Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 19, 2026

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	✓	**Morgan Simpson**, Senior Director of Compliance
	General Counsel and Consultants		
✓*	**Jason Epperson**, General Counsel		
✓ = Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
• = Attended via Teleconference			

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

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Cheryl Hurley, Clerk to the Commission			
#3 Reappointed Board of Supervisors Commissioners **Action** D. Hodge, MD, Chair	Fresno County has re-appointed Supervisor Garry Bredefeld as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Rusty Robinson as alternate. Madera County has re-appointed Supervisor David Rogers as Commissioner and Supervisor Jordan Wamhoff as alternate for a term of three years.		***Motion:*** *Ratify BOS Commissioners.* *10 – 0 – 0 – 7* *(Neves / Soares)* *A roll call was taken*
#4 Consent Agenda • *Commission Minutes dated 10/16/25* • *Finance Committee Minutes dated 9/18/25* • *QI/UM Committee Minutes dated 10/16/25* • *QI/UM Committee Minutes dated 9/18/25* • *Compliance Report* • *Code of Conduct* • *Fraud Prevention Plan* **Action** David Hodge, MD, Chairman	All consent items were presented and accepted as read.		***Motion:*** *Consent Agenda was approved.* *10 – 0 – 0 – 7* *(Neves / Bredefeld)*
#5 Closed Session	Jason Epperson reported out of closed session. The Commission went in closed session to discuss the item agendized for closed session discussion, which is item five, Public Employee Appointment pursuant to government code section 54957. The item was discussed in closed session and direction was given to staff. Closed session was recessed at 1:34 PM.		***No Motion*** **Lisa Lewis joined meeting during closed session* **Kerry Hydash joined meeting at 1:35 pm at the end of closed session*

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#6 Annual Administration **Information** D. Hodge, MD, Chair	Dr. Hodge reminded the Commission the Form 700 is due on an annual basis, due this year on 4/1/26. Commissioners will receive notification from the Commission Clerk via email. Anyone due for an updated Ethics Certification will be notified.		***No Motion***
7. Justice Involved Data Sharing Agreement **Action** J. Nkansah, CEO	Jeff Nkansah reported, effective January 1, 2026, the Department of Health Care Services' Justice Involved initiative will require coordination and data sharing among managed care plans, counties, and partner agencies. While DHCS anticipates having two memorandum of understanding (MOU) templates addressing confidentiality and data exchange, only one template has been released to date. To ensure continuity of collaboration with partners such as correctional officers, probation departments an initial data-sharing agreement has been drafted by Health Net and reviewed by Anthem, Kaiser, CalViva Health and the Fresno County Probation Department. The agreement is being presented to the RHA Commission so the RHA Commission can provide approval to execute the Justice Involved Data Sharing Agreement as presented.		***Motion:*** *Approve the Justice Involved Data Sharing Agreement* *12 – 0 – 0 – 5* *(Prado / Naz)*
8. Revised 2024 Annual Delegation Oversight of Health Net **Action** J. Nkansah, CEO	Jeff Nkansah presented a revised report for Commission's review and approval. The item was returned following the February 20, 2025, presentation due to a previously undetermined section regarding performance standards, pending additional information related to audits and HEDIS® and MCAS measures. Based on finalized data from Measurement Year 2024 and consideration of Measurement Year 2025 information, staff determined that Health Net is in violation of performance standards related to regulatory audits. The violation is an uncorrected audit deficiency that has remained unresolved for more than 18 months. The deficiency involves post-stabilization processes identified through Department of Managed Health Care (DMHC) audits. Despite multiple audit cycles and opportunities to implement corrective action, the issue remains uncorrected. As a result, staff will assess a $1.2 million performance penalty against Health Net. This action is also informed by DMHC's referral of the finding to its Office of Enforcement for further review.	*Aldo De La Torre asked how the $1.2 million was arrived at?* *Jeff Nkansah replied, it is stated in the contract.* *Aldo De La Torre asked if the Plan is fined by enforcement what if the fine is larger than $1.2M?* *Jeff Nkansah stated whether the fine is less or more, HN remains responsible for that fine as a result of the contractual arrangements in place between RHA and HN.*	***Motion:*** *Approve the Revised 2024 Annual Delegation Oversight of Health Net* *13 – 0 – 0 – 4* *(Neves / Rahn)* **Soyla Griffin joined meeting at 1:42 pm*

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	Health Net will, in turn, work with its contracted and non-contracted providers to address compliance gaps, particularly regarding post-stabilization notification requirements. Hospitals are required to notify the plan within specified timeframes, and deficiencies in adherence to these processes have been identified. Health Net will undertake provider education and corrective efforts to bring hospitals into compliance.	*Joe Prado asked regarding the level of noncompliance, is it significant in the sense that the Plan is only seeing 20% compliance or 80% compliance, as he is curious about thresholds.* *Jeff Nkansah responded that essentially the finding was that HN didn't meet compliance at all.*	
9. 2025 Annual Delegation Oversight of Health Net **Action** J. Nkansah, CEO	Staff presented the Measurement Year 2025 annual review of Health Net's delegated functions, including oversight audits and related reports, as required under NCQA standards. The purpose of the review is to document oversight activities conducted throughout the year and determine whether to approve continuation of Health Net's delegated functions for an additional year. During Measurement Year 2025, oversight audits were conducted across approximately 15–20 functional areas. While audits are expected as part of routine oversight, staff noted that a number of audits are closing with corrective action plans (CAPs). Some CAPs reflect more significant compliance concerns, while others are process improvement in nature. Staff discussed the need to further evaluate how corrective actions are categorized and whether distinctions should be made between more egregious findings and less severe deficiencies. The performance standards section remains consistent with Measurement Year 2024, with no significant new activity to report.		***Motion:*** *Approve the 2025 Annual Delegation Oversight of Health Net and approve Health Net to continue their delegated functions for another year.* *13 – 0 – 0 – 4* *(Bredefeld / De La Torre)*
10. Health Net Community Solutions Contract – Update **Information** J. Nkansah, CEO	Staff provided a follow-up regarding the Health Net Community Solutions contract between Health Net and the RHA (CalViva Health). The Commission was previously advised that a verbal agreement had been reached, with the contract effective retroactively to July 1, 2025, pending regulatory approval from the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS).		***No Motion***

