%	60%		62%	66%	45%	57%	55%	57%	56%	63%		49%	48%	44%	44%		54%	56%	60%			46%	56%	
Total Screened and Refused/Decline	43	27	62	35	16		9	6	72	33	57	32	28	29		108	82	96	113		87	122	57			399	266	
Unable to Reach	97	64	123	64	39		59	57	145	191	170	128	110	100		246	264	251	226		261	489	210			987	960	
Total Cases Closed	109	85	96	83	88		63	77	100	104	81	88	104	90		312	276	304	267		240	273	194			1,159	707	
Cases Remained Open	324	300	323	297	300		277	267	277	253	287	308	297	295		296	339	300	300		277	308	295			300	295	
Total Cases Managed	444	402	429	401	398		353	364	388	384	388	418	419	401		622	615	601	582		528	572	521			1,479	1,018	
Complex Case	51	46	45	45	40		34	38	35	29	28	37	38	49		99	86	69	60		48	42	54			176	94	
Non-Complex Case	393	356	384	356	358		319	326	353	355	360	381	381	352		523	529	532	522		480	530	467			1,303	924	
Transitional Care Services						Transitional Care Services						Transitional Care Services						Transitional Care Services						Transitional Care Services				
Total Number Of Referrals	611	641	827	680	572		577	502	511	514	623	502	660	642		704	797	1,745	2,079		1,590	1,639	1,302			5,325	4,531	
Pending	-	-	2	8	117		-	-	-	-	-	-	-	7		-	-	-	127		-	-	7			127	7	
Ineligible	17	4	22	12	7		7	1	2	3	2	2	4	4		97	26	24	41		10	7	8			188	25	
Total Outreached	594	637	803	660	448		570	501	509	511	621	500	656	631		607	771	1,721	1,911		1,580	1,632	1,287			5,010	4,499	
Engaged	359	402	440	346	246		519	456	462	466	558	442	581	521		375	466	1,082	1,032		1,437	1,466	1,102			2,955	4,005	
Engagement Rate	60%	63%	55%	52%	55%		91%	91%	91%	91%	90%	88%	89%	83%		62%	60%	63%	54%		91%	90%	86%			59%	89%	
Total Screened and Refused/Decline	33	34	35	34	27		8	3	10	6	6	-	6	7		58	39	103	96		21	12	13			296	46	
Unable to Reach	202	201	328	280	175		43	42	37	39	57	58	69	103		174	266	536	783		122	154	172			1,759	448	
Total Cases Closed	273	310	343	354	326		322	232	283	285	253	303	320	323		279	298	795	1,023		837	841	643			2,395	2,321	
Cases Remained Open	386	423	490	419	383		298	332	324	301	367	364	395	418		107	233	423	383		324	364	418			383	418	
Total Cases Managed																												

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024 - Trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	2025 - Trend	Q1-2024	Q2-2024	Q3-2024	Q4-2024	2024 - Quarters Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	YTD-2024	YTD-2025	Year trends
	Behavioral Health Care Management						Behavioral Health Care Management									Behavioral Health Care Management				Behavioral Health Care Management				Behavioral Health Care				
Total Number Of Referrals	122	83	98	94	88		127	106	154	158	132	133	115	121		245	287	320	280		387	423	236			1,132	1,046	
Pending	-	-	-	-	11		-	-	-	-	-	-	-	12		-	-	-	11		-	-	12			11	12	
Ineligible	6	5	3	2	1		6	-	1	6	4	1	-	1		14	13	13	6		7	11	1			46	19	
Total Outreached	116	78	95	92	76		121	106	153	152	128	132	115	108		231	274	307	263		380	412	223			1,075	1,015	
Engaged	82	58	78	68	52		81	74	112	114	94	100	80	75		162	152	213	198		267	308	155			725	730	
Engagement Rate	71%	74%	82%	74%	68%		67%	70%	73%	75%	73%	76%	70%	69%		70%	55%	69%	75%		70%	75%	70%			67%	72%	
Total Screened and Refused/Decline	5	-	1	3	1		1	1	-	-	1	-	-	-		5	18	6	5		2	1	-			34	3	
Unable to Reach	29	20	16	21	23		39	31	41	38	33	32	35	33		64	104	88	60		111	103	68			316	282	
Total Cases Closed	50	60	71	53	52		49	53	57	90	65	54	29	30		93	151	173	176		159	209	59			593	427	
Cases Remained Open	160	152	152	157	161		153	142	169	124	101	70	86	97		142	141	152	161		169	70	97			161	97	
Total Cases Managed	233	234	243	240	232		216	219	236	232	174	140	125	132		237	297	341	366		338	282	171			801	529	
Complex Case	14	19	20	18	16		16	15	17	16	9	9	9	10		19	19	25	23		22	16	10			51	30	
Non-Complex Case	219	215	223	222	216		200	204	219	216	165	131	116	122		218	278	316	343		316	266	161			750	499	
	First Year of Life Care Management						First Year of Life Care Management									First Year of Life Care Management				First Year of Life Care Management				First Year of Life Care				
Total Number Of Referrals	34	25	25	24	28		35	38	50	54	46	47	57	37		108	86	115	77		123	147	94			386	364	
Pending	-	-	-	-	-		-	-	-	-	-	-	-	-		-	-	-	-		-	-	-			-	-	
Ineligible	2	-	-	-	-		-	-	1	-	-	1	1	-		2	1	2	-		1	1	1			5	3	
Total Outreached	32	25	25	24	28		35	38	49	54	46	46	56	37		106	85	113	77		122	146	93			381	361	
Engaged	32	25	24	24	28		35	38	44	54	46	46	49	36		106	85	103	76		117	146	85			370	348	
Engagement Rate	100%	100%	96%	100%	100%		100%	100%	90%	100%	100%	100%	88%	97%		100%	100%	91%	99%		96%	100%	91%			97%	96%	
Total Screened and Refused/Decline	-	-	1	-	-		-	-	-	-	-	-	-	-		-	-	4	1		-	-	-			5	-	
Unable to Reach	-	-	-	-	-		-	-	5	-	-	-	7	1		-	-	6	-		5	-	8			6	13	
Total Cases Closed	12	14	21	27	23		32	23	23	34	24	29	46	28		20	28	37	71		78	87	74			156	239	
Cases Remained Open	308	319	319	317	322		278	296	327	357	375	395	396	400		196	254	319	322		327	395	400			322	400	
Total Cases Managed	321	332	342	345	346		350	355	369	393	405	427	442	428		217	282	357	394		424	479	487			480	639	

