Jeff 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: March 13, 2026

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, February 19, 2026
1:30 pm to 3:30 pm

Where to attend:

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

Meeting materials have been emailed to you.

Currently, there are **14** 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

March 19, 2026
1:30pm - 3:30pm

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

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D Attachment 3.E	**Consent Agenda:** • Commission Minutes dated 2/19/26 • Finance Committee Minutes dated 10/16/25 • QI/UM Committee Minutes dated 11/20/25 • Public Policy Committee Minutes dated 12/3/25 • Revised Public Policy Committee Charter *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4 **Information**	No attachment	**Closed Session:** **The Board of Directors will go into closed session to discuss the following item:** A. Conference with Legal Counsel - Anticipated Litigation. Significant exposure to potential litigation, one potential case. Pursuant to Government Code section 54956.9(b)	J. Nkansah, CEO
5 Action	Attachment 5.A	**FKM RHA Commission Meeting Location** • BL 26-008 RHA Commission Meeting Location *Action*: Keep Meeting Location in Fresno County; or direct CEO to resurvey Commissioners on the issue of meeting location for 2027.	J. Nkansah, CEO
6 Action	Attachment 6.A Attachment 6.B	**CYBHI MOU CBH-MCP ASO Payment Model** • BL 26-009 CYBHI Carelon Behavioral Health MOU • California Children and Youth Behavioral Health Initiative Network Support, Claims Processing and Payment Remittance MOU *Action: Approve CYBHI ASO Payment Model MOU*	J. Nkansah, CEO

7 Action	*No attachment*	**Community Support & DHCS Reinvestment Program Ad-Hoc Committee Selection** • Select ad-hoc Committee *Action: Selection of Ad-Hoc Committee*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 8-9* ***One vote will be taken for combined items 8-9***	
8 Action	Attachment 8.A Attachment 8.B	**2026 Quality Improvement & Health Education** • 2026 Program Description & Change Summary • 2026 Work Plan *Action: Will be taken under one vote for Agenda Items #8 & #9*	P. Marabella, MD, CMO
9 Action	Attachment 9.A Attachment 9.B	**2026 Utilization Management** • 2026 Program Description & Change Summary • 2026 Work Plan *Action: Approve 2026 Quality Improvement & Health Ed Program Description, 2026 Quality Improvement & Health Ed Work Plan, 2026 Utilization Management Program Description, 2026 Utilization Management Work Plan*	P. Marabella, MD, CMO
10 Action		**Standing Reports**	
	Attachment 10.A	**Finance** • Financials as of January 31, 2026	D. Maychen, CFO
	Attachment 10.B	**Compliance** • Compliance Report	M.L. Leone, CCO
	Attachment 10.C	**Equity** • Health Equity Report	S. Xiong-Lopez, EqO
	Attachment 10.D Attachment 10.E Attachment 10.F Attachment 10.G	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment 10.H	**Executive Report** • Executive Dashboard *Action: Accept Standing Reports*	J. Nkansah, CEO
11		**Final Comments from Commission Members and Staff**	
12		**Announcements**	
13		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on 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**	D. Hodge, MD, 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 May 21, 2026 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 – E.

Consent Agenda

- Commission Minutes dated 2/19/26
- Finance Committee Minutes dated 10/16/25
- QI/UM Committee Minutes dated 11/20/25
- Public Policy Committee Minutes dated 12/3/25
- Revised Public Policy Committee Charter

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.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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:
	  ○ Previously blended perinatal and first year of life case management roles were restructured.
	  ○ 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.*

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

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

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

	• 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:
	  ○ Importance to members
	  ○ Plan performance
	• Four-quadrant framework identifies:
	  ○ High importance & strong performance = "Keep it up"
	  ○ High importance & poor performance = "Opportunity to improve"
	  ○ Low importance & strong performance = "Maintain"
	  ○ 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)

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

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

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

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

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

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

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

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

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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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:
	  ○ Most reports require a three-year look-back.
	  ○ 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	• 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. ○ 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**		

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

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

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

October 16, 2025

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

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 11:30 am, a quorum was present.		
#2 Finance Committee Minutes dated September 18, 2025 Attachment 2.A Action, D. Maychen, Chair	The minutes from September 18, 2025, Finance meeting were approved as read.		Motion: *Minutes were approved* *4 – 0 – 0 – 3* *(Neves / Frye)*
#3 Baker Tilly presentation of Fiscal Year 2025 Audit Results	Rianne Suico, and Eleanor Garibaldi, representatives of Baker Tilly, presented the results of the audit. Baker Tilly's audit will result in the issuance of an unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed.		Motion: FY 2025 Audit Results approved to move forward to Commission *4 – 0 – 0 – 3* *(Neves / Frye)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#4 Financials – as of August 31, 2025 Action D. Maychen, Chair	As of August 2025, total current assets were approximately $525.1M; total current liabilities were approximately $347.9M. Current ratio is approximately 1.51. TNE as of the end of August 2025 was approximately $186.8M which is approximately 677% above the minimum DMHC required TNE amount. For DHCS standard, the minimum required TNE is approximately $192M, which the Plan is short by approximately $5.2M. Premium capitation income actual recorded was approximately $321.1M which is approximately $25.1M less than projected primarily due to DHCS not paying the Plan the MCO taxes in August 2025. If we remove the effect of DHCS not paying the MCO taxes in August, the actual income recorded was approximately $37.7M more than projected primarily due to enrollment and rates being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $244.7M which is approximately $36.6M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $9.5M which is approximately $402K more than budgeted due to enrollment being higher than projected. MCO taxes actual recorded was approximately $62.8M which is approximately $62.8M less than budgeted due to DHCS not paying the Plan the MCO taxes after July 2025. There was a CFO meeting with DHCS in October 2025 and DHCS communicated they did not receive approval from the Federal Government in relation to whether they were going to approve the three year transition period for MCO taxes. DHCS did indicate they will continue to pay the MCO taxes retroactive to August through September 2025 in the November 2025 capitation month. The Plan is obtaining clarification from DHCS if they will continue to pay MCO taxes October 2025 going forward pending their response. It appears DHCS believes it is likely that CMS or the Federal Government will approve the transition period; but ultimately the Plan is waiting to hear the final word. At this point, it does not appear a revised budget needs to be brought to the Commission. Total net income for the first two months of FY 2026 was approximately $2.7M, which is approximately $1.3M more than budgeted primarily due to enrollment and rates being higher than projected.	*John Frye asked what the difference is between the tax expense and the tax revenue?* *Daniel Maychen responded for July 2025, it was approximately $240K higher than the MCO tax expense ; however, for any gain, the Plan records this as a liability in the Amount Due to DHCS balance sheet account.*	Motion*: Financials as August 31, 2025, were approved* *4 – 0 – 0 – 3* *(Frye / Neves)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#5 Announcements/Comments	Daniel Maychen thanked Baker Tilly, and the CVH Accounting team for their work with the audit.		
#6 Adjourn	Meeting was adjourned at 11:48 am		

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

Dated: 2-19-26

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 2/19/26

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

November 20th, 2025

CalViva Health
7625 North Palm Avenue; Suite #109
Fresno, CA 93711

Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	**Patrick Marabella, M.D.,** Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Senior Director of Medical Management Services
	David Cardona, M.D., Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓	**Mary Lourdes Leone,** Chief Compliance Officer
	Christian Faulkenberry-Miranda, M.D., Pediatrics, University of California, San Francisco	✓	**Sia Xiong-Lopez,** Equity Officer
✓*	**Ana-Liza Pascual, M.D.,** Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group	✓*	**Morgan Simpson,** Senior Director of Compliance
✓	**Carolina Quezada, M.D.,** Internal Medicine/Pediatrics, Family Health Care Network	✓	**Maria McDivitt,** Senior Compliance Manager
✓	**Joel Ramirez, M.D.,** Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Nicole Sihota, RN,** Medical Management Services Manager
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA **(Alternate)**	✓	**Zaman Jennaty, RN,** Medical Management Nurse Analyst
		✓	**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 am. Dr. Pascual arrived at 10:03 am.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#2 **Approve Consent Agenda** Committee Minutes: October 16, 2025 - Standing Referrals Report (Q3 2025) - Specialty Referrals Report- HN (Q3 2025) - California Children's Services Report (Q3 2025) - Concurrent Review IRR Report (Q3 2025) - Evolent (NIA) (Q3 2025) - A&G Inter-Rater Reliability Report (Q3 2025) - Quarterly A&G Member Letter Monitoring Report (Q3 2025) - A&G Validation Audit Summary (Q2 2025) - Customer Contact Center DMHC Expedited Grievance Report (Q3 2025) - Call Center Inquiry Audit Report (Q3 2025) - Potential Quality Issues (PH & BH) (Q3 2025) - Provider Preventable Conditions (Q3 2025) - Initial Health Appointment Quarterly Audit (Q2 2025) - County Relations Quarterly Report (Q3 2025) - Health Equity Defining the	The October 16th, 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. *There were no questions or comments from committee members.* A link for Medi-Cal Rx Contract Drug List was available for reference.	**Motion:** *Approve* Consent Agenda (Ramirez/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Community Report RY2025 - PA Member Letter Monitoring Report (Q3 2025) - Medical Policies Provider Updates (Oct., Sept. 2025) - Pharmacy Provider Updates (Q3 2025) - Preventive Health Guidelines 2025 - Provider Office Wait Time Report (Q3 2025) - Provider Appointment & Availability & After-Hours Access Survey Results - Access Work Group Quarterly Summary (Nov. 2025) (Attachments A-W) **Action** Patrick Marabella, M.D., Chair		
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (Sept. 2025) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member Report (Q3) - Appeals & Grievances Classification Audit Report (Q3)	The **Appeal & Grievance Data Analysis Report Q3 2025** was presented and reviewed to highlight member satisfaction based on the resolved appeals and grievances cases quarterly to better understand CAHPS results, rate movement, and areas of improvement. As defined by NCQA, a "Grievance" is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of one's health plan, or its providers, regardless of whether remedial action is requested. An "Appeal" is a request for your health plan to review a decision that denies a benefit or payment. **Year Over Year Comparison - Q3 2025 Appeals & Grievances Volume by County:** Compared to Q3 2024, appeals volume increased by 13.9% in Fresno County, and 150% (lower volume, increased from 6 to 15) in Kings County, while Madera County remained steady. Grievance volumes showed	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (Sept. 2025) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member Report (Q3) - Appeals &