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	Both parties submitted the contract to their respective licensing councils, and the agreement has completed DMHC regulatory review. DMHC did not request any material changes, providing only comments related to clarification on accounting for compliance with the Mental Health Parity and Addiction Equity Act. After discussions, no substantive revisions to the contract were required. DMHC has conditionally approved the contract, contingent upon DHCS review and approval, and submission of fully executed copies. The contract was submitted to DHCS on February 12, 2026, and staff are awaiting feedback. Assuming no material changes are required by DHCS, the contract will return to the Plan for execution, the Board will be informed, and the agreement will proceed under its established terms. Staff also noted that the performance standards section includes defined severity standards under the new contractual arrangement.		
11. Remote Participation and Telephonic Participation **Action** J. Nkansah, CEO	Jeff Nkansah presented a review of the Commission's Remote Participation and Telephonic Access Policy, originally established in 2011, and provided background information outlined in the Board letter. The item was brought forward for discussion and direction, noting that any decision may have downstream impacts on advisory committees, including the QI/UM, Finance, and Public Policy Committees. Following the expiration of pandemic-related flexibilities, staff reviewed recent amendments to the Brown Act under Senate Bill 707. Legal counsel advised that the RHA Commission is not classified as an "eligible legislative body" under the new law and therefore is not required to provide teleconferencing. However, if the Commission elects to continue teleconferencing, it must comply with specific statutory requirements. Staff noted that some Brown Act requirements are currently being met, such as roll call votes and public agenda postings, but continuation of teleconferencing may require further policy revisions and additional compliance measures (e.g., mandatory video participation and other procedural safeguards). Currently, only the Commission utilizes teleconferencing; all advisory committees meet in person.	*Dr. Naz recommended retiring the telephonic participation policy.* *Supervisor Bredefeld and Dr. Hodge both recommended retiring the telephonic participation policy and allow for ADA participation when needed.* *Dr. Lisa Lewis asked if this would represent a hardship for public who needed to comment publicly and could not appear in person at the meeting location?* *Rosary Mary Rahn added that in the time she has been on the Commission there has not been that much public*	***Motion:** Approve to retire the AD-101 Telephonic Policy.* *9 – 4 – 0 – 4* *(Naz / Bredefeld)* *Bosse – No* *Bredefeld – Yes* *Cardona – Yes* *De La Torre – Yes* *Griffin – No* *Hodge – Yes* *Hydash – No* *Lewis – No* *Naz – Yes* *Neves – Yes* *Prado – Yes* *Rahn – Yes*

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	Regardless of the Commission's decision on teleconferencing, the RHA is required to provide reasonable accommodations for individuals participating remotely due to a qualifying ADA-related need. Staff requested direction on whether to: 1. Continue the telephonic access policy and revise it to ensure compliance with SB 707; or 2. Retire the teleconferencing policy and limit remote participation to ADA-required accommodations, thereby simplifying procedures. Staff also noted that commissioners who serve on other legislative bodies may have heard different guidance, as SB 707 applies differently depending on the entity. The telephonic participation policy is not permanent and may be revisited at a future date. The Commission retains the flexibility to reconsider and amend the policy in one year, five years, or at any time circumstances or statutory requirements change. A review of meeting attendance from 2022 through 2025 shows an average in-person attendance of approximately 9–13 members. During that period, teleconference participation was not required to establish a quorum.	*comment. There has been minimal public attendance.* *Soyla Griffin stated that the decision regarding teleconference availability would not affect her personal attendance and that she does not hold a bias on the matter. However, she expressed support for maintaining teleconference access, noting that it may increase accessibility and encourage greater participation, particularly among members with lower attendance or those who live a significant distance from meeting locations. It was further noted that policy decisions should prioritize practicality and access rather than administrative convenience.* *Kerry Hydash noted that in-person meetings may require two to three hours of travel time, which can be burdensome. Drawing from experience with another regional board that transitioned primarily to virtual meetings to accommodate geographic expansion, she expressed concern that limiting meetings to in-person attendance may impact*	*Soares - Yes*

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		equitable regional representation. She questioned whether requiring attendance in Fresno could limit participation from members representing other parts of the Commission's service area. *Joe Prado recommended that if the telephonic access policy is retired, staff should track regional representation data over the next year. After one year, the data should be reviewed to determine whether any region is underrepresented and whether the policy decision should be reevaluated.* *Sara Bosse commented the current practice of holding all meetings within a single location (Fresno) in the three-county region. It was noted that representatives from Madera and Kings Counties are consistently required to travel, resulting in additional time commitments beyond the meeting itself due to travel. Given that meetings are intended to allow member participation and public comment, consistently holding meetings in one location may create barriers for individuals in other*	

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		counties. Rotating meeting locations among the counties should be considered to promote equity, reduce travel burden, and improve accessibility for members wishing to address the Commission.	
12. Compliance • 2025 Annual Compliance Program Evaluation • 2026 Compliance Program Description • 2026 Privacy and Security Plan • 2026 Emergency Preparedness & Crisis Response Plan **Action** M.L. Loene, CCO	Mary Lourdes Leone provided a Compliance Program Overview. **Major Accomplishments (2025)** • Achieved NCQA Health Equity Accreditation (June 2025). • Maintained network adequacy through annual and subnetwork certifications; 2024 submission approved by DHCS. • Completed HSAG Network Validation Audit (approved November). • Filed and managed over 300 regulatory filings (excluding routine monthly/quarterly reports). • Submitted and received approval for CalAIM Transitional Rent Model of Care (effective January 1). • Executed multiple MOUs with third-party entities in alignment with contractual requirements. • Implemented DEI training curriculum as required. • DMHC Routine Financial Examination (March 2025) closed with no findings. **Regulatory Audits & Corrective Action Plans (CAPs)** DHCS Audits: • 2023 Focused Audit (Behavioral Health & Transportation): All responses submitted; awaiting closure pending issuance of updated transportation APL. • 2024 Audit: CAP closed May 2025. • 2025 Audit: Four findings related to: 1. EPSDT criteria application in medical necessity denials (<21). 2. ECM benefit discrimination notification via NOA. 3. ECM core service components delivery. 4. ECM member-facing materials completeness. 5. Initial responses submitted; monthly CAP updates ongoing until closure.		***Motion:*** *Approve the 2025 Annual Compliance Program Evaluation; 2026 Compliance Program Description; 2026 Privacy and Security Plan; 2026 Emergency Preparedness & Crisis Response Plan.* *13 – 0 – 0 – 4* *(Prado / Cardona)*