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024-Trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	2025-Trend	Q1-2024	Q2-2024	Q3-2024	Q4-2024	2024 - Quarters Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	YTD-2024	YTD-2025	Year trends
Services	TAT Compliance Goal: 100%						TAT Compliance Goal: 100%									TAT Compliance Goal: 100%						TAT Compliance Goal: 100%						
Routine Pre-Service Authorization TAT (non-BH)	100%	100%	100%	100%	100%		100%	100%	100%	96%	100%	98%	100%	98%		100%	95%	100%	100%		100%							
Routine Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	100%	98%	100%	100%	100%		94%	98%	98%	74%	66%	68%	86%	93%		100%	99%	99%	100%		97%							
Expedited Pre-Service Authorization TAT (non-BH)	98%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	80%	94%		98%	97%	99%	100%		100%							
Expedited Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	100%	100%	100%	100%	100%		100%	100%	75%	80%	100%			100%		100%	100%	100%	100%		88%							
Post-Service Authorization TAT (non-BH)	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%		100%							
Concurrent Authorization TAT (non-BH)	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	98%	100%		100%	100%	100%	100%		100%							
	CCS ID Rate						CCS ID Rate									CCS ID Rate						CCS ID Rate						
CCS %	8.52	8.51	8.52	8.55	8.47		8.43	8.57	8.42	8.34	8.43	8.36	8.35	8.47		7.59	8.52	8.51	8.51							8.28	8.43	

Item #10

Attachment 10.D

Medical Management

Quarterly Summary Report



REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

FROM: Patrick C. Marabella, MD Chief Medical Officer
Amy R. Schneider, RN Senior Director Medical Management

COMMITTEE

DATE: October 16th, 2025

SUBJECT: CalViva Health QI, UCM & Population Health Update of Activities Quarter 3 2025(Oct 2025)

Purpose of Activity:

This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Care Management and Population Health Management performance, programs, and regulatory activities in Quarter 3 of 2025.

I. Meetings

Two QI/UM meetings were held in Quarter 3, in July and September. On July 17th and September 18th, 2025, the QI/UM Committee met, and the following **guiding documents** were approved:

1. 2024 Care Management Program Evaluation
2. 2025 QI & Health Education Work Plan Mid-Year Evaluation
3. 2025 UCM Work Plan Mid-Year Evaluation
4. Health Disparities Analysis and Actions Report 2025
5. Population Health Management Program Effectiveness Report 2025
6. RY2025 HEDIS® Results & QI Update

In addition, the following **general documents** were adopted/approved at the meetings:

1. Medical Policies
2. Pharmacy Provider Updates
3. Quality Improvement Policies & Procedures Annual Review

The following **Oversight Audit Results** were presented and accepted at the July meeting:

1. 2025 Behavioral Health MY2024
2. 2025 Quality Management MY2024
3. 2025 Credentialing MY2024

New presentation at the QI/UM Committee:

1. **Skilled Nursing Facility (SNF) Quality Assurance Performance Improvement 2025 Q1 Dashboard Report.**

This new component of our Quality Improvement Utilization Management program was presented and discussed at the September meeting.