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments X-AA) **Action** Patrick Marabella, M.D., Chair	a slight decline of 0.2% in Fresno County but rose sharply by 68.4% in Kings County and 46.3% Madera County. **One-Year Look Back of Appeals & Grievances Volume Comparison by County:** In Q3 2025, appeals volume continued to trend upward – rising by 4% in Fresno County and increasing by 87.5% (again lower volume, increasing from 8 to 15) in Kings County. Madera County maintained a 31.8% decrease compared to the previous quarter, signaling a consistent downward trend. Grievance volume in Q3 2025 declined by 4.8% in Fresno County, while Kings County saw an increase of 30.6%, and Madera County experienced a rise of 1.7%. **Year-Over-Year Comparison - Q3 2025 Top Appeals & Grievances Trend by Classification Codes:** In Q3 2025, appeals related to the Not Medically Necessary classification code declined by 10.5% compared to Q3 2024. Grievance volumes showed upward movement in four of the top five (4/5) classifications: 39.1% in Access to Care, 6.9% in Balanced Billing, and increased 94.4% in Interpersonal. Transportation grievances saw an increase of 1.5%. Administrative Issues showed a decline of 20.7%. **One Year Look Back - Top Appeals & Grievances Trends by Classification Codes:** In Q3 2025, there was a 2.5% decline in appeals for the Not Medically Necessary classification code compared to the previous quarter. For grievances, an increase was noted in three of the top five (3/5) grievances in volume quarter over quarter: 10.7% in Access to Care, 1.5% in Transportation, and 75% Interpersonal. There was a decrease of 38% in Balance Billing and 5.4% in Administrative Issues. Further trending of both Appeals and Grievances by category and volume were reviewed with the following summary: **Summary and Opportunities for Appeals:** • In Q3 2025, we observed an increase in appeal volume, with 161 total appeals – a clear continuation of the year-over-year upward trend. • 119 appeals (73.9%) were classified as Not Medically Necessary. • Top Drivers of Appeals (52.8% of appeals are under these drivers): Diagnostic MRI, Diagnostic, CAT Scan, Self-injectable Medications, Outpatient Procedures, DME-CPAP Machine, Medically Tailored Meals, and Housing Deposits. • Opportunities to improve in the Not Medically Necessary category include: o Educate providers on the criteria for medical procedures coverage and what needs to be submitted to avoid unnecessary denials and procedure delays.	Grievances Classification Audit Report (Q3) (Pascual/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Ensure providers are submitting all needed information prior to medically necessary procedures. • Opportunities to improve in the Community Supports – Medically Tailored Meals category include: ○ Educate providers on the criteria to qualify for medically supportive meals. • Opportunities to improve in the Community Supports – Housing Deposits category include: ○ Educate providers – particularly Community-Based Organizations – on the requirements for Housing Deposit benefits. Emphasize the importance of including a comprehensive Individualized Housing Plan and submitting all required documentation to prevent unnecessary submission and avoidable denials. **Summary and Opportunities for Grievances:** • Grievances continue to increase 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. • Opportunities to improve in the Prior Authorization Delay include: ○ Continue providing live and recorded provider training webinars to address prior authorizations on a regular basis. • Opportunities to improve in the Transportation Missed Appointment category include: ○ Request feedback from the vendor on how they will address complaints related to no-show transportation and make reliable transportation accessible to members. • Opportunities to improve in the PCP Referral for Services category include: ○ Establish or reassess the current audit referral process and turnaround approval times. • Opportunities to improve in the Network Availability category include: ○ Expand telehealth services, leverage same-day provider access, and offer diverse payment options. • Opportunities to improve in the Availability of Appointments with Specialist category include: ○ 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.	
#3 **QI Business** - Lead Screening Quarterly Report (Q2 2025)	The **Lead Screening Quarterly Report (Q2 2025)** 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	**Motion:** *Approve* - Lead Screening Quarterly Report (Q2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment BB) Action Patrick Marabella, M.D., Chair	receive anticipatory guidance related to lead poisoning prevention, blood lead level testing, and follow-up services from providers. The Q2 2025 report provides CVH's performance on blood lead level screenings and anticipatory guidance monitoring from Q3 2024 – Q2 2025. • The Facility Site Reviews show in Q2 2025, 90.70% (39/43) of Pediatric Lead Blood Screening records were compliant, and 52.38% (11/21) of sites were compliant in documenting and completing lead blood screening. • In Q2 2025, through claims and encounter data, the overall compliance was 26%, which is a 5.6% decrease from Q3 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. The QI Team is collaborating with the PE team to identify potential barriers and solutions and will report out in Q3 with findings. • In Q2 2025, the overall compliance for CPT Code 83655 (only) was 25%, which demonstrates a 6.6% decrease compared to Q3 2024. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. QI is collaborating with PE and QIRA analysts to identify potential barriers and solutions, and will report in Q3 any findings. • In Q2 2025, the compliance for CPT 83655 + Anticipatory Guidance or annual well-visit codes* shown in Table 4, was 22%, which is a 19.20% increase compared to Q1 2025 (2.80%). This increase was due to the revision in anticipatory guidance methodology discussed in the Analysis/Findings/Outcomes section. • CalViva has issued a Corrective Action Plan to Health Net for the continued poor performance with documentation of anticipatory guidance. *Discussion:* *Dr. Ramirez asked if using the WCV code to track the use of Anticipatory Guidance is acceptable for DHCS?* *Dr. Marabella indicated that the DHCS wants Anticipatory Guidance documented, but hasn't specifically indicated how to do it. We did learn that the codes DHCS provided to us a couple of years ago cannot be used in conjunction with a Well Child Visit (WCV). Previously, we could only track this measure through medical record reviews. We are now adding the WCV codes in order to capture when the blood lead test has been performed at the WCV. Establishing the best practice for electronically obtaining credit for this measure is what we're trying to achieve within the CAP.* *Amy Schneider added that as an element of the CAP, HN will validate the correlation between the presence of a WCV code and finding documentation in the medical record that Anticipatory*	2025) (Ramirez/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Guidance was provided for Lead Screening.	
#4 Key Presentations - Annual Regulatory CAHPS Summary Report (Attachment CC) Action Patrick Marabella, M.D., Chair	The **Annual Regulatory CAHPS® Summary Report** was presented and reviewed. • CVH has monitored member satisfaction for many years. • DHCS conducted surveys through HSAG every other year for Medi-Cal Managed Care Plans in California. • On the "Off-Years", a scaled-back survey was conducted to continuously monitor access to care. • Now that CVH is NCQA Accredited, annual member satisfaction surveys are required. • This is our first "Regulatory CAHPS® Survey" conducted by Press Ganey and used for NCQA accreditation. • **Survey Objectives and Methodology:** o The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care, including: o How well plans are meeting their members' expectations and goals o To determine which areas of service have the greatest effect on members' overall satisfaction o To identify areas of opportunity for improvement o 4,146 qualified respondents received access to complete the survey (mail, phone, or online) o 500 eligible responses were collected, resulting in a 12.1% response rate (500 completed/4,146 valid samples) • **Dashboard Key**: o Press Ganey uses a proprietary statistical model they have developed and tested to identify the key drivers of the ratings of the health plan. o This model provides: ▪ Identification of the elements that are driving the ratings. ▪ Relative importance of each element. ▪ How members think the Plan performed on the elements. ▪ Presented in a format that provides clear direction on actions to improve. • **Satisfaction Survey:** o Press Ganey uses a 1-5 Likert scale to assess member satisfaction.	**Motion:** *Approve* - Annual Regulatory CAHPS Summary Report (Quezada/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Scores represent the number of members who gave CVH a "5" on each measure. ○ CVH is ranked against the Quality Compass® All Plan Benchmark. ○ **PG Benchmark Information:** The source for data contained within the PG Book of Business (BOB) is all submitting plans that contracted with PG for MY 2024. • **2025 Dashboard (Opportunities identified)** ○ Q26. Rating of Health Plan 65.3%, 68th percentile, Opportunity ○ Q8. Rating of Health Care 52.4%, 12th percentile, Opportunity ○ Q18. Rating of Personal Doctor 64.8%, 10th percentile, Opportunity ○ Q22. Rating a Specialist, 64.9%, 22nd percentile, Opportunity ○ Q9. Getting Needed care: Getting care, tests, or treatment 77.2%, 4th percentile, Opportunity ○ Q12. How well Dr. explained things: 90.6%, 13th percentile, Opportunity ○ Q13. How well Dr. listened carefully: 92.0%, 20th percentile, Opportunity ○ Q14. How well Dr. showed respect: 92.4%, 8th percentile, Opportunity ○ Q15. How well Dr. spent enough time: 87.2%, 8th percentile, Opportunity • **Key Performance Metrics** ○ Q28. Rating of Health Plan, 65.3%, 68th percentile (positive result) ○ Customer Service 90.5%, 58th percentile (positive result) ○ Q17. Coordination of Care 87.2%, 59th percentile (positive result) • **POWeR Chart** categorized survey measures into four quadrants: Power, Opportunity, Wait, Retain ○ Power: Q17. Coordination of Care ○ Opportunity: ▪ Q13. Dr. listened carefully ▪ Q14. Dr. showed respect ▪ Q22. Rating of Specialist ▪ Q12. Dr. explained things ▪ Q15. Dr. spent enough time ▪ Q18. Rating of Personal Doctor ▪ Q8. Rating of Health Care ▪ Q9. Getting care, tests, or treatment ○ Wait:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Q6. Getting routine care ▪ Q20. Getting a specialist appointment ▪ Q41. Rating of the interpreter provided ▪ Q4. Getting urgent care ▪ Q43. Got an appointment in a timely manner ▪ Q44. Had to wait for an appointment due to limited hours or few available appointments ▪ Q27. East of Filling Out Forms ▪ Q25. Treated with courtesy and respect o Retain: ▪ Q24. Provided information or help • **Performance to Star Cut Points** shows how the Plan's Estimated Health Plan Rating (HPR) scores are used for accreditation ratings compared to the most recent Quality Compass® thresholds published by NCQA (Fall 2024). o CVH's Rating of Health Plan is at or above the 67th percentile o The following categories for the Plan are below the 67th percentile: ▪ Getting needed care ▪ Getting care quickly ▪ Rating personal doctor ▪ Rating of Health Care • **Satisfaction Survey Results:** o CVH had an adequate sample size with 500 responses. This has been a problem in the past with HSAG surveys. o CVH performed well for the Rating of Health Plan at the 68th percentile. o Coordination of Care (COC) performed well for CalViva at 87.2% (59th percentile), and this was identified as a high-impact area for CVH where we will promote and leverage strengths. o CVH has an opportunity for improvement in the following: ▪ Getting Needed Care (75.9%) ▪ Getting Care Quickly (78.5%) ▪ Rating of Personal Doctor (64.8%) ▪ Rating of Health Care (52.4%)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Next Steps: o CVH is currently assessing these results further to identify potential strategies that will maintain and improve scores. o Areas of greatest opportunity will be identified and actions taken to improve in those areas. o Regulatory CAHPS® Surveys will continue annually. o Both Adult and Children's results will be shared. *Discussion:* *Dr. Ramirez asked if the sample size of 4,100 patients was a qualified sample size, not the entire universe.* *Dr. Marabella stated that Press Ganey's methodology is to obtain 500 qualified responses (the minimum needed to participate) out of the 4,100 randomized sample.*	
#4 Key Presentations - Health Equity Geo Access Report 2025 (Attachment DD) **Action** Patrick Marabella, M.D., Chair	The **Health Equity Geo Access Report 2025** was presented and reviewed to examine the Race, Ethnicity, and Language of CVH Members and Provider Network for the calendar year 2024. **Methodology:** The Health Equity team uses direct data collected from state or federal electronic file feeds, including Race, Ethnicity, and Language preferences, to examine the composition of CVH membership. This is compared to Provider Race, Ethnicity, and Language data collected during the contracting and credentialing review processes. **Sources:** Data in this report is extracted from the 2019-2023 U.S. Census American Community Survey, CVH's 2024 Membership database, and 2024 Provider Network Management rosters. • Race, Ethnicity, and Both Written and Spoken Language Preferences are obtained directly from the Members and Providers. • According to the Institute of Medicine's "Unequal Treatment" Report, o "Language concordance between patients and providers results in greater patient understanding, increased satisfaction, better understanding of diagnosis and treatment, and better medication adherence." .1.*1. Institute of Medicine Report, Unequal Treatment Report, page 192 (2003)* • The top five (5) most common languages in California other than English (55.94%) include: o Spanish (28.21%) o Chinese, including Mandarin, Cantonese (3.44%)	**Motion**: *Approve* - Health Equity Geo Access Report 2025 (Quezada/Pascual) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Tagalog (2.08%) ○ Vietnamese (1.52%) ○ Korean (0.96%). • Nearly 44% of Californians speak a language other than English at home. **Comparison of CVH's Member Language Need and Provider Language Ability: Gap Analysis** • CVH provides services in three (3) California counties: Fresno, Kings, and Madera. • CVH's membership has diverse language preferences: with the five (5) highest volume non-English languages spoken in the analysis: Spanish (145,774 members at 33.75%), Hmong (5,724 members at 1.33%), Arabic (1,203 members at 0.28%), Lao (782 members at 0.18%), and Armenian (681 members at 0.16%). • To facilitate communication between members with Limited English Proficiency (LEP) and their providers, CVH maintains a linguistically diverse provider network. • Geographic analysis of CVH's contracted provider network compared to its members' linguistic needs provides a quick overview of the locations where gaps exist. The methodology used identifies gaps between members and providers based upon three (3) parameters that include both distance and time: • **Urban:** within 10 miles or 30 minutes from residence or workplace. *Urban = population density is greater than 3,000 persons per square mile* • **Suburban:** within 15 miles or 30 minutes from residence. *Suburban = population density is between 1,000 and 3,000 persons per square mile* • **Rural**: within 30 miles or 60 minutes from residence. *Rural = population density is less than 1,000 persons per square mile* **Gap Analysis** For Fresno County, a language gap exists for PCPs in Lao and for both PCPs and Specialists in Hmong. A language gap exists for PCPs in Arabic for all three CVH Counties. **Conclusions:** • Providers are not able to meet all member language needs for several reasons, including limited bilingual staff and large language diversity within their patient population. • Health Equity Department developed and executed a plan to address the gaps to increase awareness and utilization of the language support services (telephonic & in-person) that are available through CVH.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Plan for Improvement: Coordinate and conduct cultural competency training/workshops for contracted providers and provider groups. • **Progress Toward Objective:** LAP training included 93 providers and provider office staff in attendance in 2024. Live training on track for October 2025. On-Demand training to be available after the live training until the next one in 2026. o **Strategy 1:** Promote Office of Minority Health (OMH) cultural competency training through the Provider Operations Guide and provider updates to be included in the annual provider LAP update. o **Progress Discussion:** Provider Updates to cover the following required topics: LAP services (to include diversity of members), culture and health care topic, promote online cultural competence/OMH training, and health literacy. LAP Provider Update was developed in Q2 2025. Distribution to all contracted providers in July 2025. o **Strategy 2:** Promote on-demand Video Remote Interpretation services for providers with a high membership of people with limited English proficiency. o **Progress Discussion:** Developed and implemented five (5) successful pilot programs in 2023 for on-demand VRI services. Secured funding for the 2025 VRI program services. Ongoing workgroup meetings to scale the program and disseminate more broadly. o **Strategy 3:** Enable direct access to telephone interpretation through CVH Member Services o **Progress Discussion:** Launched direct access line to interpretation vendor for CVH. *Discussion:* *Dr. Ramirez asked if there were enough Providers in the targeted languages.* *Dr. Marabella indicated that there is a shortage of Providers who speak the targeted languages, so we will have to pivot to the use of language support services.* *Amy Schneider added that, newly improved this year, members and providers are directly connected to an interpreter if needed when they call member services rather than a two-step process.*	
#4 **Key Presentations** - PHM Assessment Report 2024 (Attachment EE)	• The **PHM Assessment Report 2024** was presented to provide an annual analysis of the CVH population to identify the needs and characteristics of the enrolled population including SDOH issues, and key sub-populations such as children, SPDs, members with mental health issues, etc. and to also: Evaluate the extent to which current organization-wide population health management activities and resources address the needs identified in this analysis and	**Motion:** *Approve* - PHM Assessment Report 2024 (Waugh/Pascual)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	determine if modifications are needed to better meet the needs of the enrolled population. • Evaluate the integration of community resources into population health management activities to address member needs not covered by the benefit plan and make recommendations if changes are needed. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: • Medical and behavioral claims/encounters • Pharmacy claims • Laboratory results • Health appraisal results • Electronic health records • Data from health plan UM and/or CM program • Advanced data sources such as all-payer claims databases or regional health information Parameters: Time Period of Data: January 2024 through December 2024. • Age Ranges: o Age cohorts are the following: Birth to age 19, age 20 to 64, and ages 65 and over. o Children and adolescents are defined as: Age 2 through age 19. o Adults: Unless otherwise specified, adults are age 20 and older. o Specific methods are used to identify and assess the needs of persons with disabilities and SPMI. • Gender, Age, & Race/Ethnicity Distribution: o Total Members 427,090; Male 46.1%; Female 53.9% o Age: 0-19 42.7%, 2-19 39.4%, 20-64 50.9%, 65+ 6.3% o Race/Ethnicity: n=431,963 as of 12/31/24 ▪ Latino/Hispanic: 295,729, 68% ▪ White/Caucasian: 44,306, 10% ▪ Asian/Pacific Islander: 36,753, 9% ▪ Unknown/Blank: 24,833, 6% ▪ Other: 9,054, 2% ▪ African American/Black: 19,226, 4% ▪ American Indian/Alaskan Native: 2,062, 1%	5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The Population Analysis reflects the following **key findings:** o Top needs of child and adolescent members: Pulmonary conditions o Top needs of members with disabilities: Cardiovascular and Pulmonary conditions o Top needs of members with serious and persistent mental illness (SPMI): Anxiety and Mood disorders o Top Race/Ethnicity: Hispanic, White, Black, Asian o Top Health Conditions: Pulmonary, Cardiac, and Pregnancy • **Actions Taken for Improvement:** Gaps were addressed in a chart in the categories of Heart Disease, Pregnancy, Pulmonary Care, SUD, and Mental Health. o The success of these activities is measured through MCAS measures, member satisfaction, and other established metrics. o These results will be reported in our PHM Effectiveness Analysis Report in February 2026. o Some interventions may be modified, and new interventions may be added at that time. *There were no questions or comments from committee members.*	
#4 **Key Presentations** - CalViva Operations Guide Annual Review (Attachment FF) Action Patrick Marabella, M.D., Chair	The **CalViva Operations Guide Annual Review** was presented and reviewed. In 2024 all Medi-Cal Managed Care Plans signed a new contract with the Department of Health Care Services (DHCS). Article A, Section III,3.2.4 requires that a Provider Manual be issued to network providers, subcontractors, and downstream subcontractors regarding covered services and responsibilities. **DHCS Contract** The Provider Manual must be updated at least annually and include information on: • Basic Population Health Management • Care Coordination for Non-Covered Services • Policies and Procedures • Quality Improvement & Monitoring • UM & Prior Authorization clinical protocols • Timeliness Standards & Telephone Access • Credentialing • Appeals and Grievances & State Fair Hearings* • Other regulations and reporting requirements	**Motion:** *Approve* - CalViva Operations Guide Annual Review (Ramirez/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	*The contract includes specific requirements regarding A & G-related information to be addressed. • The Purpose of this activity is to: o Obtain information/suggestions regarding the development of future Provider Manuals. o Clarify New and Revised Policies and Procedures. o Identify information that is omitted or missing from the guide. **Discussion & Recommendations:** Review of Chapters • Who to Contact • Enrollment & Disenrollment • Access to Care • Medical Standards • Sensitive and Referral Services • Public Health Carve-out Services • Public Health Waiver Programs • Health Care Management • Claim Billing and Encounter Information • Grievance and Appeal Procedures **Areas of Interest:** **Pg 4 Community Supports with revised definitions were reviewed.** **Pg 42 New to Submission of Prior Authorization Requests:** • Fax the prior authorization form to the Plan. Use the fax number on the form to submit requests 24 hours a day, seven days a week. You can also request authorization by phone or through the Plan's provider website. **Pg 52 Medi-Cal for Kids & Teens/Early & Periodic Screening Diagnostic & Treatment (EPSDT):** • New Language: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means the provision of medically necessary comprehensive and preventive health care services provided to members less than 21 years of age in accordance with requirements... • Such services may also be medically necessary to correct or ameliorate defects and physical or behavioral health conditions. All EPSDT services are covered services unless they are specifically carved out from managed care, i.e. dental services, specialty mental health services, California Children's Services. • PCPs, along with delegated PPGs or the Plan, are responsible for arranging for all medically	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	necessary EPSDT services identified at a preventive screening or other visit identifying the need for treatment. Providers are required to ensure all EPSDT services are provided in a timely manner. **Pg 116 Balance Billing:** • Balance billing is strictly prohibited by state and federal law and the PPA. Balance billing occurs when a participating provider balance bills Medi-Cal beneficiaries for amounts in excess of any Medi-Cal required copayments and deductibles for services covered under a member's benefit program, or for claims for such services denied by the Plan or the affiliated PPG. • Providers are prohibited from charging Medi-Cal members for the completion of any form that is required by, or is necessary for the administration of, the Medi-Cal benefit. • Participating providers are prohibited from charging a Medi-Cal member for a missed appointment. Medi-Cal managed care members are not share-of-cost beneficiaries and are not subject to copayments or deductibles for office visits, so they cannot be held accountable for these charges in the event of a missed appointment. ***Discussion:*** *Dr. Ramirez commented that the expectations are onerous, but the language is good.* *Dr. Pascual asked if the policy has always been not to charge for no-shows?* *Dr. Marabella stated that it has always been the policy that Medi-Cal members are not charged for a visit, so they cannot be charged for not showing up.*	
#5 **UM/CM/PHM Business** - Key Indicator Report and Turnaround Time Report (Sept. 2025) - UM Concurrent Review Report (Q3 2025) - Care Management and CCM Report (Q3 2025) - Over Under Utilization Report (Q1-Q2 2025) (Attachments GG-JJ)	The **Key Indicator Report and Turnaround Time Report, UM Concurrent Review, and CM and CCM Report** through September 2025 were presented. • MCE (Medicaid Expansion): Acute admissions and utilization remained stable, showing only minimal variance from 2024 averages. • TANF (Temporary Assistance for Needy Families): Continued stability with slight declines in admissions and utilization compared to 2024. • SPD (Seniors and Persons with Disabilities): Continued declines across all acute care metrics, with the steepest reductions in admissions (-25.8%) and bed days (-35.1%) versus 2024 benchmarks. **Average Length of Stay (ALOS):** • MCE: Q3 ALOS: 4.9 days, outperforming the annual goal by 14% • TANF: Q3 ALOS: 4.1 days, slightly above the annual goal	**Motion:** *Approve* - Key Indicator Report and Turnaround Time Report (Sept. 2025) - UM Concurrent Review Report (Q3 2025) - Care Management and CCM Report (Q3 2025) - Over Under