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	DMHC Follow-Up Audit (2025) Final Report • There were two DMHC determinations: 1. The deficiency related to not identifying PQIs in exempt grievances was corrected. 2. The deficiency related to inappropriately denying post-stabilization care was not corrected and will be referred to the Office of Enforcement; CAP remains open. **External Quality Review (EQR)** • Resolve the findings from the 2024 DHCS Audit • Improve MY2023 HEDIS® measures • Clarify methodologies used by DHCS for calculation of network adequacy indicators. The Plan submitted its response on August 4, 2025. **Encounter Data Validation Study:** Completed; awaiting final report. **Contract Amendments (DHCS)** 1. Executed Amendments #4 through #8 which focused mainly on Capitation Payment Rates and other contractual requirements such as: member rights/responsibilities; CCS; network adequacy; minor consent services; MLR requirements; and Operational readiness deliverables. 2. **Enforcement & Sanctions** • $25,000 DHCS sanction (October) for failure to meet MY2024 MCAS minimum performance levels. **2025 Compliance Program Documents** • All were approved by the Board. **Delegation Oversight & Internal Compliance** • Multiple oversight audits conducted (Health Net); some CAPs remain open (e.g., post-stabilization, prior authorization deferrals). • Additional corrective actions issued:		

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	1. Blood lead screening outreach. 2. Discrimination grievance reporting timeliness. 3. Prior authorization deferral letter compliance. 4. Non-compliant member mailings (doula materials). • Internal audit of employees/commission/committee members completed successfully (no CAP). • Annual compliance and required staff trainings completed. **Reporting & Monitoring Activities** • 31 MC 609 Fraud, Waste & Abuse reports filed. • 50 privacy/security incident reports submitted. • 322 provider communication approvals. • 73 provider directory reviews. • Annual EOC reviewed and submitted to DHCS/DMHC. • 5,000 provider engagement interactions conducted. **Appeals, Grievances & Hearings** • 3,000 total appeals/grievances; 3,013 resolved (timing overlap explains variance). • Seniors & Persons with Disabilities grievances: 100% resolved. • Exempt grievances: 100% resolved. • 56 state hearings received; timely responses provided. **2026 Compliance Program Documents Updates** • Compliance Program: 1. All policy categories were designated as "key." • Privacy & Security Plan: 1. Expanded medical information definition (includes place of birth, immigration status). 2. Added judicial warrant requirement for immigration enforcement requests. • Emergency Preparedness Plan: 1. Added cooperative agreement language with local healthcare partners (operationalized via MOUs). **2026 Key Focus Areas**		

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	• Medi-Cal enrollment freeze (effective January 1). • Implementation of new DMHC/DHCS APLs (timely access standards). • Federal Interoperability & Prior Authorization Final Rule (7-day review requirement). • Optimization of ECM and Community Supports provider capacity across three counties. • Anticipated joint DHCS/DMHC audit in 2026.		
13. 2025 Annual Quality Improvement & Health Education and Wellness Work Plan Evaluation **Action** P. Marabella, MD, CMO	**Quality Improvement (QI) & Health Education and Wellness Annual Evaluation** The committee reviewed the prior year's QI Evaluation, which includes three components: (1) Work Plan Initiatives, (2) Ongoing Activities, and (3) the Enterprise Quality Improvement Performance Tracker activities log. The QI structure encompasses Peer Review Sub-committee, Credentials Sub-committee, Access Workgroup, and the QI/UM Work Group with the Appeal and Grievance Work Group reporting to the QI/UM Work Group. These Sub-committees and Work Groups report up to the QI/UM Committee and up to the RHA Commission. Three additional sections were added to the QI & Health Education Work Plan in 2025, bringing the total to 11 focus areas. **Overall Performance** A total of 71 out of 83 objectives were met (85.54%) last year. • Behavioral Health: 6 of 6 • Chronic Conditions: 6 of 6 • Hospital Quality/Patient Safety: 8 of 11 • Member Engagement: 2 of 2 • Pediatrics/Perinatal/Dental (combined): 28 of 30 • Pharmacy: 3 of 3 • Preventive Health: 9 of 12 • Provider/Community Engagement: 9 of 13 **Key Initiative Highlights**		*Motion: see item #17 for action. One vote taken for items 13-17.*

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	Behavioral Health Focused on follow-up after ER Visit related to substance use and/or mental health issues (FUAF/FUM). Interventions included: • Coding training (SMART Phrases) at Saint Agnes Medical Center to improve documentation for HEDIS credit. • Hispanic cultural competency training to address identified disparities. • Collaboration with the Resiliency Center to expand access to services. Project implementation concluded at 2025 year-end; data collection continues for August 2026 submission. **Chronic Conditions** Targeted asthma, hypertension, and diabetes management through outreach and provider education. Promoted best practice prescribing practices for asthma combination therapy resulting in improvement across all three counties, meeting targets. **Hospital Quality/Patient Safety** Hospitals met reporting requirements. Improvements were noted in some areas; however: • No systemwide improvement in central line infections, catheter-associated infections, surgical site infections, or MRSA. • C. difficile rates declined (positive outcome). • C-section performance declined overall; with only 2 of 5 hospitals meeting targets. Last year 3 of 5 hospitals met targets. Goal remains for continued directional improvement in targeted measures. **Member Engagement and Experience (CAHPS Survey)** Met benchmarks in customer service, care coordination, and overall rating of the health plan. Three of eight measures met the 25th percentile threshold. Additional improvement strategies are forthcoming. **Pediatrics/ Children's Health** Focused on well-child visits and immunizations. Implemented a disparity project with Black Infant Health (BIH) to improve outcomes for African American infants		