Purpose & Goals of this report include the following:

To utilize a summary of key quality, regulatory, satisfaction and performance measures for SNFs serving CalViva Members for oversight monitoring and identification of opportunities for improvement.

- There are 36 licensed SNFs in the CalViva Health designated service area.

- In the last 12 months, CalViva Health Members were admitted to 90 different nursing homes statewide.
- CalViva utilizes a weighted 5-point scale for key metrics in designated Quality Categories as indicators of overall quality of care and outcomes for the skilled nursing facilities in Fresno, Kings and Madera Counties to assign an overall score for each facility. Initial results identified three facilities to target for improvement. Initiatives have begun and their effectiveness will be monitored and evaluated over time.

II. **QI Reports** - The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard & Quarterly A & G Reports** provide a summary of all grievances in order to track volumes, turn-around times, case classifications, and use of clear and concise language in member letters. A year-over-year and Quarterly Analysis was presented in September to identify trends over time and evaluate the effectiveness of actions taken for improvement.
 - a. Compared to Q2 2024, appeals volume increased in all three counties.
 - b. Grievance volumes also increased during this same time period.
 - c. When compared to the previous quarter, appeals increased by 16% in Fresno County, 14% in Kings County, but declined by 21% in Madera County.
 - d. In Q2, 2025, grievance volumes increased in Fresno County by 14%, Kings County by 20%, and Madera County by 9% when compared to Q1 2025.
 - e. The majority of appeals were classified as Not Medically Necessary (78%).
 - f. Grievance increases were most often associated with Access to Care, particularly due to prior authorization delays and missed transportation appointments.
2. **Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.
 PQI reviews may be initiated by a member, non-member, or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review.
 - In quarter 2 there was one (1) non-member-generated Physical Health (PH) PQI, scoring level II. Member-generated PQIs increased compared to previous quarters, to forty-one (41) PH cases and two (2) Behavioral Health (BH) cases. Outcome scores were reported as twenty-two (22) level zero, eight (8) level I, nine (9) level II, and two (2) cases scored at level IV.
 - Twenty-three (23) Peer Review cases were generated (all PH). Sixteen (16) cases were closed, and seven (7) cases were open.
 Nineteen (19) Peer Review cases reviewed from April through June needed further action. None (0) were BH. Outcome scores were reported as ten (10) level zero, six (6) level I, and three (3) at level II.
3. The **Facility Site & Medical Records and PARS Report** displays completed activity and results of the DHCS required PCP Facility Site (FSR) and Medical Record Reviews (MRR) for CVH. The new FSR/MRR tools and standards began on 7/1/22, including revised Physical Accessibility Review Survey (PARS) assessment of provider offices. The results are analyzed for the purpose of monitoring and improving the performance of PCPs against DHCS and CVH standards.
 Fifteen (15) FSRs and eighteen (18) MRRs were completed during Q3-Q4 2024.
 - The FSR mean rate for Q3-Q4 2024 was 97%.
 - The MRR mean rate for Q3-Q4 2024 was 92%.
 - Thirteen (13) PARS were completed with seven of the thirteen (7/13) PARS having Basic level access. PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal to 90% do not have to submit a CAP (exempt pass). One (1) MMR required an on-site focused review to verify corrections. One (1) failed review occurred during this period.
4. The **Lead Screening Quarterly Report** is a Quarterly Assessment of Blood Lead Screening compliance in Children to ensure that CalViva members receive blood lead level testing and follow-up when indicated

and that parents/caregivers receive anticipatory guidance from providers related to blood lead poisoning prevention. Improvement has been noted in HEDIS® rates for this measure in RY2025, but challenges still exist. The provision of anticipatory guidance continues to be problematic and was a DHCS finding in 2022.

- In Q1 2025, the **overall compliance** was twenty-two-point ten (22.10%), which is a one-point seven percent (1.7%) decrease compared to Q2 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year.
- In Q1 2025, the overall compliance for **Anticipatory Guidance** was reported at two-point eight percent (2.80%). Due to the persistent low compliance, the QI team continues to explore potential barriers and solutions.
- This is a persistent compliance issue that requires additional action.

5. **Additional Quality Improvement Reports** approved include Behavioral Health Performance Indicator Report, Initial Health Appointment Quarterly Report, Provider Preventable Conditions, County Relations Report, Member Incentives Program report, Performance Improvement Updates (PIPs), Provider Satisfaction Survey Results 2024, and others scheduled for presentation at the QI/UM Committee during Q3.

III. **Access Reports** – The following is a summary of the access related reports and topics reviewed. These reports may be submitted by the Access Work Group or other access-related monitoring functions.

1. Access Work Group minutes from January 28th, March 25th, May 27th, June 24th, 2025, were reviewed and approved.
2. The **Access Work Group Q3 Summary Report** was presented. This report provides the QI/UM Committee with an update on the CVH Access Workgroup activities since the last QI/UM Committee report. A variety of reports were presented and discussed at the workgroup including, but not limited to, reports on access related grievances, network adequacy and capacity, Call Center metrics, Triage & Screening results, Telehealth and more. Several standing reports related to the annual DMHC Timely Access Reporting (TAR) filing were discussed and brought back for final approval due to their length and complexity. Updates were provided on Network Certifications and other regulatory filings.