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	• SPD: Q3 ALOS: 5.5 days, a 15% reduction from the annual goal **30-Day Readmission Trends:** • MCE: Declined from a 2024 average of 13.5% to 11.6% in Q3 2025. • TANF: Remained stable at 4% in Q3 2025 and below the 2024 Average of 4.8%. • SPD: Improved significantly, moving from a 20.2% 2024 average to 14.7% in Q3 2025. **Next Steps:** • Maintain rigorous utilization review practices aligned with discharge planning to support continued reductions in readmission rates. • Strengthen collaboration between utilization management and case management teams to ensure seamless care transitions and improved member outcomes. • Continue outreach to key hospital partners, including St. Agnes, to establish an onsite presence and enhance coordination for members transitioning to lower levels of care. • Continue use of the Transitional Care Services (TCS) program as part of a broader strategy to support member recovery and reduce avoidable readmissions. **Physical Health Care Management (PH CM):** • Referral volume decreased 22% in Q3. • Q3 consistently has fewer referrals than Q2 (in review of 2024 and 2023 data). • Critical-Complex Acuity cases as a percentage of total cases managed increased 64.3% from Q2 to Q3. • Q2 to Q3, the Engagement Rate increased from 56% to 60%. **Transitional Care Services (TCS):** • Total number of referrals increased 22.6% to 2010, from Q2 to Q3. • Engagement rate decreased to 86% in Q3 from 90% in Q2. • Total cases managed increased 21.5% for a total of 1491 in Q3. **Behavioral Health Case Management (BH CM):** • Q2 to Q3, Total number of referrals decreased 14.4% to 362 in Q3. • Engagement rate decreased from 75% in Q2 to 69% in Q3. • Total cases managed decreased 30.1% to 197 cases in Q3. **Perinatal Case Management (PCM):** • Total number of referrals decreased 17.2% to 751 in Q3. • Engagement rate increased from 64% in Q2 to 68% in Q3.	Utilization Report (Q1-Q2 2025) (Pascual/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Total cases managed increased 5.9% to 523 in Q3. **First Year of Life (FYOL):** • Total number of referrals decreased 6.8%, Q2 to Q3. • Engagement rate quarterly average decreased from 100% to 93% in Q3. • Total cases managed increased 5.8% to 507 cases in Q3. **CM Outcomes for PH/BH CM** • The effectiveness of the program is evaluated based on the following measures: • Readmission rates • ED utilization • Overall health care costs • Member satisfaction **Readmission Rate:** • 960 members met outcome inclusion criteria • 90 days following CM enrollment, there was a 2.8% decrease in readmission rate • (27.6% readmission rate after Program) This was below our 5% goal. • Total admissions 90 days after CM enrollment decreased by 60.6%. **ED Claims before and after CM enrollment:** • ED claims decreased by 579 (19.8% for Q2), well above our 10% goal. • For a breakdown of reduction by claim type, see Appendix. **Outcomes for TCS:** • **Readmission rate:** o 1,718 members met outcome inclusion criteria o 90 days following CM enrollment, there was a 1.8% decrease in readmission rate. o 18.0% readmission rate after the Program • **ED claims before and after CM enrollment:** o ED Claims decreased by 185 members 90 days following CM enrollment **PCM:** • 184 members met outcome inclusion criteria for prenatal visit measure; 70 met for Pre-term delivery measure; 938 met for postpartum visit measure. • Members enrolled in the Pregnancy Program demonstrated the following: o 4.3% greater attendance rate at the first prenatal visit within the first trimester, below the	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	8% goal. o 4.7% fewer pre-term deliveries for High-risk members, exceeding the 2% goal. o 12.7% greater attendance rate at postpartum visits, exceeding the 10% goal. **Outcomes for FYOL:** • 197 members met outcome inclusion criteria for the avoidable ED measure. • Members enrolled in the FYOL Program demonstrated the following: o ED Claims per 1,000 members per year decreased by 277 (29.9% for Q2). **CM Satisfaction Survey Report was comprised of 13 questions:** • 69 members successfully completed the survey by mail or by phone. • Some members did not respond to all questions; therefore, the denominator varies. • 91% of members surveyed were happy with the CM program. • Three (3) questions scored equal to or greater than 90%, Seven (7) questions scored below 90%. *There were no questions or comments from committee members.* The **Over Under Utilization Report Q1-Q2 2025** was presented to review the impact of the UM Programs to detect and correct potential under and over-utilization through comprehensive monitoring efforts. Key Trends (PTMPY analysis was used to adjust for changes in membership): • **Inpatient Count:** The data reflects a steady decline in year-over-year (YOY) in adjusted IP count across all three (3) counties. Declining trend continues in the first half of 2025. Of all three counties, Madera consistently has the lowest IP utilization. Lower IP PTMPY trend has continued with the closure of Madera Community Hospital for the past couple of years. IP PTMPY utilization in Kings County historically tends to be somewhere between Fresno and Madera. In 2024, IP utilization in Kings surpassed Fresno. This trend continued in the first half of 2025. • **Emergency Room Utilization**: The data reflect a steady decline in YOY in population-adjusted ER utilization across all three (3) counties. • **Procedure Patterns:** C-section, bariatric surgery, and appendectomy rates have steadily declined in Fresno and Kings counties. In 2024, C-sections in Madera surpassed Kings with the highest rates in Fresno. This trend continued in Q1 2025. Bariatric surgery and appendectomy	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	rates are holding steady in Madera County with no appreciable long-term change. With better availability of prenatal care and Doulas, a decline in C-section rates is expected and in line with state and national trends. Availability of GLP-1 medications has led to a change in practice patterns and a decline in bariatric surgery. Again, this is in line with state and national experience. This trend is expected to continue. • **Barrier Analysis:** Cultural and linguistic barriers may lead to underutilization in the population. Transportation, housing instability, and limited access to specialty care can skew trends in counties with large populations residing in rural areas. Provider shortages in certain specialties or geographic areas can also limit access to services. The limited availability of post-discharge destinations in the region artificially raises inpatient utilization. Inpatient utilization in Madera County saw a 25-50% increase in most of 2023, the first year of closure of Madera Community Hospital. Inpatient utilization stabilized at lower than baseline levels in 2024 (Year 2 of hospital closure). So far, in 2025, inpatient utilization has declined to lower than baseline levels. We will monitor the effects of hospital reopening (March 2025) on inpatient utilization. • **Actions Taken/Next Steps:** In 2025, UM continues focused reviews of admitting diagnoses and utilized InterQual® criteria to ensure medical necessity. Integrated care teams consisting of Concurrent Review, Public Programs, Medical Directors, and CM continue daily rounds in 2025 to review all inpatient cases. These teams work together to create a safety net of services and cultivate alliances with community resources such as Disease Management, Community-Based Adult Service (CBAS) facilities, and behavioral health care. The discharge navigator, along with nurses, continued working with hospitals to improve follow-up appointments upon discharge. CVH continues to support the adoption of Enhanced Case Management (ECM), Community Supports (CS), and Community Health Workers (CHW) to resolve barriers and improve community health outcomes. Future Remediation Consideration: As a result of the review of the Over Under Utilization Report, the Plan will evaluate the following targeted opportunities: Implications for UM: o Review high-growth surgical service lines for coding consistency and best-practice alignment. Implications for CM: o Strengthen post-discharge planning to reduce readmissions, especially for high-growth surgical and chronic condition cohorts. o Implement targeted complex CM for frequent utilizers.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Address social determinants impacting ER utilization through stronger community resource partnerships. CHWs continue to play a vital role in building trust and understanding of the care delivery system in the region. ER Utilization Management: Launch education, triage support, and alternative care site awareness campaigns. Integrated UM/CM Approach: Align UM and CM interventions for high-risk patients to improve outcomes and manage cost trends. *Discussion:* *Dr. Ramirez asked how the Madera C-Section rates are getting measured, since the Madera hospital doesn't offer any OB services.* *Dr. Marabella clarified that rates are based on where the member lives, and not the hospital where the procedure was performed.* *Dr. Ramirez indicated that it is hard to influence changes, as this would require working on the behavior of Fresno area hospitals, as opposed to working with Madera Hospital.* *Dr. Marabella agreed that it is similar to when patients use Out-of-Area providers, like those in Modesto.* *Mary Lourdes Leone asked how this report actually measures Over or Under-utilization? It indicates volume fluctuation in utilization, but how do we really know if a measure is being Over or Underutilized?* *Dr. Marabella stated that we use Regional, Statewide, and National benchmarks to track averages for comparison. We've also requested that the authors of the report add narratives about why utilization is going up or down. We will also request that utilization be reported by the facility, as this data is claims and encounter-based.* *Dr. Ramirez added that there are no OBGYNs in Madera County, so all C-sections will be performed in Fresno.* *Dr. Marabella indicated that the State wants the Plans to track utilization to show that we're not restricting care. There's not a lot of active restriction in the Central Valley. There is under care as we have less access to care in certain categories (i.e., specialists, post-discharge destinations, etc.).* Mary Lourdes Leone left the meeting at 11:13 am and returned at 11:22 am.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Zaman Jennaty left the meeting at 11:23 am and returned at 11:26 am.	
#6 Pharmacy Business - Pharmacy Executive Summary (Q3 2025) - Pharmacy Operations Metrics (Q3 2025) - Pharmacy Top 25 Prior Authorizations (Q3 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q3 2025) (Attachments KK-NN) Action Patrick Marabella, M.D., Chair	The **Pharmacy Executive Summary Q3 2025** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q3 2025. o Overall, TAT for Q3 2025 was 100%. o PA volume in Q3 2025 was similar to Q2 2025, with some drug-specific differences. September had a higher volume compared to all other months in Q3 2025. • Top Pharmacy PA Requests o The top requests in Q3 2025 were similar compared to Q2 2025. • Provider and Pharmacy Updates o 25-680m Medication Trend Updates and Formulary Changes – 3rd Quarter 2025 ▪ Preferred Biosimilars ▪ Changes to Medi-Cal drug benefits The **Pharmacy Operations Metrics Q3 2025** provides key indicators measuring the performance of the PA Department in service to CVH members. The turnaround time (TAT) expectation is 100% with a threshold for action of 95%. • Pharmacy prior authorization (PA) metrics were within standard at goal in all months of Q3 2025. The average TAT for Q3 2025 was 100%. PA turnaround time is monitored to identify PA requests that are approaching the required turnaround time limits. • Q3 2025 TAT was met with an average of 100%. Approval rate was similar in all months of the quarter. Volume in September was higher than in all months in Q3 2025. Trending in volume and TAT will be monitored to ensure consistent procedures by the PA team. The **Pharmacy Top 25 Prior Authorizations Q3 2025** identifies the most requested medications to the Medical Benefit PA team for CVH members and assesses potential barriers to accessing medications through the PA process. The top 25 requests in Q3 2025 were mostly consistent with the top 25 drugs reviewed in Q2 2025, with a few placement variations. More variance is seen as	**Motion: Approve** - Pharmacy Executive Summary (Q3 2025) - Pharmacy Operations Metrics (Q3 2025) - Pharmacy Top 25 Prior Authorizations (Q3 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q3 2025) (Ramirez/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	we review the top 15 to 25 drugs. Some variances can be explained by the intervals between treatment and the length of auth assignment per the criteria. • Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products. • Several drug requests in Q3 2025 had a 100% denial rate based on non-preferred requests. The **Quality Assurance Reliability Results (IRR) for Pharmacy Q3 2025** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten (10) prior authorizations [four (4) approvals and six (6) denials] from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas, with a threshold for action of 90%. • Ninety percent (90%) threshold met. The 95% goal was not met; the overall score was 91%. • No (0) sample cases missed TAT after plan. • Six (6) sample cases had potential criteria application or documentation issues after plan review. • Two (2) sample cases had letter language that could have been clearer and more concise after plan review. • Three (3) sample cases were determined to have a questionable denial or approval after plan review. • In Q3 2025, Criteria Application was an area of concern, and after review of the documentation, it was determined that the decisions were not consistent with criteria requirements and led to two (2) questionable approvals and one (1) questionable denial. The denial was reviewed, and additional information that was needed for approval was not received before TAT expired. A more detailed review and QA on cases in Q3 2025 has been performed, and results will be shared with PA management to address concerns. Nicole Sihota left the meeting at 11:44 am and returned at 11:45 am.	
#7 **Policy & Procedure Business** - UMCM & Public Health Policy & Procedure Annual Review & Clinical Criteria	The **UMCM & Public Health Policy & Procedure Annual Review including annual review of criteria for Physical Health and Behavioral Health** was presented to the committee. The following policies were presented for annual review with no changes made:	Motion: Approve - UMCM & Public Health Policy & Procedure Annual