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	(0-30 months). . Consistent referrals to BIH, increased education, and promoted use of the CDC Milestone Tracker app using slides, flyers, tabletop posters with QR codes. Project ended 12/31/25, data collection continues, and final submission due in August 2026. **Perinatal/Reproductive Health** All CalViva counties exceeded the 50th percentile for prenatal care, postpartum care, and chlamydia screening; Kings County exceeded the 90th percentile for postpartum care. Fresno and Madera counties exceeded the 75th percentile for timely prenatal visits. Efforts continue to address African American disparities. **Preventive Health** Breast and cervical cancer screening initiatives included mobile mammography, comprehensive provider education, building relationships with screening partners, and culturally responsive member education and outreach. **Provider Engagement** Quality Edge funding supported clinic workflow improvements, coding accuracy, and capital investments (e.g., lead screening equipment). 91 Quality Edge funding requests were approved. **Continuity and Coordination** CalViva utilizes NCQA as a roadmap for improvement. In 2025, CalViva was focused on integration of physical and behavioral health through provider education and use of resources, with a focus on seamless information transfer. **Access and Availability** Behavioral health appointment access improved for Psychiatry and non-physician mental health providers for four of five access survey measures comparing MY24 to MY23. Psychiatrist access remains limited, particularly in Kings and Madera counties. Contracting and clinical leadership are engaged to address gaps. Three new behavioral health HEDIS® measures were added in MY26. Access, availability and service survey performance met goals in several areas, including after-hours access (100%).		

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	Health Education Health Education programs were aimed at increasing participation in Well Care Visits, Breast Cancer Screening, Cervical Cancer Screening, and Childhood Immunizations. Transitioned many materials from print to QR codes, electronic flyers, and webinars. The most ordered topics included lead poisoning, diabetes, nutrition, and weight management/exercise. Utilization of the health education phone line remains low (13 calls). **HEDIS® Measurement Year MY2024 MCAS Results** Overall performance: 76% • Fresno: 78% • Kings: 61% • Madera: 89% Key gaps included behavioral health follow-up (FUA/FUM) in Fresno and Madera counties, Well Child Visits (0-30 months) in Fresno County, and all Children's Domain measures in Kings County, Flu vaccination requirements within the CIS 10 measure remain a significant barrier due to parental consent requirements, and hesitancy, particularly for children under two years of age. The committee discussed ongoing efforts to improve immunization rates and behavioral health access and emphasized continued monitoring and targeted interventions in underperforming areas.		
14. 2025 Annual Utilization Management Case Management Workplan Evaluation **Action** P. Marabella, MD, CMO	Utilization Management (UM) Case Management (CM) – End of Year Summary Overall Performance: Year-end results were largely positive, with most accreditation and regulatory requirements met. Key areas of concern were identified and are being addressed. 1. Accreditation & Regulatory Compliance: All standards were met except 1.4 – Compliance with Regulatory Standards, related to post-stabilization requirements, and 1.7 Annual review, approval and update of UM clinical criteria.		*Motion: see item #17 for action. One vote taken for items 13-17.*

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	• 1.4 DMHC issued final results from 05/05/25 Audit identifying that the Post Stabilization CAP was not corrected. • 1.7 regarding the annual review and update of clinical criteria. A Corrective Action Plan (CAP) was issued to Health Net Behavioral Health for failure to complete the review of all clinical criteria related to UM decision making annually, BHT/CASP UM criteria were not reviewed. 2. Monitoring the UM Process: All objectives were met except for 2.2 Timeliness of authorizing requests and 2.3 Conduct annual Interrater Reliability testing of healthcare professionals involved in UM decision-making. • 2.2 Deferral cases did not meet turnaround time standards for greater than 6 months. CAP was issued and is still open. • Corrective actions were implemented; compliance improved within 4–5 months, with perfect performance (100%) in October and November, followed by one metric not meeting compliance in December.2.3 Inter-Rater Reliability & Training. General Inter-rater reliability activities were conducted, however, required training related to the World Professional Association of Transgender Health was not completed during calendar year 2025. It is anticipated to be completed by the end of Q1 2026. • 3. Monitoring Utilization Metrics. All objectives were met. • 3.3 Two PPGs experienced performance challenges during the calendar year. Actions were taken expeditiously including hiring new staff, shifting resources, and modifying team assignments which resulted in return to acceptable rates by year-end. 4. Monitoring Coordination with Other Programs and Vendor Oversight: • Coordination with other programs and vendors all objectives met. • Behavioral health coordination activities for 2026 are under review and may be expanded in the 2026 UMCM Work Plan. 5. Monitoring Activities for Special Populations: • All objectives met for CCS, SPD, CBAS, and mental health tracking.		

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	• 6. Adequacy of UMCM Program Resources: CalViva has determined that program resources did not fully meet the needs of CalViva membership and providers due to staffing challenges associated with element 2.2 Timeliness of Processing the Authorization Requests. • Suboptimal staffing levels contributed to failures to meet turn-around times for prior authorizations. • During the calendar year new clinical staff were onboarded to ensure turn-around time requirements are met going forward. 7. Program Scope, Processes, Information Sources: • The scope of services offered to CalViva members meets the state of California requirements for Medi-Cal Managed Care Plans. • Ongoing out-reach and monitoring efforts have successfully engaged members in preventive care and services. • Annual DHCS survey (2025) had only two areas identified for improvement (EPSDT & ECM). • Identification of opportunities to improve processes, care, and service is a consistent priority. 8. Practitioner Participation and Leadership Involvement in the UM Program: • Contracted network providers consistently participated in the QI/UM Committee and Credentialing and Peer Review Sub-Committees. • Providers engaged and actively participated with Medical Management on Quality Improvement Projects and Annual Clinic Visits. • Medical Management consistently participated in Weekly Multi-disciplinary Care Rounds. • Leadership and staff provided reports, participated in improvement activities, and attended monthly meetings. The UM program demonstrated strong overall performance with identified deficiencies primarily related to authorization timeliness and specific regulatory requirements. Corrective actions have led to measurable improvement, and		

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	ongoing monitoring continues to support sustained compliance and quality outcomes.		