Some of the key reports presented this quarter included:

- **The Integrated Accessibility Report** which included results from both the Provider Satisfaction Survey and the Enrollee Experience Survey, and monitoring of member grievances across all four (4) 2024 quarters.
- **Timely Access Metrics** - MY 2024 PAAS results show that the seventy percent (70%) DMHC compliance threshold was met for both Urgent Care and Non-Urgent appointments across all survey types when combined across all counties, even though individual providers may not have met the compliance threshold.
- **After-Hours Survey** - The Provider After-Hours Survey was fielded via telephone to CVH PCPs. The survey collected responses based on two metrics used to measure performance with Access to After-Hours services. The performance goal of ninety percent (90%) was met in all three (3) CVH counties for both After-Hours Emergency Instructions and the Ability to contact an on-call physician after hours.

3. **Additional Access Related Reports** approved include the Specialty Referral Report, Provider Office Wait Time Report, Accessibility of Service Report (Primary, BH, & Specialty Care), Assessment of Network Adequacy (BH & Non-BH), and the Standing Referral Report.

IV. UCMCM Reports - The following is a summary of the reports and topics reviewed:

1. **The Key Indicator Report (KIR) & Concurrent Review Report** provided data through July 31st, 2025, and Q2 respectively. A presentation analyzing key UM and CM metrics at the mid-year was presented with the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through Q2 2025. Annual and quarterly comparisons were presented with the following highlights:
 - Average Length of Stay (ALOS):
 - MCE: Acute admissions and utilization remained stable.
 - TANF: Continued stability with slight declines in admissions and utilization compared to 2024.
 - SPD: Marked and sustained declines across all acute care metrics in admissions, negative twenty-point three percent (-20.3%) and bed days negative twenty-four-point three percent (-24.3%) versus 2024 benchmarks.
 - 30-Day Readmission Trends:
 - MCE: Declined from a 2024 average of thirteen-point five percent (13.5%) to twelve-point seven percent (12.7%) in Q2 2025, representing a six percent (6%) reduction.
 - TANF: Saw the most substantial improvement, dropping from a four-point eight percent (4.8%) average in 2024 to three-point seven percent (3.7%) in Q2 2025, a twenty-three percent (23%) reduction.
 - **Key Takeaways:** 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.
 - One area requiring improvement identified related to **Noncompliant Turnaround Times for Routine Prior Authorization Deferral Letters**. This performance issue has persisted from January to June 2025 with declining rates over time indicating a need for corrective action.
2. **The Care Management and CCM Report** provides a summary of the various case management and care coordination services offered to CalViva members. The programs include physical health case management, perinatal case management, behavioral health case management, transitional care services (the entry point for most CM programs) and the First Year of Life. Reports for Q1 and Q2 were presented in July and September respectively. The **outcome measures** include Readmission rates, ED utilization, Pre-term deliveries for the OB population, Member satisfaction, and Overall Healthcare costs. Positive results were seen for most outcome measures with the following exceptions:
 - There was a four-point five percent (4.5%) decrease in readmission rate for post-enrollment in BH/PH CM. This was just below our five percent (5%) goal.
 - Transitional Care Services (TCS) saw a one-point four percent (1.4%) decrease in readmission rate, which was below our five percent (5%) goal. Low reduction is attributed to one member with multiple readmissions.
 - Members enrolled in Perinatal CM saw a one-point four percent (1.4%) increase in the first prenatal visit within the first trimester which did not meet the eight percent (8%) goal.
3. **Additional UCMCM Reports** include Concurrent Review IRR Report, TurningPoint, MedZed Report, Evolent Report (NIA), CCS Report, SPD HRA Report, Top 10 Inpatient Diagnoses MY2024, PA Member Letter Monitoring report, ECM and Community Supports, and others scheduled for presentation at the QI/UM Committee during Q3.

V. Pharmacy Quarterly Reports The following is a summary of the reports and topics reviewed:

Pharmacy reports include Executive Summary, Operation Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR) which were all reviewed. Since the implementation of Medi-Cal Rx in January of 2022, pharmacy activities are focused on Medical Benefit drugs.

1. Pharmacy Prior Authorization metrics were within 5% of standard for the second quarter.

2. PA volumes remained consistent in Q2 compared to Q1 with April volumes highest compared to all other months.
3. Overall Turn-around Time was 100% compliant in Q2.
4. Second quarter's Top Medication Requests were consistent with quarter 1.
5. Inter-rater Reliability results met the 90% threshold for action and the 95% goal was also met; the overall score was 96.67%. Clear and concise language in member letters was the most common issue in Q2. A more detailed review was completed in Q2 and the results were shared with PA Managers.