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments OO) Action Patrick Marabella, M.D., Chair	• UM-003 Standing Referral to Specialty Care • UM-004 Delegation Evaluation and Determination of UM • UM-007 Major Organ Transplant • UM-010 Second Opinion • UM-011 Long Term Care • UM-012 Discharge Planning • UM-013 Provision of Enteral Nutritional Supplements/Replacements • UM-014 Long Term Care Transition to Managed Care • UM-030 Potential Over and Under Utilization • UM-040 System Controls Policy & Procedure • UM-050 Communications and Accessibility to UM • UM-060 UM Decisions and Timely Access to Care • UM-065 Skilled Nursing Facilities • UM-100 Emergency Care and Services • UM-103 Continuity of Care • UM-111 Identification and Referral of CCS Members • **UM-113* Criteria for Utilization Management Care Management Decisions - Full Policy attached for annual criteria review.** • UM-116 Clinical Criteria for Medical Management Decisions • UM-117 Clinical Practice Guideline Development • UM-118 Separation of Medical Management from Administrative and Financial Management • UM-119 Concurrent Review • UM-121 Dental Services and IV Sedation and General Anesthesia • UM-208* Appropriate Professionals and Use of Board-certified Physicians in UM decision making • UM-211 Experimental and Investigational Services • UM-212 Transgender Services • CMP-015 Seniors and Persons with Disabilities (SPDs) Health Risk Stratification and Assessment • CMP-030 Tuberculosis Services and the Local Health Department (LHD) Direct Observed Therapy (DOT) • CMP-040 HIV/AIDS Coordination with HCBS Waiver Program	Review & Clinical Criteria (Ramirez/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CMP-050 Developmental Disability and Community Resources Linkage • CMP-051 Coordination of Care for Children in Foster Care • CMP-102 WIC Coordination • CMP-107 Care Coordination/Case Management Services • CMP-108 Referrals to Specialty Mental Health, Alcohol and Substance Abuse Treatment Services • CMP-109 Transitional Care Management • CMP-110 Targeted Case Management • CMP-112 Medi-Cal Disease Management Programs • CMP-123 Case Management Program Effectiveness • CMP-124 CalViva Pregnancy Program (CVPP) Case Management Services • CMP-125 Case Management and Members Under 21 Receiving Private Duty Nursing Services • CMP-400 Palliative Care Program • CMP-401 Advance Directives The following policies were presented for annual review and were approved with the following changes: • UM-001 Post Stabilization Inpatient Care Requested by Contracted/Non-Contracted Hospitals: Revisions in alignment with DHCS, DMHC & other regulatory language. Minor updates to definitions. • UM-002 Pre-Certification and Prior Authorization: Updated APL 25-011: Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP). • UM-005 Specialty Referral System: Added standing referral procedure for HIV/AIDS Specialists. • UM-015 Management of Enrollees in Subacute Long-Term Care: Added compliance section on APL 25-007: Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions. • UM-016 Intermediate Care Facilities for Members with Developmental Disabilities: Updates to align with APL 23-012: Annual Health Assessment and APL 25-007: Assembly Bill 3275 Guidance (Claim Reimbursement) • UM-120 Hospice Care Services: APL 25-008: Hospice Services and Medi-Cal Managed Care updates. Full policy attached. • UM-210 Referrals to Non-Participating Practitioners/Providers: Minor edits to ensure	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	consistency with language in APL 25-006: Timely Access Requirements regarding timely access and transportation services. • UM-300 CBAS Authorization Process: Updated with Telehealth for alternate service locations and Personal Emergencies, such as time-limited illness or injury, crises, or care transitions, that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by the Plan. • CMP-500 Enhanced Care Management Program Overview and Requirements: Updated ECM services review to annually. Other minor changes throughout. • CMP-501 Administration of CalAIM Community Supports: Added presumptive authorization for specific Community Supports. The following are new policies that were approved. The full policies were provided in the packet: • PH-030 Application of Medical Necessity Guidelines for Mental Health and Substance Use Disorder Treatment • PH-031 Authorization for Transcranial Magnetic Stimulation (TMS) • PH-047 Mandatory Child/Elder Abuse Reporting – Exceptions to Confidentiality • UM-061 Technology Supported Authorization Screening • CMP-502 Administration of Transitional Rent *Key NCQA Policies	
#7 **Policy & Procedure Business** - Prior Authorization Changes for 2026 (Attachments PP) Action Patrick Marabella, M.D., Chair	The Prior Authorization Changes for 2026 were presented to the committee. • The PA timelines for standard requests will change effective January 1, 2026. The current timeline is at least five business days from the date of request. The new timeline will be seven (7) calendar days.	Motion: Approve - Prior Authorization Changes for 2026 (Ramirez/Quezada) 5-0-0-3
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Q4 2025)	The **Credentialing Sub-Committee Quarterly Report Q4 202** was presented. The Credentialing Sub-Committee met on October 16, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. The 2025 Credentialing Sub-Committee meeting dates were presented and approved. Reports covering Q2 2025 were reviewed for delegated entities, and for Q3 2025 for Health Net (HN) and HN Behavioral Health (BH). A summary	Motion: Approve - Credentialing Subcommittee Report (Q4 2025)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment QQ) Action Patrick Marabella, M.D., Chair	of Q2 2025 data was presented. • The **Credentialing Adverse Actions** report for Q3 2025 for CVH from the HN Credentialing Committee was presented. o There was one (1) case presented for discussion in Q3. The case was placed on pending status awaiting adjudication by the Medical Board of California. Agreed with this decision and with imposing HN's Chaperone Agreement with quarterly chaperone oversight. • The **Adverse Events Q3 2025** 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. o Credentialing submitted one (1) new case to the Credentialing Committee in Q3 2025 involving an individual practitioner. ▪ The case stemmed from a state licensing board action. ▪ The case was placed on pending status awaiting adjudication of the board investigation as well as a chaperone agreement, and one (1) case was approved for termination for CVH. ▪ Zero (0) cases involved behavioral health. ▪ There were no (0) reconsiderations or fair hearings during Q3 2025. o July, August, and September credentialing, recredentialing, denial, and termination rosters were submitted and approved. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2025. o 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 Q3 2025. o August and September delinquent license reports for termination and monitoring were submitted and approved. o Zero (0) cases required reporting for 805 in Q3 2025. • The **Access & Availability Substantial Harm Report Q3 2025** was presented and reviewed. This report aims to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked by severity level. This report now includes	(Quezada/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	behavioral health cases in addition to physical health. o 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). o The Investigations Team submitted twenty (20) cases to the Peer Review Committee in Q3 2025. o 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. o Zero (0) incidents involving appointment availability issues resulted in substantial harm to a member or members in Q3 2025.	
#8 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q4 2025 (Attachment RR) Action Patrick Marabella, M.D., Chair	**Peer Review Sub-Committee Quarterly Report Q4 2025** was presented. The Peer Review Sub-Committee met on October 16, 2025. • The county-specific **Peer Review Sub-Committee Summary Reports for Q3 2025** were reviewed for approval. No (0) significant cases to report. The 2026 Peer Review Sub-Committee meeting dates were presented and approved. • The **Q3 2025 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs), and Credentialing Adverse Action (AA) cases identified during the reporting period. o 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. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2025.	Motion: Approve - Peer Review Subcommittee Report Q4 2025 (Waugh/Pascual) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ 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 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 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. ○ 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 twenty (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	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(1) case is pending closure for CAP compliance.	
#9 **Compliance Update** - Compliance Regulatory Report Mary Lourdes Leone, CCO (Attachment SS)	The **Compliance Report** was presented and reviewed. **CVH Oversight Activities: Health Net (HN):** 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 & availability, specialty referrals, utilization management data, grievances, and appeals etc. **Oversight Audits.** The following annual audits are in progress: Access & Availability, Internal Compliance FWA, UMCM, Privacy and Security, Transportation, and Provider Network. The following annual audits have been completed since the last Committee report: Marketing (No CAP), Call Center (No CAP), Claims/PDR (No CAP). **Fraud, Waste & Abuse Activity.** Since the 10/16/2025 Compliance Report to the Committee, seven (7) MC609 filings have been filed with DHCS. • DHCS Referral - A whistleblower reported that a skilled nursing facility intentionally delayed discharging Medi-Cal patients who had already met their therapy goals or rehab potential, in order to continue billing for unnecessary services. The report also claimed the facility delayed hospice referrals to prolong higher reimbursements. • DHCS Referral - A licensed psychiatrist was identified as a top Medicare prescriber among his peers. • DHCS Referral - A participating provider under the national contract for California Medicaid for potential billing of non-covered or unauthorized services. • DHCS Referral – A podiatrist's office billing of a HCPCS Q-code (Skin Substitute) that is considered not a covered service as it does not support medical necessity and is not a preferred product. • A non-participating DME provider was identified by the Special Investigations Unit (SIU) as an ineligible provider. • A non-participating Hospice and Palliative Care provider is being investigated for possible non-rendered services. • A non-participating DME provider for possible services not rendered or inappropriate billing.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation. The Plan continues to await DHCS' acceptance and CAP closure. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit.** The Plan continues to await the DMHC's Final Audit Report. **Department of Health Care Services ("DHCS") 2025 Medical Audit.** The Plan received the 2025 DHCS Audit Final Reports on 11/5/25. • The Primary Contract (Medical) - There were four findings and a corresponding CAP: o The Plan did not ensure that the delegate, HN, applied EPSDT criteria in medical necessity denial decisions for members under 21 years of age. o The Plan did not ensure that the delegate, HN, provided members with all ECM core service components. o The Plan did not ensure that the delegate, HN, notified members of the discontinuation of ECM benefits through the NOA process. o The Plan did not ensure that the delegate, HN, included all required information in ECM member-facing written materials. The initial CAP response is due by 12/5/25 to DHCS. • The Secondary Contract (State Supported Services) - There were no (0) findings. **Memorandum of Understanding (MOU):** Since the last Commission Meeting, the Plan has executed one (1) MOU with the Madera County Local Health Department. **Annual Network Certifications:** • 2025 Subnetwork Certification (SNC) Landscape Analysis- The Plan submitted the Landscape Analysis on 10/31/2025. • 2024 Subnetwork Certification (SNC) Landscape Analysis – The Plan continues to submit quarterly updates on the status of the CAPs until they are fully resolved. The most recent quarterly update was submitted on 9/25/2025. • 2024 Annual Network Certification (ANC) - 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. **(RY)2024 (MY)2023 Timely Access Report (TAR) and Annual Network Report (ANR):** As a result of the DMHC ANR Findings Report, the Plan submitted a separate Material Modification on 8/12/25 to request new time and distance standards for specific zip codes. On 11/4/25, the DMHC issued an Order of Approval for the Alternate Access Standards.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(RY)2025 (MY)2024 Timely Access Report (TAR) and Annual Network Report (ANR): On 5/1/2025, the Plan submitted the Annual 2025 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 DMHC All Plan Letters (APLs) that have been issued in CY 2025. **Public Policy Committee (PPC):** The next Public Policy Committee meeting will be held on December 3, 2025, 11:30 am -1:30 pm located at 7625 N. Palm Ave, Suite 109, Fresno, CA 93711. Dr. Pascual left the meeting at 11:56 am and returned at 11:59 am. Morgan Simpson left the meeting at 12:04 pm.	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is on February 19th, 2026. There are a few Committee members up for term renewal in 2026. Dr. Marabella will confirm their continued participation in the QIUM Committee.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 12:06 p.m.	