15. Care Management 2025 Program Description & Change Summary
 	
Action
P. Marabella, MD, CMO
	Care Management – Program Summary
	Program description updates for Care Management were minimal for 2026.
	• Organizational chart was updated.
	• Caseload requirements were revised:
	  o Previously blended perinatal and first year of life case management roles were restructured.
	  o Roles are now separated into dedicated perinatal case managers and first year of life case managers.
	• Added requirements related to alternate language format communications.
	
	No other significant program changes were noted.
			***Motion:** see item #17 for action. One vote taken for items 13-17.*

16. Skilled Nursing Facility Quality Assurance Performance Improvement Dashboard Report Q3 2025 **Action** P. Marabella, MD, CMO	Skilled Nursing Facility (SNF) Dashboard – Q3 Update (Managed Care / Long-Term Care) Program Overview • Under Managed Care, Medi-Cal is now responsible for long-term care services, including SNFs. • To ensure regulatory compliance, a long-term care dashboard has been implemented. • Data is reported quarterly to the Board. This presentation reflects Quarter 3 (following prior Q2 report). Data Sources • Claims data • DHCS WQIP data • Public CMS and Department of Public Health data • MCAS/HEDIS® Long-term care quality measures Member Utilization and SNF Performance • 36 licensed SNFs in the CalViva Health (CVH) service area • In the last 12 months, CVH members were admitted to 90 different nursing homes statewide.		***Motion:** see item #17 for action. One vote taken for items 13-17.*

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	• Average monthly census: approximately 1,000 members in SNF settings across Fresno, Kings, Madera, and surrounding counties. • Highest census facilities include Madera Rehab (65), Healthcare Centre of Fresno (65), Community Subacute & Transitional (58), and Hanford Post Acute (58). Quality & Regulatory Performance Measures • Facilities are scored on an internally defined weighted five-point scale (5 = highest performance). Metrics include: o Antipsychotic medication utilization o Falls with injury o Pneumococcal vaccination rates o Pressure ulcers o Urinary tract infections (UTIs) o Staffing o Number of State Enforcement Actions o Infection control deficiencies o Quality of Care Deficiencies o Freedom from Abuse deficiencies o Overall CMS Star Rating o Preventable ED utilization o Preventable inpatient admissions to acute care. Top Composite Performers (Q3) • Top Performing Facilities: o California Home for the Aged o Selma Convalescent Hospital o The Terraces o Dycora Transitional Health (Fowler) o Dycora Transitional Health (Sanger) Key Quality Drivers & Interventions Based upon preventable ER utilization and acute inpatient admissions three SNFs were selected for focused improvement activities: • Manning Gardens Care Center		

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	Higher than state average rates for falls and antipsychotic medication use. The SNF is implementing the following to improve their quality outcomes: o Hydration rounds started 9/1/25 (recent improvement noted in UTI rate) o Pharmacy education for Psychotropic meds (scheduled) o Physical Therapy Team Rounds for fall prevention (started 9/1/25) • Madera Rehabilitation & Nursing Center Higher than state average for falls and antipsychotic medication use Strength: improved pressure ulcer rates. The SNF is implementing the following to improve their quality outcomes: o ED companion program to start in Q4 (pre-transport clinical review and accompany resident to ED) o Pharmacy education for appropriate antipsychotic medication use (11/6/25) o Physical Therapy Team Rounds (twice monthly) • Community Subacute & Transitional Care Center Better than state average for fall rates and antipsychotic medication use. Rates of UTIs and pressure ulcers higher than state averages, resulting in higher-than-expected ED utilization and inpatient admissions. The SNF is implementing the following to improve their quality outcomes: o Hydration Rounds (started 9/1/250 o Physical Therapy Team Rounds (twice monthly) All new admissions are assessed by PT within 48 hours. • System-Level Opportunities for Improvement o Staffing challenges contributing to quality and utilization outcomes. o Unreported Falls continue as a challenge.		
17. Member Satisfaction Annual Regulatory CAHPS Summary Report **Action** P. Marabella, MD, CMO	CAHPS Member Satisfaction Survey – NCQA Reporting Summary Purpose & Regulatory Context • NCQA requires the Board to review CAHPS survey results as part of accreditation. • This was the first official NCQA CAHPS survey conducted for the Plan by Press Ganey.		***Motion:*** *Approve the 2025 Annual QI & Health Ed and Wellness Work Plan Evaluation; the 2025 Annual UMCM Work Plan Evaluation; the Care Management 2026 Program*

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	• Objective: assess member satisfaction, identify what most affects satisfaction, and highlight opportunities for improvement. • Survey is conducted annually, with separate surveys for adults and children. Survey Response • Qualified respondents: 4,100 • Completed surveys: 500 • Response rate: 12% (1 in 8 members responded) Methodology • Results analyzed via Press Ganey's "power grid" to show: o Importance to members o Plan performance • Four-quadrant framework identifies: o High importance & strong performance = "Keep it up" o High importance & poor performance = "Opportunity to improve" o Low importance & strong performance = "Maintain" o Low importance & poor performance = "Monitor" • Scoring: 1–5 scale; only "5" responses used for benchmarking against other Medi-Cal plans nationally. Key Findings Areas of Strong Performance • Rating of health plan: high percentile • Coordination of care: 87% positive, exceeds benchmark • Some aspects of personal doctor care also performed well Opportunities for Improvement • Access to care: obtaining needed care, timely care • Provider performance: doctor listening, showing respect, explaining care, time spent with patients • Overall healthcare rating • Percentiles indicate several categories below the 25th percentile, signaling focus areas		*Description; the SNF Quality Assurance Performance Improvement DB Report Q3 2025; and the Member Satisfaction Annual Regulatory CAHPS Summary Report* *13 – 0 – 0 – 4* *(Naz / Neves)*