VI. HEDIS® Activity

In Q3, HEDIS® related activities were focused on analyzing the results for MY2024 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. CalViva saw improvement in MY24 when compared to MY23 with five (5) additional measures meeting MPL in both Fresno and Kings Counties and Madera County remaining compliant with all but two (2) MCAS measures.

A review of final HEDIS® results for CalViva for MY 2024 (RY25) reveals the following:

- **Fresno County** did not meet the Minimum Performance Level (MPL) of the 50th percentile for the following measures: Follow up after ED Visit for Mental Health/SUD and Well-Care Visits (W30-15 & W30-30) a total of **four (4) measures** (Children's and Behavioral Health Domains).
- **Kings County** did not meet the MPL of the 50th percentile for the following measures: Childhood IZ, Adolescent IZ, Child and Adolescent Well-Care Visits, Developmental Screening in Children, and Well-Care Visits (W30-15 & W30-30). A total of **five (5) measures** all in the Children's Domain.
- **Madera County** met the MPL of the 50th percentile for all measures except Follow up after ED Visit for Mental Health/SUD a total of **two (2) measures** in the Behavioral Health Domain.

The number of MCAS measures required to meet the MPL for MY25 remains at eighteen (18) for each county.

VII. Quality Improvement Activities

1. Two Performance Improvement Projects:

- A. **Clinical Disparity PIP** - Improve Infant Well-Child Visits in the Black/African American(B/AA) Population in Fresno County.
 - **Annual Report** submitted to HSAG/DHCS on 08/07/25 with two interventions. Statistically significant improvement is noted in one of two outcome measures. HSAG feedback received on 09/30/25; a response is being prepared that is due 10/28/25.
 - Continuing Intervention #1 to **refer all B/AA pregnant** or newly delivered members to Black Infant Health (BIH) inclusive of member incentives.
 - Continuing 2nd intervention to utilize **CDC Milestones Tracker app** via BIH to support timely completion of WCV.
 - New BIH Leadership supportive of interventions. PIP closes 12/31/2025.
- B. **Non-Clinical PIP** - Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue.
 - **Annual Report** submitted to HSAG/DHCS on 08/07/25. Statistically significant improvement is noted in the outcome measure. HSAG feedback received on 09/30/25; a response is being prepared that is due 10/28/25.
 - Implementing three interventions at Saint Agnes Medical Center:
 - #1 Staff Training on use of **"Smart Phrases"** to meet HEDIS® specifications.
 - #2 **Cultural Competency** focusing on the Hispanic Population to increase Follow up.
 - #3 Facilitate referrals to local CBO (**Resiliency Center**) for follow-up services.
 - PIP closes 12/31/2025.

2. DHCS Collaboratives

1. ***Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative***
Completed 5 Interventions in Phase 1 (March 2025); – Phase 2 Kick-off September 25th, 2025.
Initial planning with Clinica Sierra Vista underway. Baseline assessment due 10/23/25.
2. ***Institute for Healthcare Improvement (IHI) Behavioral Health Collaborative*** Phase 1 concluded June 2025. Anthem Blue Cross and Fresno County Behavioral Health declined to participate in Phase 2. Awaiting direction from DHCS.
3. ***DHCS County Projects- All projects in progress with final submissions due in October/November 2025***
 - a. ***Fresno County – Transformational Equity Improvement Projects for 3 Domains***
 1. *Behavioral Health Domain*
 2. *Children’s Domain*
 3. *Chronic Conditions Domain (Asthma)*
 - b. ***Kings County – Comprehensive Equity Improvement Projects for 2 Domains***
 1. *Children’s Domain*
 2. *Chronic Conditions Domain (Asthma)*
 - c. ***Madera County - Lean Equity Improvement Project for 1 Domain***
 1. *Behavioral Health Domain*

VIII. Findings/Outcomes

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of utilization management, care management, population health and the quality and safety of care provided to CalViva members.

Two areas of non-compliance were identified through routine monitoring during Quarter 3:

1. Utilization Management Turnaround Times for Prior Authorization Deferrals.
2. Blood Lead Screening in Children – provision of anticipatory guidance by providers.

Health Net was notified of the unsatisfactory performance in these areas and Corrective Action Plans were requested and are in progress. Oversight and monitoring processes will continue.