NEXT MEETING: February 19th, 2026

Submitted this Day: February 19, 2026

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

Acknowledgment of Committee Approval:

X Patrick B Marabella MD
Patrick Marabella, MD, CMO, Committee Chair

Public Policy Committee
Meeting Minutes
December 3, 2025

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

	Committee Members		Community Base Organizations (Alternates)
✓	Joe Neves, Chairman	✓*	Jeff Garner, KCAO
✓	Miguel Rodriguez, Provider Representative	✓*	Roberto Garcia, Self Help
	Martha Miranda, Kings County Representative		**Staff Members**
✓	Araceli Sanabria Gaona, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations & Marketing
✓	Kristi Hernandez, Fresno County Representative	✓	Cheryl Hurley, Commission Clerk / Director, HR /Office
✓	Maria Arreola, At-Large Representative	✓	Steven Si, Compliance Manager
✓	Norma Mendoza, Madera County Representative	✓	Morgan Simpson, Senior Director of Compliance
		✓	Sia Xiong-Lopez, Equity Officer
		✓	Mary Lourdes Leone, Chief Compliance Officer
		✓	Dr. Marabella, Chief Medical Officer
		✓	Maria McDivitt, Senior Compliance Manager
		✓	Amy Schneider, Sr. Director of Medical Management
		*	= late arrival/left early
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:31 am. Roll call was taken to establish a quorum.		
#2 Meeting Minutes from September 3, 2025 **Action** Joe Neves, Chair	The September 3, 2025, meeting minutes were reviewed and approved.		**Motion:** Approve September 3, 2025, Minutes 7-0-0-2

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
			(R. Garcia / M. Rodiguez) *J. Garner not included in vote; arrived late*
#3 Annual Public Policy Committee Charter Review **Action** Joe Neves, Chair	The PPC reviewed the Charter and approved to move forward to Commission for approval with stated revisions.		**Motion:** Approve PPC Charter to move forward to Commission for final approval. 7-0-0-2 (R. Garcia / M. Rodiguez) *J. Garner not included in vote; arrived late*
#4 Enrollment Dashboard **Information** Maria McDivitt	Maria Sanchez presented the enrollment dashboard through September 2025. Membership as of September 30, 2025, was 430,342. CalViva Health maintains a 66.79% market share.		**No Motion**
#5 Health Education **Information** Steven Si	Accomplishments: Member Incentives • 3,383 members participated in Q1–Q2 2025 • $84,575 in gift cards distributed • 100% of participants from Fresno County • 33% increase in incentives compared to last period Member Materials • 18,652 educational materials ordered • Providers and members can request materials online or through Member Services Health Education Information Line • 5 total calls received	*Courtney Shapiro asked if the 5 total calls received, out of all the Plan's health education programs, only 5 members called in about Health Education?* *Steven Si stated yes, this line is only geared toward health education inquiries.* *Courtney Shapiro asked if this is a benefit that maybe members don't know about?*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• 1 about asthma education; 4 about member benefits FindHelp Referrals • 204 referrals total • Fresno 169; Madera 21; Kings 14 Next Steps for 2025 Q3-Q4 • Launch new CalViva-PREV-2025 member incentive program on July 1, 2025 (supports HEDIS measures and the Quality Edge Strategy). • Continue promoting digital health education tools (QR codes, online resources). • Ongoing updates to health education materials per DHCS guidelines; support digital and print ordering. • Partner with Member Services to increase awareness of available health education programs. • Continue promoting BCS and CCS screenings through Every Woman Counts. • Continue promotion of Kick It California tobacco cessation program. • DHCS approved new Diabetes Prevention Program (DPP) in January 2025.	*Steven Si responded that internally this has been a discussion as well, due to lack of calls. Weighing pros and cons of the effort that went into promoting the Health Education line and lack of response, it was decided it was better to focus effort elsewhere.* *A comment from the Health Education team suggests adding social media posts for Health Education.* *Steven Si clarified the phone number on the back of the member ID card will direct members to needed inquiries.*	
#6 DHCS Community Reinvestment **Information** Courtney Shapiro Jeff Nkansah	Courtney Shapiro provided a recap of the DHCS Community Reinvestment program and how it is a new way of how the Plan will fund the community. This is a standing agenda item for the Public Policy Committee. For today's PPC meeting, there are no updates; however, the PPC was polled to see if there are any non-profits that the committee would like for the Plan to meet with. And if there are any issues within their communities that they think need to be addressed. All PPC members were encouraged to contact Courtney with any recommendations. The Plan has to be very specific so that it fits into one of the required "buckets".	*Araceli Sanabria Gaona asked if CVH could share what the Plan has planned already.* *Courtney provided a recap of some of the community based organizations that have received funding for their programs.*	**No Motion**
#7 Health Equity	Sia Xiong-Lopez reported on the 2025 Health Equity Work plan Mid-Year Evaluation and the 2025 Language Assistance Program.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
2025 Work Plan Mid-Year Evaluation 2025 Language Assistance Program Mid-Year Report 2025 Geo Access Report **Information** Sia Xiong-Lopez	As of June 30, all activities are on target to be completed by the end of the year with some already completed. Highlights are: • Fifty-two staff completed their bilingual assessment/re-assessment. • Responded to 15 cultural and linguistic related grievances (14 medical, 1 behavior health) and 5 interpreter complaints. • Cultural competency training for providers in January, 344 attendees. • NCQA Health Equity Accredited awarded in June 2025. • 89% (32) of the total identified students (Fresno Unified) were tested and are reading at grade level. • Kings County Public Health and Behavior Health, Pear Suite, Kings Community Action Organization (KCAO) and CVH developed a flyer, survey, and pre-screening assessment and will launch the Perimenopause and Menopause Awareness Campaign in September. For Language Assistance Services in Q1 and Q2: • Member Services Department representatives handled a total of 81,375 calls across all languages. Of these, 44,136 (54%) were handled in Spanish and Hmong languages. • A total of 2,300 interpreter requests were fulfilled for CalViva Health members, 1,820 (79%) of these requests were fulfilled utilizing telephonic interpreter services with 419 (18%) for in-person, 61 (3%) for sign language interpretation, and no requests for video remote interpreting. • Behavior Health Member Services Department and Clinical Operations representatives handled a total of 2,294 calls across all languages and 381 (17%) calls handled in a language other than English (ASL, Cantonese, Farsi, Russian, Persian, and Punjabi) with 374 (98%) of these calls being handled in Spanish and none handled in Hmong. • There were 253 requests for interpreter services that were fulfilled for behavior health members. Of these 253 requests, 71 (28%) were fulfilled for in-person, 151 (60%) for sign language interpretation, and 31 (12%) for Video Remote Interpretation. • No alternate format request was received from CalViva Health members during this reporting period.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• A total of 31 English material reviews were completed for CalViva Health documents/materials. • A total of 15 grievance cases were received and reviewed by the Health Equity Department		
#8 Medical Management Quality Improvement & HEDIS Update MY2024 **Information** Dr. Marabella, CMO	Dr. Marabella gave an update on the Reporting Year 2025 / Measurement Year 2024 HEDIS® Results and Quality Improvement. The four domains for Managed Care Accountability Set Measures RY 2025 are: 1. Child & Adolescent Health a. Child and Adolescent Well-Care Visits (WCV) b. Childhood Immunization Status: (CIS-10) c. Developmental Screening in the First 3 Yrs (DEV) d. Immunizations for Adolescents: Combination 2 (IMA) e. Lead screening in Children (LSC) f. Topical Fluoride for Children (TFC) g. Well-Child Visits in the First 15 Months of Life h. Well-Child Visits 15-30 Months 2. Behavioral Health a. Follow-Up After Emergency Department (ED) Visit for Mental Illness –30 days (FUM) b. Follow-Up After ED Visit for Substance Abuse – 30 days (FUA) 3. Reproductive Health & Cancer Prevention a. Cervical cancer screening (CCS) b. Chlamydia screening (CHL) c. Breast cancer screening (BCS) d. Prenatal care (PPC Pre) e. Post partum care (PPC Post) 4. Chronic Disease a. Controlling high blood pressure (CBP) b. Comprehensive Diabetes A1C poor control >9% (HBD) c. Asthma medication ratio (AMR)		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	MCAS Measures Not Meeting Minimum Performance Level by Domain RY2025 Per CalViva County are: 1. Fresno County: ▪ Did not meet Child & Adolescent Domain ▪ Did not meet Behavioral Health Domain 2. Kings County: ▪ Did not meet Child & Adolescent Domain 3. Madera County: ▪ Did not meet Behavioral Health Domain The two Performance Improvement Projects (PIPs) consist of: 1. Performance Improvement Project (PIP) Improve Well Child Visits (WCV) for AA/Black Children 0 to 15 months in Fresno County. 2. Performance Improvement Project (PIP) Improve Follow up with Provider after ED Visit for Behavioral Health/Substance Use in Fresno and Madera Counties. The three DHCS County Projects in progress are: 1. Lean Project for Madera County: Lean Health Equity Quality Improvement Project in Madera County based on RY24 MCAS results. 2. Comprehensive Project for Kings County: Comprehensive Health Equity Quality Improvement Projects in Kings County (RY24 results) 3. Transformational Project for Fresno County: Transformational Health Equity Quality Improvement Projects in Fresno County (RY24 results) The two Institute for Healthcare Improvement (IHI) collaborative projects are: 1. Improving Well Child Visit Rates, and 2. Improving F/U After ED Visit for SUD/MH In summary: • RY2025 MCAS results showed improvement in all counties. • MY25 (RY26) results are on track to maintain positive results with ongoing improvements.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Medical Management Team is continuing Annual Clinic Visits at CalViva's larger FQHCs in each county to share RY25 results and discuss opportunities for improvement and collaboration.		
#9 Appeals, Grievances and Complaints **Information** Maria McDivitt	For Q3 2025 there were 45 Coverage Disputes (Appeals), 113 Disputes Involving Medical Necessity (Appeals), 28 Quality of Care, 224 Access to Care, and 374 Quality of Service, for a total of 784 appeals and grievances for Q3. The majority of which are from Fresno County. There were 128 appeal cases for Fresno County, 17 for Kings County, and 13 for Madera County, for a total of 158 for Q3 2025. There were 499 grievances cases in Fresno County, 62 for Kings County, and 65 for Madera County for a total of 626 for Q3 2025. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for Standard Grievances, Standard Appeals, and Expedited Appeals. The compliance rate for Expedited Grievances was 97.2%. There was a total of 456 Exempt Grievances received in Q3 2025. Of the total grievances and appeals received in Q2, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 212 • Appeals: 43 • Exempt: 51 The majority of appeals and grievances are from members in Fresno County, which has the largest CalViva Health enrollment. The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Other, Administrative, and Interpersonal. The majority of quality of care (QOC) cases resolved were categorized as PCP Delay, PCP Care, and Other.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	The top categories of appeal cases resolved were related to Advanced Imaging, Community Supports, and DME. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received.		
#10 Annual Review of the Provider Operations Guide **Information** Mary Lourdes Leone	The PPC members were provided a redline version of the current CalViva Health Operations guide showing the highlights of the most recent changes made to the manual. CalViva signed a new contract in 2024 with the Department of Health Care Services (DHCS) along with all other health plans in California that provide services to individuals receiving Medi-Cal. The new contract includes a number of new or revised regulations mandating health plan compliance. One of these new regulations requires that each year the Plan obtain Public Policy Committee feedback on the Operations Guide. The CalViva Operations Guide is available online and in print. It contains essential information about managing the care of Medi-Cal patients in Fresno, Kings, and Madera counties. The guide describes use and access to services, physician responsibilities on various topics such as care coordination, prior authorizations, public program referrals, and much more. The Plan's goal for this process is to: 1. Identify opportunities to improve the accuracy of the information currently available. 2. Identify areas that need clarification. 3. Identify information that is missing from or should be added to the Operations Guide.	*PPC member Norma Mendoza stated she has a family member that was charged a co-pay.* *Mary Lourdes Leone stated there should be no charge to the Medi-Cal member whatsoever.* *PPC member Araceli Sanabria Gaona also questioned the copay.* *Mary Lourdes stated the Providers are paid by the State and it is prohibited to charge Medi-Cal members.* *PPC member Araceli Sanabria Gaona also inquired about members with Asthma and where can they find assistance and services.*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
		Mary Lourdes stated members can call member services to inquire about access to asthma remediation services. *PPC member Araceli Sanabria Gaona asked what happens to support and services for disabled persons after age 18?* *Dr. Marabella stated the disability had to happen prior to 18 years of age and then will continue for life.* *Sia Xiong-Lopez stated services through Central Valley Regional Center can also support disability services.* *PPC member Araceli Sanabria Gaona added that she had a bad experience with CVRC when requesting services for her son. She stopped ABA services for her son due to the inadequate services provided.* *Dr. Marabella recommended she talk to the clinic Providers directly to explain her sons needs.*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
		PPC member Maria Arreola inquired about a situation she experienced with CalAIM regarding the request for a ramp for her disabled child. *Elizabeth Campos responded that she could connect with Maria on the home modification service and delve into the issue as to why she was denied.*	
#11 2023 DHCS Focused Audit – CAP Update **Information** Mary Lourdes Leone	Mary Lourdes Leone reported the State has not closed this audit out as of yet		**No Motion**
#12 2025 DHCS Focused Audit – CAP Update **Information** Mary Lourdes Leone	Mary Lourdes Leone reported the Plan did receive the findings report noting four (4) findings. CalViva is currently in the process of responding.		**No Motion**
#13 2025 DMHC Follow-Up Audit **Information** Mary Lourdes Leone	Mary Lourdes Leone reported that CalViva has submitted all required information and currently pending DMHC's response.		**No Motion**
#14 Population Health Management Collaboration Update **Information**	Elizabeth Campos presented the Population Health Management presentation. For Fresno County from January 2024 – December 2025, MCPs will collaborate with the Fresno County Department of Public Health (FCDPH) and key community partners to identify and implement targeted community and MCP interventions to		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
Elizabeth Campos	Improve Childhood Immunization Status Combination 10 to exceed the DHCS benchmark 50th percentiles. All intervention efforts and data on vaccination trends by vaccination type, demographics, geography, and well child visits will be reported bi-annually by the MCPs and shared with the FCDPH. Results will compare baseline data. For Kings County, from January 2024-December 2025, Kings County Department of Public Health, community stakeholders, and MCPs will collaborate to identify and implement targeted community and MCP interventions to improve Childhood Immunization Status to exceed the DHCS benchmark 50th percentiles. All interventions efforts will be reported bi-annually. Results will compare baseline data to utilization claims data. For Madera County, the DPH and MCPs are aligned on an objective to increase utilization and network for Community Health Workers serving Madera County. By 2028, increase the use of Community Health Workers (CHWs) in Madera County to connect and refer to services. And to complete a CHW landscape analysis to determine gaps in service and utilization in Madera County, via Madera County CHW Access to Care Sub-Workgroup.		
#15 Announcements / Final Comments from Committee Members and Staff	Araceli Sanabria Gaona requested if the PPC meeting materials could be available in Spanish. Courtney Shapiro stated she will keep working on a way to provide Spanish material for all packet documents. Maria Arreola shared the CVH promotores were invited and to attend the Camarena Health & Wellness conference. The promotores also attended the Liver Expo by UCSF. The promotores held a dance event to raise awareness for breast cancer. Norma Mendoza shared additional events the CVH promotores attended. Jeff Garner thanked CalViva Health for their support in Kings County.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Miguel Rodriguez shared that UHC opened a health center in Delano, one in south Fresno on Ceasar Chavez, and another one in Fresno off of Shields and Marty. He also thanked CalViva for their support.		
#16 Announcements	None.		
#17 Public Comment	Public comments were made throughout the meeting; see above.		
#18 Adjourn	Meeting adjourned at 1:32 pm.		