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	Additionally: • Survey is member-reported; individual bad experiences may influence scores. • Survey insights align with internal grievance data; issues with access and provider service are consistently reflected. • Next steps: strategy development to address priority areas, ongoing monitoring, and annual CAHPS surveys for trend analysis. The CAHPS survey provides the Board with a benchmarked view of member satisfaction, highlighting strong performance in care coordination and health plan rating, while signaling opportunities in access, provider communication, and overall healthcare experience. Results will guide quality improvement initiatives and support continued NCQA compliance.		
18. Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of December 31, 2025</u> As of December 2025, total current assets were approximately $622.6M; total current liabilities were approximately $437.1M. Current ratio is approximately 1.42. TNE as of the end of December 2025 was approximately $195.2M which is approximately 655% above the minimum DMHC required TNE amount. For the DHCS standard, the minimum required TNE is approximately $194.2M, which the Plan is approximately $1M above the DHCS standard. Interest income actual recorded was approximately $4.5M which is approximately $1.6M more than budgeted due to rates being higher than projected. Premium capitation income actual recorded was approximately $1.16B which is approximately $138.4M more than budgeted primarily due to rates and enrollment being higher than projected. In terms of enrollment, the Plan projected it to decline but enrollment has been relatively steady; however, enrollment has started to decrease beginning January 2026 which could be due to the reinstatement of the Medi-Cal asset limit test effective 1/1/26, and also due to the freeze of Medi-Cal enrollment on the undocumented individuals aged 19 and		***Motion:*** *Commission approved standing reports* *10 – 0 – 0 – 7* *(De La Torre / Naz)* **Kerry Hydash left meeting at 3:16 pm, no vote for #18.* **Sara Bosse left meeting at 3:35 pm, no vote for #18* **Supervisor Neves left meeting at 3:36 pm, no vote for #18*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	older effective 1/1/26. Total Cost of Medical Care expense actual recorded was approximately $746.1M which is approximately $133.5M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $28.4M which is approximately $1.5M more than budgeted due to enrollment being higher than projected. Consulting and Accreditation fees recorded was approximately $39K, which is approximately $234K less than projected due to the Plan's retention consultant fees being lower than projected. Labor expense actual recorded was approximately $2.3M which is approximately $413K less than projected mainly due to an open position related to succession planning for a key management position. License expense actual recorded was approximately $644K, which is approximately $247K less than projected due to the DMHC license fee being less than projected, noting that their fee increases were less than their prior year increases. With regard to taxes, in past meetings, we communicated that as part of the One Big Beautiful Bill Act of 2025, the MCO taxes in California were non-compliant with the new rule changes because the One Big Beautiful Bill added stricter requirements in relation to MCO taxes, specifically regarding the taxes being required to be broad-based and uniform; the One Big Beautiful Bill Act of 2025 also removed a loophole in relation to the broad-based and uniformity requirements. It did offer a transition period subject to CMS approval. Initially the State received a transition period through the end of June 30, 2026; as of earlier this month, CMS allowed the State of California a transition period through the end of the 2026 calendar year, which coincides with the end of the current California MCO tax term. Total net income through the first six months of FY 2026 was approximately $11M, which is approximately $6.4M more than budgeted primarily due to interest income being approximately $1.6M more than projected and enrollment and rates being higher than projected. **Medical Management**		
• **Medical Management** P. Marabella, MD, CMO	<u>Appeals and Grievances Dashboard</u>		

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	Dr. Marabella presented the Appeals & Grievance Data Analysis Report for Q4 2025. The board reviewed a year-over-year comparison and a rolling four-quarter trend analysis of appeals and grievances. Rates were standardized per 1,000 members per year to account for enrollment fluctuations. In summary for Appeals, in Q4 2025 the Plan observed a decrease in appeal volume, with 150 total appeals. 122 appeals were classified as Not Medically Necessary. Top Drivers of Appeals representing 52% of all appeals, were the following: • Self-injectable Medications • Outpatient Procedures • Inpatient- Admission • DME-Other • Diagnostic MRI • Housing Deposits • Medically Tailored Meals Appeal Outcomes Breakdown • 43% Overturned • 42% Upheld • 9% Partial Uphold • 6% Withdrawn Community Supports Appeals None (0%) of Medically Tailored meals were overturns and 50% of Housing Deposits were overturned. Opportunities for Improvement • Educate Providers on the criteria for medical procedures coverage and what needs to be submitted to avoid unnecessary denials and procedure delays.		

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	• Ensure providers are submitting all needed information prior to medically necessary procedures. • Educate providers (CBOs) on the requirements for Housing Deposit benefits. In summary, for grievances, overall, grievances continue to increase year over year, with Access to Care services remaining the most frequently cited category. In Q4 2025, a total of 659 grievances were received, with 222 categorized under Access to Care. Top Access to Care Drivers of Grievances representing 26.1% of all Grievances: • Prior Authorization Delay • Network Availability • Transportation Missed Appointment • PCP Referral for Services • Availability of Appointments Specialist Opportunities for Improvement • The provider should keep members informed of the prior authorization timeline for approval. • Continue providing live and recorded provider training webinars to address prior authorization on a regular basis. • Expand telehealth services, offering diverse payment options, and utilizing data analytics to optimize network design and ensure equitable access to care. • Request feedback from vendors on how they will address complaints related to no show transportation and make reliable transportation accessible to members. • Establish or reassess current referral process and turnaround approval times. • Expand specialist network in rural areas through the Provider Network team. • Leverage contract language to incentivize provider groups to increase volume, as well as meet member experience expectations. <u>Key Indicator Report</u>		

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	Dr. Marabella presented the Key Indicator Report (KIR) through Q4 2025. Acute Admissions & Bed Days Quarterly Acute Admissions • Overall acute admissions remained stable or trending downward. • SPD population: Clear downward trend in admissions. • TANF: Stable with minimal decreases. • MCE: Generally stable. Per 1,000 Member Per Year • Same downward or stable trends observed when adjusted for membership. Acute Bed Days • SPD bed days significantly decreased. • TANF decreased slightly. • MCE remained relatively stable. Length of Stay (LOS) • LOS decreased across populations. • SPD admissions decreased both in volume and duration. • MCE LOS decreased and outperformed established goals. • Shorter stays have not resulted in increased readmissions. Readmissions • Readmission rates remain stable or below average. • TANF readmissions are notably down compared to historical averages. • SPD readmissions also decreased. • Overall: Fewer admissions, shorter stays, and no increase in readmissions indicate positive performance. UM Turnaround Times • Pre-service extension/deferral turnaround times showed variability earlier in the year, particularly in Q2 and Q3 due to staffing shortages. • Additional staffing was implemented, resulting in improved compliance in later quarters.		