Item #10

Attachment 10.E

Equity Report



Current Health Equity Project(s) and Initiative(s):	Objective	Status
Perimenopause/ Menopause Project- Hanford	The goal is to bring Perimenopause/ Menopause into the light through education, awareness and advocating for women's health needs.	10/2025: Our first focus group was held on October 6, 2025, at the KCAO location in Hanford. A total of 24 individuals registered for the focus group through a QR code and outreach completed by Valley Voices. On the day of the event, 27 non-registered participants attended, bringing the total number of participants to 51. Dr. Lewis from Kings County Behavioral Health provided valuable education on perimenopause and menopause. The participants were very receptive and engaged; they asked questions about their health, shared their vulnerabilities, and expressed gratitude for the information provided. Nicole Fisher, a Public Health Nurse from Kings County Public Health, informed attendees about next steps and how to advocate for their personal health and wellness. The PearSuite and Valley Voices Community Health Worker team coordinated the process flow and offered resources and referrals to individuals who requested additional services, both related and unrelated to perimenopause and menopause. Translation services in Spanish were provided to 30 individuals through Linguistica, an existing partner of CalViva. Although the outcome analysis of the first focus group has not yet been completed, based on the assessment completed that evening, we were able to identify 22 individuals with symptoms of perimenopause/menopause, 7 who are at risk, and 4 who are at high risk. To ensure we meet the needs of the Kings County community, our second focus group will be held on October 14 at Veterans Hall in Avenal, hosted by Valley Voices. The final focus group will take the RAC (Recreation Association of Corcoran), a trusted partner of KCAO.
Madera County- Healthy People Strong Community Workgroup	CHIP GOAL: Prevent and manage rates of diabetes and heart disease	9/2025: CVH has been co-leading the Healthy People Strong Community Workgroup with Madera Live Well to address chronic diseases such as diabetes and heart health. We have been making adjustments to our workflow to advance some of the CHIP activity objectives and address 3 main challenges identified by the group. The first challenge was the inconsistent representation at meetings, which led to the subgroups having to explain the minutes from prior meetings. This took away valuable time from focusing on the current topics and delayed



		our progress. Second, even though people were familiar with each other and their organizations, not everyone knew who was in the room or what each organization contributed. Finally, while team leads had been identified previously, they lacked direction on the next steps. **Solution:** 1. We requested support from the backbone team to ensure that representatives from other organizations, managed care plans, and residents who play a vital role in this work were included/ returned to the discussions. 2. One of our key objectives was to invite outside organizations to present their services and see if there was alignment with the CHIP activities. However, it was essential for everyone to first understand who was currently in the room so that we could make the most of the existing participants. 3. We started hosting team lead debriefings one month before the scheduled Healthy People Strong Community Workgroup meetings. Team leads are now responsible for updating the activity tracking grid and sharing updates and new information with their groups. As co-chair, I have been more present in Madera, brainstorming with the team on how we can continue to progress the activities and overcome barriers. Our planned initiative will be presented to the entire group on October 14.
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Health Equity Annual Activities	Status
Diversity, Equity and Inclusion Survey and training	8/2024- DEI Surveys distributed and completed for Board, Committee, and staff members. 11/2024- Mandatory Diversity, Equity, and Inclusion training for all CalViva Staff Completed 12/2024- Implemented one DEI opportunity based on Survey Findings 12/2024- Submitted Diversity, Equity, and Inclusion training Curriculum to DHCS (APL-24-016) 2/2025 DEI training was approved 9/2025 Annual DEI Surveys will be distributed this month, please keep an eye out for the survey.
NCQA Health Equity Accreditation-	12/2024- Completed gathering all required CVH evidence for NCQA Health Equity Accreditation. On Schedule for Submission for 3/11/2025 1/9/2025- Introductory Call with NCQA Surveyor was completed. 3/2025- All Evidence for Health Equity was Submitted 3/11 for NCQA review 5/2025- NCQA returned minimal issues with our initial submission on 4/2. All outstanding issues were addressed, and the final submission was completed on 4/11 and sent back to NCQA for Preliminary review. The closing call was completed on 4/28 with the suggestion to revise the Health Equity Work Plan to include more specific details in SMART goals. 2025 HE



	Work Plan has been updated to reflect the SMART goals per NCQA's request. Preliminary report by NCQA reviewers was returned 5/2 with one remaining issue, specifically asking CVH's HE Program Description to connect back to the Work Plan's SMART Goals. At this time, CVH decided not to rebut the 1 outstanding issue remaining to move the accreditation process along to the final stage for Health Equity accreditation. CVH will hear back from NCQA about accreditation status, hopefully by the end of May. 6/2025- CVH received its NCQA Accreditation on June 4. Out of the 26 applicable points, CalViva Health received all 26 points
Health Equity Annual Oversight Audit- HN	Oversight Audit Started April 2025, HealthNet Oversight audit completed with 100% Compliance, September 2, 2025.