NEXT MEETING March 4, 2026, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: March 4, 2026

Submitted By: _____
Courtney Shapiro, Director Community Relations & Marketing

Approval Date: March 4, 2026

Approved By: _____
Joe Neves, Chairman

Fresno-Kings-Madera Regional Health Authority
Public Policy Committee Charter

I. Purpose:

A. The purpose of the Public Policy Committee ("PPC") is to provide a committee structure for the consideration and formulation of CalViva Health ("CalViva" or the "Plan") policy on issues affecting Plan members. Plan Members shall be afforded an opportunity to participate in establishing the public policy of the Plan.

B. The Plan will determine the total number of established PPCs reasonably necessary to ensure the fulfillment of PPC requirements and allow for meaningful engagement with Members in their service area. Health Plans operating in multiple counties may have one PPC across multiple counties or separate and distinct PPCs for each county as needed to support engagement. The Plan is operating one PPC across multiple counties.

II. Authority:

A. The PPC is given its authority by and reports to the Fresno- Kings-Madera Regional Health Authority ("RHA") Commission. This authority is described in the RHA Bylaws.

III. Definitions:

A. Public Policy means acts performed by the Plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the Plan's facilities to provide health care services to them, their families, and the public. (Rule 1300.69)

B. Fresno-Kings-Madera Regional Health Authority (RHA) Commission – The governing board of CalViva Health.
   1. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. On April 15, 2010, the RHA Commission adopted the name "CalViva Health" under which it will also do business.

IV. Committee Focus:

A. The PPC's recommendations and reports will be regularly and timely reported to the Commission. The Commission shall act upon these reports and recommendations and the action taken by the Commission will be recorded in the minutes of the Commission's meetings.

B. Principal Responsibilities:

1. Review a quarterly summary report regarding the specific nature and volume of complaints received through the grievance process and how those complaints were resolved.
2. Make recommendations concerning the structure and operation of the Plan's grievance process including suggestions to assist the Plan in ensuring its' grievance process addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities.
3. Review and evaluate member satisfaction data.
4. Advise on health education and cultural and linguistic service needs through review of a population needs assessment, demographic, linguistic, and cultural information related to the Plan's population to make recommendations regarding:
   - 4.1. Linguistic needs of populations served and identify any enhancements or alternate formats that Plan materials may need.
   - 4.2. ~~Policies needed for increasing member access to services where there may be barriers resulting from cultural or linguistic factors.~~ Recommendations to the Plan regarding the cultural appropriateness of communications, partnerships, services and program design.
   - 4.3. Changes needed to the provider network to accommodate cultural, linguistic, or other ethnic preferences.
   - 4.4. Improvement opportunities addressing member health status and behaviors, member health education, health equity, social determinants of health ("SDoH"), and gaps in services. PPC will identify and advocate for Preventive Care practices to be utilized by the MCP.
   - 4.5 Input on Quality Improvement.
5. Advise on outreach and education plans for Non-Specialty Mental Health Services (NSMHS).
6. Review Local Health Jurisdiction Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) findings and provide input to inform CalViva Health's strategies and workstreams.
7. Review and validate Community Reinvestment Plans prior to submission to DHCS to ensure investments align with community needs.
8. Advise or reform to improve health outcomes, accessibility of services, and coordination of care for Members. ~~on problems related to the availability and accessibility of services.~~
   - 8.1. Review data/other Plan information and make recommendations for policy or Plan/provider network changes needed related to Americans with Disabilities Act (ADA) requirements or to minimize barriers and increase access for members with disabilities (e.g., identifying potential outreach activities, etc.).

9. Review member literature and other plan materials sent to members and advise on the effectiveness of the presentation.
   9.1 Review and provide input on Plan marketing materials and campaigns to ensure alignment with member needs and cultural appropriateness.
10. Make recommendations or suggestions for member outreach activities, topics or articles/information for publication on the member website, in member education materials or newsletters, etc.
11. Recommend review/revision and/or development of policies and procedures to the RHA Commission or other Plan committees as appropriate based on the Committee's review of grievance, member satisfaction, and other Plan data.
12. Review financial information pertinent to developing the public policy of the Plan.
13~~1~~. Review and provide input in annual reviews and updates to relevant policies and procedures affecting ~~quality~~ Quality of Care, ~~and~~ Health Equity, Health Disparities, Population Health Management (PHM), and children services. CalViva health will provide a feedback loop to inform PPC members how their input has been incorporated.
14. Review and provide input on the development and updates of the Provider Manual to ensure it meets member and community needs.
15. Recommend and provide feedback on diversity, equity, and inclusion (DEI) training programs for Plan staff and network providers.
16. Communicate identified needs for network development and assessment, including gaps in access or specialty providers, to the Commission and Plan leadership.
17. Provide recommendations regarding community resources and information to improve member knowledge and access to services.
18. Advise on coordination and member communications related to carved-out services to support integrated care and reduce confusion.
19. Other matters pertinent to developing the public policy of the Plan.

V. Committee Membership:

Composition

1. The RHA Commission Chairperson shall appoint the members of the PPC selection committee. CalViva Health, in consultation with their Health Equity Officer, will ~~make a good faith effort to~~ ensure that the PPC selection committee is comprised of a representative sample of each of the persons mentioned below to bring different perspectives, ideas, and views to the PPC while providing recommendations to the Plan:

1.1. Persons who sit on the PPC selection committee are a representative sample of RHA Commission members from the following stakeholder areas: Safety Net Providers including FQHCs, behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community based service Providers; and

1.2. Persons and community based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

2. The Plan will designate a PPC Coordinator who will be responsible for managing the operations of the PPC in compliance with all statutory, rule, and contract requirements as outlined in 5.2.11.E.2.(e) of the Medi-Cal Contract (see VII.A. below). The PPC Coordinator will facilitate scheduling the selection committee meeting(s). The PPC selection committee must select all its PPC members promptly no later than 180 calendar days from the effective date of the 2024 DHCS Medi-Cal contract.

3. The PPC shall consist of not less than seven (7) members, who shall be appointed as follows:
   3.1. One member of the RHA Commission who will serve as Chairperson of the PPC;
   3.2. One member who is a provider of health care services under contract with the Plan; and
   3.3. All others shall be Plan members (who collectively must make-up at least 51% of the committee membership) entitled to health care services from the Plan. PPC Plan members shall be comprised of the following:
      3.3.1. Two (2) from Fresno County
      3.3.2. One (1) from Kings County
      3.3.3. One (1) from Madera County
      3.3.4. One (1) At-Large from either Fresno, Kings, or Madera Counties

   3.4. Two (2) Community Based Organizations (CBO) representatives shall be appointed as alternate PPC members to attend and participate in meetings of the Committee in the event of a vacancy or absence of any of the members appointed as provided in subsection 3.1 above.
      3.4.1. The alternates shall represent different Community Based Organizations (CBO) that serve Fresno, Kings, and/or Madera Counties and provide community service or support services to members entitled to health care services from the Plan.
      3.4.2 Two (2) alternates from the same CBO shall not be appointed to serve concurrent terms.

3.5. The Plan members and CBO representatives shall be persons who are not employees of the Plan, providers of health care services, subcontractors to the Plan or contract brokers, or persons financially interested in the Plan.

3.6. In selecting the members and/or CBO representatives of the PPC, the RHA selection committee shall make a good faith effort to ensure the PPC reflects the general Medi-Cal population in the Plan's service area (i.e., Fresno, Kings and Madera counties). Consideration will be given to Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), and those with Limited English Proficient (LEP). To ensure at least 5% of the committee members represent a culturally diverse group of community members, consumers, and individuals, additional factors to be considered are race, ethnicity, sexual orientation, gender identity, SDoH, demography, occupation, and geography. Any such selection of a Plan member or a CBO representative shall be conducted on a fair and reasonable basis.

B. Term of Committee Membership

1. The Commissioner member may be appointed for a three (3) year term and his/her term will be coterminous with their seat on the Commission.
2. The provider member may be appointed for a three (3) year term.
3. Subscriber/enrollee members' and CBO representative terms shall be of reasonable length (one, two, or three years) and shall be staggered or overlapped so as to provide continuity and experience in representation.
4. At the conclusion of any term, a PPC member may be reappointed to a subsequent three-year term.

C. Vacancies

1. If vacancies arise during the term of PPC membership, the selection committee will appoint a replacement member. Should a PPC member resign, is asked to resign, or is otherwise unable to serve on the PPC, CalViva Health must make its best effort to promptly replace the vacant seat within 60 calendar days of the vacancy.

D. Voting

1. All members of the PPC shall have one vote each.
2. When attending a meeting in place of a regular member, an alternate member shall be entitled to participate in the same manner and under the same standards as a regular member, to the extent that the alternate member is not otherwise disqualified from participating in discussion and voting on an item due to a conflict of interest.

VI. Meetings:

The PPC must hold its first regular meeting promptly after all initial PPC members have been selected by the PPC selection committee and quarterly thereafter. Regularly scheduled PPC meetings will be open to the public, meetings information will be posted publicly on CalViva Health's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

A. Frequency
   1. The frequency of the PPC meetings will be quarterly.
   2. The Committee Chairperson or RHA Commission may call additional ad hoc meetings as necessary.
   3. A quorum consists of at least 51% of the membership.
   4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Place of Meetings
   1. CalViva Health will provide a location for PPC meetings and all necessary tools and materials to run meetings, including, but not limited to, providing onboarding materials for PPC members, providing resources to support PPC members in their PPC activities, and making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.
   2. Sites selected for PPC should match or coincide with locations where Plan members reside or go to access services and have the ability to support virtual participation. The following should be considered when selecting a meeting site:
      2.1. Meeting room must be able to accommodate PPC participants comfortably.
      2.2. Safety protocols must be identified (exits, facility contact in case of emergency, etc).
      2.3. Electrical outlets and wall space to accommodate presentation equipment (if needed).
      2.4. Access to nearby parking and/or transportation lines.
      2.5. Wheelchair accessible.