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	• Some isolated areas remain out of compliance, but overall improvement noted. • CCS rates remain stable. Care Management Increased care management engagement may be contributing to improved utilization outcomes. Physical Health • Referrals increased significantly (approx. 4,000 vs. 2,900 prior year). • Engagement rates slightly improved. • Total cases managed remain stable due to case turnover. Behavioral Health • Increased referrals and engagement. • Overall engagement percentage improved. Perinatal / First Year of Life • Increased engagement with stable, strong engagement rates. Transitional Care • Significant increase in volume (over 7,200 referrals). • 87% engagement rate. • Approximately 4,200 active cases. • Transitional care continues to function as the triage point directing members to appropriate programs. Key Takeaways • Acute admissions and bed days are decreasing, particularly in the SPD population. • Length of stay is decreasing and outperforming targets. • Readmissions are stable or declining. • UM turnaround times improved after staffing adjustments. • Care management programs showed substantial increases in referrals and engagement, likely contributing to improved utilization metrics.		

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	Overall, trends indicate improved utilization management performance and effective care coordination efforts. <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q4 2025. Two QI/UM meetings were held in Quarter 4, one on October 16, 2025, and one on November 20, 2025. Documents reviewed and approved included Program Documents, General Documents, and Oversight Audit Results. The following Quality Improvement Reports were reviewed: Appeal and Grievance Dashboard & Quarterly A&G Reports; Skilled Nursing Facility Quality Assurance & Performance Improvement Dashboard for Q2, Facility Site & Medical Records and PARS Report, and additional QI Reports for Q2 and Q3. The Access Related Reporting includes Provider Appointment Availability & After-Hours Access Survey Results, Access Workgroup Quarterly Report for November, and the Access Work Group minutes from July 29th, 2025. The Utilization Management & Case Management reports reviewed were the Key Indicator Report and UM Concurrent Review Report, and additional UMCM Q3 reports. The quarterly Pharmacy reports reviewed were Pharmacy Executive Summary, Operations Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR). The Q4 HEDIS® Activities were focused on analyzing the results for MY2024 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of the 50th percentile. The new HEDIS® HSAG Audit season has begun for MY2025. HSAG has shared a timeline for this season including timeframe for completing the HEDIS® Audit, initial and final data submission dates, Roadmap due date, etc. The Medical Management Team has continued Annual Clinic Visits focused on high volume FQHC's/Clinics throughout Fresno, Kings, and Madera counties.		

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	Quality Improvement Activities included two Performance Improvement Projects, Improve Infant Well-Child Visits (WCV) in the Black/African American(B/AA) Population in Fresno County, and Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue. DHCS Collaboratives included Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative, and Institute for Healthcare Improvement (IHI) Behavioral Health Collaborative. DHCS County Projects included Fresno County, Transformational Equity Improvement Project; for Kings County, Comprehensive Equity Improvement Project; and for Madera County, Lean Equity Improvement Project. Two areas of non-compliance that were identified through routine monitoring during Quarter 3 continue with open corrective action plans through Quarter 4: 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 received and are in progress. Oversight and monitoring processes will continue. <u>Credentialing Sub-Committee Quarterly Report</u> The Credentialing Sub-Committee met on October 16, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2025 were reviewed for delegated entities, and the third quarter of 2025 for Health Net and Behavioral Health (BH). The Credentialing Adverse Actions report for Q3 for CalViva from Health Net Credentialing Committee was presented. There was one (1) CalViva case presented for discussion in Quarter 3. The case was placed on pending status, awaiting adjudication by the Medical Board of California.		

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	The Adverse Events report for Q3 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 one (1) new case to the Credentialing Committee in Q3 2025 involving an individual practitioner. There were no (0) reconsiderations or fair hearings during the third quarter of 2025. There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the third 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 third quarter of 2025. August and September delinquent license reports for termination and monitoring were submitted and approved. Zero (0) cases required reporting for 805 in Q3 2025. The Access & Availability Substantial Harm Report Q3 2025 was presented and reviewed. The purpose of this report is 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 Issue (PQI) cases Severity Level III and IV related to identified appointment availability issues. 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 third 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). •The Investigations Team submitted 20 cases to the Peer Review Committee in the third quarter of 2025. Of the twenty (20) cases, three (3) cases were related to appointment availability issues without significant harm, and two (2) were related to significant harm without appointment availability issues. Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q3 2025. The Credentialing Sub-Committee Reports for Q3 2025 were reviewed. The county-specific Credentialing Subcommittee Reports of significant subcommittee activities for July through September 2025 were presented. There was one (1)		

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	new case identified in Fresno County in July, and one (1) case identified in Madera County in August, with a Monitoring/CAP in these reports for Q3 2025. <u>Peer Review Sub-Committee Quarterly Report</u> The Peer Review Sub-Committee met on October 16th, 2025. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2025 were reviewed for approval. There were no significant cases to report. The Q3 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 eight (8) cases identified in Q3 2025 that met the criteria and were submitted to the Peer Review Committee. One (1) case involved a practitioner, and seven (7) cases involved organizational providers (facilities). Of the eight (8) cases, four (4) were tabled, one (1) was closed to track and trend with a letter of education, one (1) was closed to track and trend with a letter of concern, and two (2) were closed to track and trend. Seven (7) cases were quality of care grievances, one (1) was a potential quality issue, zero (0) were a lower-level case, and zero (0) were track and trend. One (1) case involved a senior and person with disabilities. Zero (0) cases involved behavioral health. There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2025. Reviews completed in May, June, and July 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) The reviewing Medical Directors determined that further outreach was required for three (3) cases. Outreach can include, but is not limited to, an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. There were zero (0) cases referred to peer review for further review. Further review includes a review of trended grievances, as well as license and sanction/exclusion review. Zero (0) cases required escalation for presentation		