Closing Health Equity Community Activities	Who	Activity
	DHCS, IHI (Institute for Healthcare Improvement, California Health Care Foundation, LHPC (Local Health Plan of CA, First 5 Center for Children's Policy.	In September, I attended a quarterly gathering in Sacramento with DHCS, the Institute for Healthcare Improvement (IHI), the California Health Care Foundation, the Local Health Plan of California (LHPC), and the First 5 Center for Children's Policy. The purpose of these gatherings is to examine the rising federal and state issues and how they are affecting medical benefits. Additionally, strategize a plans to address health disparities and gaps in specific areas. Two major topics discussed were birthing supports and addressing Medicaid beneficiaries who are identified as having unsatisfactory status. The resolution proposed by DHCS, IHI, and the California Health Care Foundation suggested that the health plan's direct involvement in the community can play a key role in building stronger trust with community members while also helping to identify health gaps and disparities that data metrics may not capture. CalViva Health was identified as the lead health plan in this community work and was a key speaker on the topic of strengthening partnerships to advance health equity.

Item #10

Attachment 10.F

Executive Dashboard



	2024	2024	2024	2024	2024	2025	2025	2025	2025	2025	2025	2025	2025
Month	August	September	October	November	December	January	February	March	April	May	June	July	August
CVH Members													
Fresno	348,729	347,975	348,113	346,388	344,539	343,331	343,661	344,009	343,946	344,786	345,260	345,340	342,450
Kings	38,254	38,133	38,078	38,137	38,356	38,319	38,416	38,595	38,593	38,656	38,654	38,730	38,789
Madera	49,373	49,507	49,666	49,757	49,814	49,686	49,936	50,015	50,185	50,466	50,725	50,974	50,958
Total	436,356	435,615	435,857	434,282	432,709	431,336	432,013	432,619	432,724	433,908	434,639	435,044	432,197
SPD	47,185	47,411	47,615	48,116	48,373	47,384	47,559	47,614	47,581	47,873	48,033	48,339	48,274
CVH Mrkt Share	66.92%	66.92%	66.91%	66.87%	66.86%	66.70%	66.71%	66.75%	66.77%	66.79%	66.79%	66.78%	66.81%
ABC Members													
Fresno	154,520	154,078	154,265	153,460	152,518	152,847	152,663	152,377	151,970	151,951	151,925	151,700	149,921
Kings	24,819	24,689	24,659	24,681	24,705	24,836	24,916	25,007	24,942	25,042	25,020	25,119	25,190
Madera	28,541	28,385	28,149	27,966	27,944	27,940	27,879	27,723	27,650	27,553	27,607	27,669	27,375
Total	207,880	207,152	207,073	206,107	205,167	205,623	205,458	205,107	204,562	204,546	204,552	204,488	202,486
Kasier													
Fresno	6,645	6,936	7,161	7,601	7,873	8,130	8,479	8,737	9,020	9,356	9,681	10,001	10,252
Kings	121	129	154	153	171	187	199	206	209	206	209	215	231
Madera	1,098	1,151	1,202	1,253	1,302	1,372	1,428	1,485	1,565	1,608	1,656	1,700	1,741
Total	7,864	8,216	8,517	9,007	9,346	9,689	10,106	10,428	10,794	11,170	11,546	11,916	12,224
Default													
Fresno	59.99%	55.98%	58.51%	57.19%	60.02%		65.71%	61.18%	62.07%	60.31%	61.10%	61.50%	
Kings	53.85%	54.72%	54.02%	47.49%	56.30%			56.49%	42.30%	44.07%	57.76%	54.22%	
Madera	65.08%	66.39%	72.04%	57.60%	81.46%			63.13%	47.18%	46.80%	61.63%	64.90%	
County Share of Choice as %													
Fresno	62.71%	62.50%	63.30%	63.27%	59.51%		63.95%	64.88%	62.72%	61.33%	60.48%	61.03%	
Kings	58.59%	61.86%	69.74%	62.45%	60.92%		40.29%	61.16%	58.03%		52.59%	60.13%	
Madera	68.13%	69.84%	65.30%	64.17%	63.15%		69.36%	64.47%	71.61%	63.59%	65.45%	49.28%	

IT Communications and Systems	Active Presence of an External Vulnerability within Systems	NO	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	NO	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	NO	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	NO	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	NO	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Security Risk	2	Description: Average security risk for all hosts. 5 = High Severity. 1 = Low Severity
	Business Risk Score	24	Description: Business risk is expressed as a value (0 to 100). Generally, the higher the value the higher the potential for business loss since the service returns a higher value when critical assets are vulnerable.
	Average Age of Workstations	2.9 Years	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communications and Systems.		