C. Notice
   1. At the end of each PPC meeting, the next meeting date will be determined by consensus unless a pre-arranged schedule has been established.
   2. Committee members will be notified in writing in advance of the next scheduled meeting.

D. Minutes
1. A written draft of meeting minutes for each meeting and the associated discussions will be prepared. All minutes will be posted on CalViva Health's website and submitted to DHCS no later than 45 calendar days after each meeting. CalViva Health must retain the minutes for no less than 10 years and provide them to DHCS, upon request.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the PPC's recommendations.

VII. Committee Support:

A. PPC Coordinator

The Plan will maintain a written job description detailing the PPC Coordinator's responsibilities, which will include having responsibility for managing the operations of the PPC in compliance with all statutory, rule, and contract requirements, and the PPC Coordinator must not be a PPC member or an enrolled Plan member, including, but not limited to:

1. Attending PPC meetings regularly.
2. Preparing agenda and meeting documents with input of PPC members. Ensuring documents are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in the meetings.
3. Ensuring that members are supported in their roles on the PPC, including but not limited to providing resources to educate PPC members and in formats to ensure they are able to effectively participate in meetings. Transportation and childcare reimbursement will be provided for PPC meetings. Meeting times will be scheduled to ensure the highest PPC member participation possible.
4. Coordinating other meeting preparation arrangements.
5. Initiating and following up on action items and suggestions until completed and ensuring feedback is provided to the Committee to "close the loop".
6. Ensuring Compliance staff will include a summary of the PPC's activity and recommendations are included in Compliance Reports to the RHA Commission.
7. Informing PPC members they can simply make the PPC Coordinator aware additional assistance is required by sending an email, phone call, or text. Assistance can include, but is not limited to the following:
   7.1. Translation and Interpreter services for Committee Members upon request.
   7.2. To arrange for interpreter services for PPC members the PPC Coordinator is responsible for partnering with Health Equity to contact and request interpreter services.
8. Providing sufficient resources for the PPC to support required PPC activities

and PPC members in their PPC role including engaging in listening sessions, focus groups, and/or surveys.

VIII. Other Requirements:

1. The Plan's Evidence of Coverage (EOC) includes a description of its system for member participation in establishing public policy.
2. The Plan will also furnish an annual EOC to its members with a description of its system for their participation in establishing public policy and will communicate material changes affecting public policy to members.
3. To ensure membership is representative of Fresno, Madera, and Kings Counties, CalViva Health will annually complete and submit to DHCS a Public Policy Member Demographic Report by April 1 of each year. The Annual Member Demographic Report must include descriptions of all the following:
   - The demographic composition of the PPC;
   - How the Plan defined the demographics and diversity of its Members and Potential Members within Service Area;
   - The data sources relied upon by plan to validate that its PPC membership aligns with Member demographics;
   - Barriers to and challenges in meeting or increasing alignment between PPC membership with the demographics of the Members within Service Area;
   - Ongoing, updated, and new efforts and strategies undertaken in committee membership recruitment to address the barriers and challenges to achieving alignment between Public Policy Committee membership with the demographics of the Members within Service;
   - Area; and
   - A description of the PPC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how committee input impacted and shaped Contractor initiatives and/or policies.
     - CalViva Health shall ensure that all subcontractors and network providers comply with all applicable state and federal laws and regulations, Contract requirements, Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) guidance, including All Plan Letters (APLs) and Policy Letters related to the Public Policy Committee (PPC).

IX. Authority:

1. Health & Safety Code Section 1369
2. California Code of Regulations, Title 28, Rule 1300.69
3. RHA Bylaws
4. ~~2024~~ DHCS Medi-Cal Contract

5. DHCS APL 25-009 Community Advisory Committee (CAC) Requirements

APPROVAL:

RHA Commission Chairperson		**Date**:
	David Hodge, MD	

Item #4

Attachment 4

Closed Session

Item #5
Attachment 5.A

- BL 26-008 RHA Commission Meeting Location

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Garry Bredefeld
Board of Supervisors

Joe Prado, 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

Vacant, 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: March 19, 2026

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: FKM RHA Commission Meeting Location

BL #: **26-008**
Agenda Item **5**
Attachment **5.A**

BACKGROUND:

1. The 1st and 2nd RHA Commission meeting(s) took place on June 25, 2009 and July 30, 2009 in **Fresno County** at the Woodward Park Regional Library located at 944 E. Perin Ave., Fresno, CA 93720.
2. The following dates were set in 2009 with the meeting location(s) To Be Determined: August 27, 2009, September 10, 2009, September 24, 2009, October 15, 2009 and October 29, 2009.
3. The 3rd RHA Commission meeting took place on August 13, 2009 in **Fresno County** at the Council of Fresno County Governments, 2035 Tulare Street, Fresno, CA 93721. During this meeting Commissioners agreed to cancel the August 27, 2009 meeting and to hold the October 15, 2009 meeting in **Kings County** at the Kings County Government Center, 1400 West Lacey Boulevard, Hanford, CA 93230**.**
4. BL 09-009 was presented to the RHA Commission on September 10, 2009 and the RHA Commission voted to hold the remaining meetings in 2009 (November 6, 2009 and December 4, 2009) in **Fresno County** at the Council of Fresno County Governments.
5. On November 6, 2009, the RHA Commission voted to approve meeting locations on the 3rd Thursday of every month from 1:30pm to 3:30pm with the following meeting location and frequencies: **Madera County (3)**, **Kings County (3), and Fresno County (6).**
6. On November 9, 2010, the RHA Commission was polled on Meeting Dates, Times, and Locations through 2011. **The Commission voted to continue rotating between all three counties and keep meeting on the third Thursday of each month.**
7. On October 20, 2011, the RHA Commission requested staff to present a 2012 calendar **reducing the number of meeting(s) from monthly and cancelling the December Commission meeting(s)** since it is difficult to secure a quorum. A proposed 2012 calendar was presented with reduced meetings from monthly and approved by the RHA Commission continuing to rotate through all three counties. This continued from 2012-2016.
8. Beginning in 2017, **the RHA Commission, RHA Finance Committee, RHA QI/UM Committee and Sub-Committees held all meetings in Fresno County.** RHA Public Policy Committee continued to rotate until 2024.

Discussion:

1. Historically, the RHA Commission has been made aware of challenges with Commission meetings in reaching quorum in Kings County, as well as securing a location in Madera County to accommodate the meeting schedules of the RHA Commission and applicable advisory committees.

2. Historically, the RHA Commission has been made aware of challenges on participation particularly for Medical Management and the RHA QI/UM Committee and Sub-Committees, for reaching a quorum when meetings are held in Madera and Kings Counties.

3. Historically, the most recent meeting location survey in 2015 reflected 11 Commissioners who were in favor of all meetings being held in Fresno County and only 6 Commissioners were in favor of continuing to rotate meetings in all 3 Counties. 9 out of the 17 RHA Commissioners who participated in the survey are still presently serving on the RHA Commission.

Recommended Action:

The following actions are available for the RHA Commissions review and consideration:

1. Continue meeting locations in Fresno County at the CalViva Health office.

OR

2. Direct the CEO to resurvey Commissioners on the issue of meeting location for 2027.

Item #6
Attachment 6.A-B

CYBHI MOU CBH-MCP ASO Payment Model

- BL 26-009 CYBHI Carelon Behavioral Health MOU
- California Children and Youth Behavioral Health Initiative Network Support, Claims Processing and Payment Remittance MOU

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: March 19, 2026

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Children Youth Behavioral Health Initiative Memorandum of Understanding ("MOU") between RHA and Carelon Behavioral Health

BL #: **26-009**
Agenda Item **6**
Attachment **6.A**

BACKGROUND:

The Children and Youth Behavioral Health Initiative (CYBHI) is part of the Master Plan for Kids' Mental Health, a historic investment by the State of California that takes a "whole child" approach to address the factors that contribute to the mental health and well-being of our children and youth.

Detailed background information on CYBHI was provided to the RHA Commission on July 17, 2025 under BL # 25-012 and the Commission voted to approve a CYBHI MOU on this same date. The CYBHI Memorandum of Understanding ("MOU") the Commission voted to approve stated the implementation would occur in two phases: 1) Interim Clean Claims Payment Model and 2) ASO Payment Model.

The MOU being presented today is for the second phase (i.e., the ASO Payment Model). This MOU will allow for the exchange of eligibility data and for the ability to receive the applicable encounter data. Similar to the previous MOU, this has been finalized by the California Department of Health Care Services ("DHCS") and they are accepting no changes.

RECOMMENDED ACTION:

1. Similar to the prior CYBHI MOU approved on July 17, 2025 by the RHA Commission; approval is needed once again by the RHA Commission to execute this new MOU for the California Children and Youth Behavioral Health Initiative Network Support, Claims Processing and Payment Remittance Memorandum of Understanding as presented to the RHA Commission on March 19, 2026.

CALIFORNIA CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

NETWORK SUPPORT, CLAIMS PROCESSING AND PAYMENT REMITTANCE

ASO PAYMENT MODEL MEMORANDUM OF UNDERSTANDING

This Children and Youth Behavioral Health Initiative (CYBHI) Network Support, Claims Processing and Payment Remittance Memorandum of Understanding ("***MOU***") is made and entered into by and between _____<*insert managed care plan ("MCP")or Insurer name>,* a _____ *<insert what type of license held>* pursuant to the laws of the State of California, as amended ("***Participating Entity***"), and Carelon Behavioral Health, Inc., a Virginia Corporation ("***CBH***") to be effective as of _____ (the Effective Date) and services shall commence on the Commencement Date in section 7.1 of this MOU. Participating Entity and CBH may be referred to herein individually as a "***party***" or collectively as the "***parties***".

RECITALS

WHEREAS, the California Department of Health Care Services ("DHCS") has engaged CBH to manage certain implementation components the statewide, multi-payer, school-linked fee schedule ("CYBHI Fee Schedule")and support DHCS and Participating Entities with the management of the school-linked statewide provider network of behavioral health practitioners, which is comprised of local education agencies (LEAs), county offices of education (COEs), public institutions of higher education (IHEs), and community-based individual, group and organizational providers designated in-network by LEAs, COEs, or IHEs (collectively, "Providers");

WHEREAS, Participating Entity is participating in the CYBHI Fee Schedule as a Medi-Cal MCP, commercial health care services plan or disability insurer and will fund CYBHI Fee Schedule program claims for eligible services furnished by Providers to enrolled members of the Participating Entity;

WHEREAS, DHCS contracted with CBH (DHCS Agreement #23-30348) to administer certain implementation components of the CYBHI Fee Schedule, including but not limited to: screening, Providers to participate in the Provider network; receiving, adjudicating and approving claims for payment from Providers; sending invoices, and claims report for eligible Member claims to Participating Entities; remitting payments to Providers; managing payment disputes or other complaints from Providers; and, as applicable, managing member grievances and appeals; and,

WHEREAS, DHCS requires Participating Entities and CBH to coordinate components of the program including claims processing and payment remittance to Providers under the terms specified in this MOU.

NOW, THEREFORE, to effectuate their roles and responsibilities in the CYBHI Fee Schedule program, the parties understand and agree as follows:

ARTICLE 1: DEFINITIONS

Except to the extent otherwise defined in one or more of the Exhibits or Appendices hereto, capitalized terms used in this MOU and/or in the introductory paragraphs above, all of which are hereby incorporated by reference, shall have the meaning ascribed below.

1.1 AAA is the American Arbitration Association.

1.2 ASO Payment Model means the model that includes eligibility and encounter file exchanges, as well as described in section 5.2 and as directed by DHCS.

1.3 MOU is this Memorandum of Understanding between Participating Entity and CBH, and any amendments, exhibits, schedules, appendices, addenda and attachments hereto.

1.4 Affiliate means a subsidiary or affiliate which currently is controlled by, controlling, or under common control with Participating Entity or CBH, respectively, or which in the future may be controlled by, controlling, or under common control with Participating Entity or CBH, respectively.

1.5 Covered Services (i.e., CYBHI Fee Schedule Services) are those outpatient mental health and substance use disorder (SUD) services specified in DHCS' published CYBHI Fee Schedule, when furnished to students twenty-five (25) years of age or younger at a school site, in accordance with state law. See Welfare and Institutions Code section 5961.4; Health and Safety Code section 1374.722; and Insurance Code section 10144.53.

1.6 Clean Claim is a claim or bill for Covered Services that has no defect, impropriety, lack of substantiating documentation, including the information necessary to meet the requirements for encounter data (clinical information and data with content and in a format that comports with the HIPAA 837 requirements), and using a completed CMS-1500 form or their respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), that is received timely from an eligible Provider, and which complies with standard industry coding guidelines, and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely. Claims or bills from a participating Provider who is under investigation for fraud or abuse are not Clean Claims.

1.7 Complete Claim is the term used in Health & Safety Code sec. 1371 and 28 CCR 1300.71 (Rule 1300.71) to mean a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and…(D) For physicians and other professional providers:(i) the Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format; (ii) Current Procedural Terminology (CPT) codes and modifiers and International

Classification of Diseases (ICD-9CM or its successors) codes; (iii) entries stated as mandatory by NUCC and required by federal statute and regulations; and (iv) any state-designated data requirements included in statutes or regulations; (F) For providers not otherwise specified in these regulations:(i) A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and (ii) any state-designated data requirements included in statutes or regulations.