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	at the Peer Review Committee. Zero (0) cases required reporting for 805.01 in Q3 2025. The Access & Availability Substantial Harm Report for Q3 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. After a thorough review of all Q3 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 Investigations Team submitted 20 cases to the Peer Review Committee in Q3 2025. Of the twenty (20) cases, three (3) cases were related to appointment availability issues without significant harm, and two (2) were related to significant harm without appointment availability issues. Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q3 2025. The Q3 2025 Peer Count Report was presented and discussed with the committee. There were twenty (20) cases reviewed. Fourteen (14) cases were closed and cleared. Zero (0) cases were closed/terminated. Zero (0) cases were deferred. Five (5) cases were tabled for further information. There were zero (0) cases with CAP outstanding/continued monitoring, and one (1) case is pending closure for CAP compliance. The 2026 Peer Review Sub-Committee Meeting Calendar was presented and accepted. **Equity** <u>Equity Report</u>		
Equity Report S. Xiong-Lopez, EqO			

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	NCQA 2026 Standards Update • Annual DEI training was completed and renamed "Cultural Competency" to align with updated NCQA terminology. • The previously anticipated annual DEI survey is currently on hold. Although referenced in draft proposals, the finalized 2026 NCQA standards (released December 2026) do not yet provide clear web-based guidance. Final detailed requirements will not be available until March 2026. • The organization is pending clarification from NCQA regarding required survey format and expectations before moving forward. Reaccreditation Changes • Future reaccreditation will no longer be titled *Health Equity Accreditation*. • It will transition to Health Outcome Accreditation with a Community-Focused Care component. • The look-back period for 2028 reaccreditation has begun: o Most reports require a three-year look-back. o Certain direct opportunity measures require a 12-month look-back. • The organization is now in the formal look-back window. Next Steps: The Perimenopause and Menopause Health Equity Project will officially conclude as a standalone initiative and transition into the Kings County Community Health Improvement Plan (CHIP). The project's priorities will be integrated into the CHIP focus areas of Access to Health Care, Women and Maternal Health, and the Community Health Worker (CHW) Work Group. CalViva's Equity Officer will actively participate in these focus areas to ensure continuity, sustainability, and alignment with countywide health equity strategies. Kings County Project – Perimenopause & Menopause Initiative Community Events • Three events hosted (Hanford and Corcoran) as of December 2026. • Total attendance: 172 participants. • Interpretation services provided to 98 attendees. Risk Screening & Referrals		

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	• A risk assessment tool (adapted from a national survey) was implemented; further evaluation of its effectiveness is pending. • 36 participants identified as medium/high risk and referred to specialists. • All other symptomatic participants were referred to their primary care providers. • 140 social determinant of health (SDOH) referrals were made. o Most common referrals: housing stability, phone/utilities assistance, and supplemental income resources. Educational Outcomes (Led by Dr. Lewis) A pre- and post-education evaluation was conducted: • Median participant age: 48 years. • 121 pre-assessments; 122 post-assessments completed. • 69 assessments completed in Spanish. Knowledge Improvement • Pre-event: 11.8% reported understanding perimenopause/menopause. • Post-event: 95.8% reported confidence in their knowledge. Provider Engagement Readiness • Pre-event: 29.5% had previously discussed perimenopause/menopause with their PCP. • Post-event: 95.8% reported feeling prepared to initiate discussion with their PCP. Key Takeaways • Alignment with NCQA 2026 standards is in progress, pending final guidance. • The 2028 reaccreditation look-back period has officially begun. • The Kings County initiative demonstrated strong community engagement, significant knowledge gains, high utilization of interpretation services, and meaningful SDOH referrals. • Education efforts substantially improved participant confidence and readiness to engage with primary.		
• **Executive Report** J. Nkansah, CEO	**Executive Report**		

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	Executive Dashboard Enrollment as of December 2025 is 427,533. Enrollment for Anthem is approximately 198,391, and the enrollment for Kaiser is approximately 13,240. Market Share is currently approximately 66.89%. With regard to IT, Communications & Systems, the Call center performance met established goals. Website activity continues to grow organically. Member portal registration has reached approximately 3,800 members. With regard to Provider Network & Engagement, Health Net is undergoing a provider system migration to its parent company's platform. Due to the transition, provider data currently differs from historical norms. Certain provider counts are unavailable pending validation. Staff are reviewing and validating the data to confirm accuracy. Regarding Claims & Provider Disputes no additional significant updates. Activity remains consistent with prior reporting. The Annual Report was previously emailed to all commission members, and a hard copy was provided to each commissioner in attendance at today's meeting.		
19. Final Comments from Commission Members & Staff	Mr. De La Torre provided comment: A local autism provider that previously served plan members received a termination notice from Health Net without cause or explanation. Given that the majority of Health Net's membership in the community consists of plan members, the termination has a direct impact on local access to autism services. Concern was expressed that unilateral network decisions of this nature may negatively affect community capacity, particularly given the growing demand for autism services. The request was made for Commission support to have Jeff formally engage Health Net and encourage a meeting between Health Net and the affected provider. The goal is to facilitate dialogue, clarify the basis for termination, and explore a potential resolution. At present, Health Net has not indicated willingness to engage. Commission support was sought to help advance discussions and work toward a solution that preserves community access to needed autism services.		

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	Jeff Nkansah responded to Mr. De La Torre: Leadership will need to explore how the Board can be more formally updated so next steps can be determined. Jeff Nkansah advised he would need to engage RHA Counsel on how to proceed. Mr. De La Torre requested that the local autism provider should be allowed the opportunity for them to provide their version of events to the Commission. Jeff Nkansah noted the request. Mr. Prado raised a question regarding an earlier conversation and what process the Commission would follow to evaluate and potentially select alternative meeting locations, in response to Commissioner Bosse's earlier recommendation to consider different sites for future meetings. Jeff Nkansah responded. It was noted that Commission and Public Policy Committee meetings historically rotated locations until a permanent meeting site was established. Any reconsideration of rotating meeting sites would require formal discussion and Commission action. It was suggested that the item be placed on a future agenda to allow for discussion and potential vote.*	*This item is to be added to the Agenda for March meeting.	
20. Announcements	None.		
21. Public Comment	None.		
22. Adjourn	The meeting adjourned at 3:44 pm. The next Commission meeting is scheduled for March 19, 2026, in Fresno County.		

Submitted this Day: March 19, 2026

Submitted by: Cheryl Hurley

Cheryl Hurley
Clerk to the Commission