Member Call Center CalViva Health Website	Year		2024	2024	2024	2024	2025	2025
	Quarter		Q1	Q2	Q3	Q4	Q1	Q2
	(Main) Member Call Center	# of Calls Received	41,520	36,270	38,251	33,900	41,923	40,133
		# of Calls Answered	41,114	36,104	37,970	33,610	41,609	39,766
		Abandonment Level (Goal < 5%)	1.00%	0.50%	0.70%	0.90%	0.70%	0.90%
		Service Level (Goal 80%)	85%	98%	96%	93%	92%	94%
	Behavioral Health Member Call Center	# of Calls Received	940	864	957	827	1,008	917
		# of Calls Answered	936	859	950	816	1,004	909
		Abandonment Level (Goal < 5%)	0.40%	0.60%	0.70%	1.30%	0.40%	0.90%
		Service Level (Goal 80%)	97%	94%	93%	88%	95%	96%
	Transportation Call Center	# of Calls Received	9,469	13,007	14,196	14,123	14,958	15,899
		# of Calls Answered	9,384	12,942	13,940	14,010	14,868	15,819
		Abandonment Level (Goal < 5%)	0.60%	0.40%	1.50%	0.60%	0.40%	0.20%
		Service Level (Goal 80%)	79%	86%	63%	82%	86%	85%
	CalViva Health Website	# of Users	54,000	53,000	64,000	69,000	79,000	34,000
		Top Page	Main Page	Main Page	Main Page	Main Page	Main Page	Main Page
		Top Device	Mobile (61%)	Mobile (61%)	Mobile (67%)	Mobile (73%)	Mobile (70%)	Mobile (63%)
		Session Duration	~ 1 minute	~ 1 minute	~ 1 minute	~ 1 minute	~ 1 minute	~ 1 minute
Message from the CEO	Q2 2025 numbers were presented during the September 18, 2025 RHA Commission Meeting. Q3 2025 numbers are not yet available. At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website activities. Approximately 2,400 members have registered and created a member portal account.							

Provider Network & Engagement Activities	Year	2025	2025	2025	2025	2025	2025	2025
	Month	Feb	Mar	Apr	May	Jun	Jul	Aug
	Hospitals	10	10	10	10	10	10	11
	Clinics	161	161	161	161	161	162	165
	PCP	438	441	431	435	440	445	447
	PCP Extender	463	471	471	473	488	508	521
	Specialist	1637	1585	1589	1599	1624	1664	1690
	Ancillary	335	335	336	338	337	331	329
	Year	2024	2024	2024	2024	2025	2025	2025
	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3
	Behavioral Health	353	652	658	558	545	562	486
	Vision	108	116	113	114	112	104	106
	Urgent Care	16	16	16	17	17	16	16
	Acupuncture	3	3	3	2	3	3	3
	Year	2023	2024	2024	2024	2024	2025	2025
	Quarter	Q4	Q1	Q2	Q3	Q4	Q1	Q2
	% of PCPs Accepting New Patients - Goal (85%)	96%	94%	94%	94%	91%	89%	89%
	% Of Specialists Accepting New Patients - Goal (85%)	98%	97%	98%	97%	96%	96%	96%
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	93%	96%	97%	98%	99%	99%	99%
	Year	2025	2025	2025	2025	2025	2025	2025
	Month	Feb	Mar	Apr	May	Jun	Jul	Aug
	Providers Interactions by Provider Relations	415	487	549	408	434	505	679
	Reported Issues Handled by Provider Relations	36	46	31	29	33	16	30
	Documented Quality Performance Improvement Action Plans by Provider Relations	10	74	75	26	32	8	21
	Interventions Deployed for PCP Quality Performance Improvement	10	74	75	26	32	8	21
Message From the CEO	The hospital count increased from 10 to 11 due to the addition of Madera Community Hospital. Aside from this update, at present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

Claims Processing	Year	2023	2024	2024	2024	2024	2025	2025
	Quarter	Q4	Q1	Q2	Q3	Q4	Q1	Q2
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 98% N/A	96% / 98% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	N/A	99% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	76% / 100% NO	1% / 93% NO					
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	94% / 97% YES	88% / 99% YES	80% / 100% YES	79% / 95% YES	91% / 100% YES	84% / 99% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	47% / 89% YES	79% / 93% YES	99% / 100% NO	94% / 97% NO	96% / 100% YES	93% / 100% YES	92% / 100% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	95% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	98% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	97% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	64% / 100% NO	95% / 100% NO	79% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q2 2025 numbers are available. Management continues to monitor the performance of PPG 2. PPG 8 will no longer be a contracted PPG in the Plan's network as of 6/30/2025. Run out data will begin. Aside from those updates, there are no other significant issues or concerns as it pertains to the Plan's Claims Processing Activities.							

Provider Disputes	Year	2023	2024	2024	2024	2024	2025	2025
	Quarter	Q4	Q1	Q2	Q3	Q4	Q1	Q2
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	98%	99%	99%	99%	100%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	100%	99%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	89%					
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	81%	100%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	65%	70%	93%	99%	96%	99%	95%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	90%	97%	100%	100%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	85%	98%	97%	97%	98%	100%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	100%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	95%	100%	100%	100%	99%	100%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	100%	97%	100%	100%	100%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	100%	100%	98%	100%	100%
Message from the CEO	Q2 2025 numbers are available. All areas met goal. PPG 8 will no longer be a contracted PPG in the Plan's network as of 6/30/2025. Run out data will begin. Aside from those updates, there are no other significant issues or concerns as it pertains to the Plan's Claims Processing Activities.							