1.8 Confidential Proprietary Information is any non-public proprietary information of the parties respectively, including without limitation, the terms of this MOU, business plans and processes, customer/Member lists and information, financial records, methodologies, intellectual property, trade secrets, and other proprietary information, Participating Entity records, Participating Entity website(s) and passwords to Participating Entity website(s), information about fees, computer software, business procedures and manuals, data review criteria, manager's website, passwords to CBH website(s), CBH Provider Network databases and directories, CBH Provider Network contract rates, and CBH Case Management & Utilization Review programs. For purposes of this Agreement, Confidential Proprietary Information does not include: (a) information publicly available by means other than wrongful disclosure or lawfully obtained from third parties without any confidentiality obligations; (b) information which is required by law or by a government agency to be disclosed by a party; provided that such party immediately notifies the other party of the requirements for such disclosure and reasonably cooperates in obtaining any protective order desired by the other party, at the other party's expense, with regard to such information; (c) information independently developed by the other party; (d) Member Protected Health Information; or (e) information provided to the other party with the intention that it be published, disseminated, released or distributed by such other party to Members, participating Providers, or to the general public.

1.9 CYBHI Fee Schedule program means the statewide, multi-payer, school-linked fee schedule program established by DHCS, pursuant to the Welfare and Institutions Code section 5961.4, Health and Safety Code section 1374.722, and Insurance Code section 10144.53.

1.10 Encounter data, sent in ANSI X12 837 format, are claims data that include element such as, but not limited to, date service was rendered, diagnosis codes, and clinician information (refer to All Plan Letter 14-019 for detailed guidelines and requirements related to encounter data submission).

1.11 HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.

1.12 Insurer means a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106(b).

1.13 Managed Care Plan or MCP means a health care service plan, as defined in Health and Safety Code section 1345(f). MCP includes both Medi-Cal and commercial lines of business. MCPs must be licensed by the Department of Managed Health Care, as applicable.

1.14 Member means an individual who is enrolled and receives health insurance coverage from a Participating Entity and who meets all of the eligibility requirements for membership in the Participating Entity based on the registration file received by CBH from a Provider.

1.15 Provider means a locational educational agency (LEA), county office of education (COE), institution of higher education (IHE) or participating provider or practitioner in the DHCS CYBHI school-linked behavioral health provider network. Only participating providers or practitioners, COEs, LEAs, IHEs and designated providers and practitioners appropriately identified as part of this DHCS network will be eligible for reimbursement under the CYBHI Fee Schedule.

1.16 Non-Covered Services means those services specified by Participating Entity or DHCS as not covered benefits under the CYBHI fee schedule. A non-covered service may include services that were provided to a student not covered by the Participating Entity, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

1.17 Participating Entity means the organization that is party to this MOU. Participating Entity can be an MCP or Insurer or an organization under a delegation agreement to process claims on behalf of the MCP or Insurer who is party to this MOU.

1.18 Protected Health Information ("PHI") for purposes of this MOU, shall have the meaning as defined in 45 C.F.R §160.103 and/or applicable state law, but shall also include "Patient Identifying Information" ("PII") as defined in 42 C.F.R. Part 2, Subpart B, §2.11.

1.19 "Schoolsite" has the meaning described in paragraph (6) of subdivision (b) of Section 1374.722 of the California Health and Safety Code.

1.20 Security Event means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.21 Security Standards means the party's minimum-security standards as made available to other party and as implemented to avoid unauthorized access to or use of information and data maintained by the party.

1.22 State Regulators means the California Department of Managed Health Care (DMHC), California Department of Health Care Services (DHCS), and California Department of Insurance (CDI).

Article 2: Relationship

2.1 Relationship of Parties. In the performance of their respective roles and responsibilities in the CYBHI Fee Schedule program and the provisions hereunder, the relationship between the parties and their respective employees and agents is that of independent parties entering the MOU with each other solely for the purpose of carrying out the terms of this MOU. Nothing in this MOU or otherwise should be construed or is deemed to create any other relationship, including one of employment, agency or joint venture. Except as specifically provided for herein, the parties agree that neither CBH nor Participating Entity will be liable for the activities of the other nor their respective agents or employees, including, without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this MOU.

2.1.1. The parties understand and agree that CBH is performing these services pursuant to its contract with DHCS (DHCS Agreement #23-30348). Both parties enter into this MOU to effectuate the CYBHI Fee Schedule program and Provider Network.

2.1.2. Each party respectively shall, at all times, arrange directly with its employed staff (if any) for all salaries and other remuneration; and shall be solely responsible (with respect to its employees) for the payment of all applicable federal, state or local withholding or similar taxes and provision of worker's compensation and disability insurance.

2.1.3. Each party respectively shall not by entering into and performing this MOU become liable for any existing obligations, liabilities or debts of the other party and each party respectively shall not by this MOU assume or become liable for any of the obligations, debts and liabilities of the other unless otherwise expressly provided herein.

2.1.4. Under no circumstance will CBH be held accountable by Participating Entity to fund claims not otherwise funded by Participating Entity.

2.2 Designated Representatives. Each party shall designate in writing a representative who shall represent it in the day-to-day administration of this MOU. The parties may change the afore-referenced designations upon prior written notice to the other party as provided in section 10.6.

2.3 Authority. CBH does not have discretionary authority in the administration of CYBHI Fee Schedule claims payment except to the extent that such claims payment is the responsibilities or obligations of CBH under its agreement with DHCS and this MOU.

2.4 CBH Facilitates Claims Administration and Payment Remittance. The parties acknowledge and agree that per DHCS guidance and requirements, Providers will submit claims to CBH. CBH will review the claims to ensure proper coding. Claims found to contain errors will be returned to the respective Provider for correction. CBH will prepare and send an invoice listing

Clean Claims for eligible members to the Participating Entity. Participating Entity will review Clean Claims and send claims payment to CBH. CBH will remit payment for Clean Claims to Providers in a timely manner.

2.5 Funding. As required under the Welfare and Institutions Code section 5691.4(c), Health and Safety Code section 1374.722, and Insurance Code section 10144.53, Participating Entities are mandated under state law to provide reimbursement to providers for school-linked behavioral health services (i.e., Covered Services). Participating Entity member benefits for Covered Services shall be funded by the Participating Entity. CBH is not responsible for providing funds to pay Participating Entity benefits.

2.6 Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this MOU shall be for the sole and exclusive benefit of CBH and Participating Entity. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party, including, without limitation, a member.

2.7 Conflict of Interest. Participating Entity and CBH respectively represent that to the best of their respective knowledge and belief at the time of signature to this MOU, neither CBH nor Participating Entity, respectively, nor their respective affiliates, subsidiaries or parent companies, has financial, legal, contractual or other business interests that would conflict with their respective participation and performance under this MOU.

2.8 No Indemnification. Neither party shall require the other party to indemnify it for any expenses or liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against a party based on the other party's management decisions, claims processing determinations, or other policies, guidelines or actions.

2.9 Providers Not Indemnified. Regardless of any provision to the contrary, the parties agree that Providers are not the agents of CBH or Participating Entity and in no event shall CBH or Participating Entity be obligated to indemnify or hold the other harmless against any acts or omissions of Providers. Nothing in this MOU requires CBH or Participating Entities to indemnify providers.

2.10 Cooperation. During the term of this MOU and subject to any legal or contractual restrictions, the parties agree to reasonably cooperate to address issues associated with claims for Covered Services provided in connection with the CYBHI Fee Schedule.

Article 3: Data Sharing & Ownership

3.1 Data Sharing & Ownership. All information and materials, including computer software, provided by a party to the other party in connection with performance of services, including modifications, changes and derivatives, there to are and shall remain the property of providing party or the providing party's licensors, who shall retain all intellectual property rights therein. The receiving party obtains no right, title, or interest therein, except that receiving party may use the information and materials made available by the providing party for the sole, exclusive and limited purpose of performing services under this MOU. Each party, respectively, shall comply with the terms of any license or other agreement applicable to the disclosing party. A receiving party shall not encumber a disclosing party's information and materials in any way and promptly shall return to the materials in the receiving party's possession or control upon the disclosing party's request and in any event upon termination or expiration of this MOU. For avoidance of doubt, claim related information transferred between parties is not information and materials governed by this section.

3.2 Virus Protection and Malware Protection. The system and any software/hardware used by either party, respectively, in the performance of services hereunder shall not, to the best of such party's knowledge, contain any program routine, device, or other undisclosed feature, including, without limitation, a time bomb, virus, software lock, drop-dead device, malicious logic, worm, Trojan horse, bug, error, defect or trap door, that is capable of deleting, disabling, deactivating, interfering with, or otherwise harming the other party's hardware, data, or computer programs or codes, or that is capable of providing unauthorized access or produce unauthorized modifications. Additionally, each party shall configure malicious code and spam protection mechanisms to (i) perform periodic scans of the information system according to organization guidelines; (ii) perform real-time scans of files from external sources at endpoints and network entry/exit points as the files are downloaded, opened, or executed in accordance with organizational security policy; and, (iii) block malicious code, quarantine malicious code, or send an alert to the administrator in response to malicious code detection.

3.3 Access. If either party grants access to their system or any software/hardware: (a) will provide the other with a copy of their respective terms of use and/or security guidelines applicable to any use or access to the party's system or any software/hardware, respectively; and (b) the accessing party agrees that any of its employees or independent contractors that access the other's systems shall access only information, reports and data applicable to performance under this MOU; (c) the accessing party shall follow procedures and guidelines established by the other regarding access to their systems and/or software/hardware; and (d) agrees that data provided under this agreement to CBH by Participating Entity will be segregated within CBH's system or any software/hardware and not used for any purpose other than fulfilling the terms of this MOU. In addition, each party agrees to implement necessary security controls and adhere to and comply with, in all material respects, the other's Security Standards. Each party shall comply with any amended Security Standards of the other party as soon as possible but in no event later than the time period required for compliance indicated in any law, rule, regulation, order, judgment or decree.

3.4 Security Events. In the event that a party learns or has reason to believe that its Security Standards in relation to this MOU have been breached or the other party's Confidential Proprietary Information has been disclosed or accessed by an unauthorized party, each party will immediately give notice of such event to the other party. Furthermore, in the event that either party has a Security Event in relation to this MOU, the following shall apply: Each party acknowledges and agrees: (a) that upon a Security Event, the law may require that party to notify the individuals whose information was compromised or disclosed that a Security Event has occurred; (b) each party will notify the other immediately if either party learns or has reason to believe a Security Event in relation to this MOU has occurred and resulted in unauthorized access; (c) where applicable, each party will provide the other with a copy of the individual notice of Security Event in relation to this MOU prior to mailing same to those individuals whose data was compromised or disclosed; and (d) upon a Security Event in relation to this MOU, the parties agree to comply with any state or federal laws regarding notice the appropriate state or federal authorities.

3.5 Notification of State Regulator. The party identifying the security breach shall make the notification to the relevant State Regulator, in accordance with contractual obligations and/or state and federal law.

3.6 Security and Supervision. Each party's personnel, when on the other's premises or accessing the other's networks or providing services hereunder, will comply with all of the other party's security, supervision and other standard procedures applicable to such personnel.

3.7 Data Collection/Sharing for Reports. The parties shall cooperate with each other in collecting and sharing data that Participating Entity or CBH requires in order to perform services hereunder or to report to regulators, accreditation entities, and other third parties.

ARTICLE 4: [reserved]

ARTICLE 5: RESPONSIBILITIES OF EACH PARTY

5.1 Screening Providers. In accordance with the DHCS-approved procedures, CBH shall screen CYBHI Providers ("CYBHI Screening Process") and rescreen CYBHI Providers. CBH will screen and enroll Providers required within sixty (60) calendar days of receipt of the Standard Provider Import ("SPI"). The CYBHI Screening Process for licensed and Pupil Personnel Services ("PPS") providers shall include verification of identity such as name, date of birth, NPI, licenses or PPS credentials issued by the state, as applicable, suspended, excluded and ineligible provider databases, and various sanctions checks. Participating Entity shall accept claims from Providers screened by CBH for the CYBHI program. The CYBHI Screening Process shall include

verification of Medi-Cal enrollment, as applicable. Where a CYBHI Provider is not yet Medi-Cal enrolled, such Provider shall have a one hundred and twenty (120) calendar day period to complete the Provider Application and Validation for Enrollment ("PAVE") Medi-Cal enrollment process ("Enrollment Grace Period"). During the Enrollment Grace Period, Participating Entities shall accept and pay claims from Providers. After the Enrollment Grace Period if the Provider is not Medi-Cal enrolled, then Provider shall be disenrolled and CBH shall recoup applicable claims payment from Provider for refund to Participation Entity as appropriate.

5.2 Claims Administration and Payment Remittance. In accordance with the DHCS CYBHI Fee Schedule Program Guide, CBH shall be responsible for processing all claims information submitted by Providers for CYBHI Services. The processing of such claims shall strictly adhere to the guidance issued by the Department of Health Care Services (DHCS). The adjudication of claims will be conducted based on the eligibility of members as determined by the participating entity and shall comply with the program rules and requirements as established by DHCS. CBH shall supply Participating Entity with a weekly invoice that sets forth amounts due to CBH from Participating Entity related to claims pending for payment, recoveries, and voided and/or re-issued checks for the prior weeks. Participating Entity shall transfer funds to CBH in an amount sufficient to cover the net cost of claims for Covered Services identified within the weekly invoice within three (5) business days of its receipt. If Participating Entity fails to timely fund the invoice, CBH shall not be liable for any service level agreements pertaining to timely claims payment for the impacted claims. CBH shall not be responsible for any interest payments due to providers resulting from Participation Entity's untimely or short funding of the invoice. MCP shall not be responsible for interest payments resulting from CBH delays.

5.2.1.1. Claims shall be funded by the Participating Entity for its enrolled members when claims are submitted by eligible providers as part of the CYBHI Fee Schedule program.

5.2.1.2. CBH is responsible for verifying eligibility of Providers, in accordance with DHCS-approved policies and procedures, prior to submitting Clean Claims invoice(s) to the responsible Participating Entity for payment. DHCS will oversee and monitor compliance with its contract with CBH, including associated policies and procedures for the CYBHI Fee Schedule program.

5.2.1.3. Participating Entity shall transmit to CBH at a frequency mutually agreed upon by CBH and Participating Entity during discovery phase of implementation a daily eligibility file that includes up to date collection of accurate and historical member eligibility information co-payments deductible status for individuals enrolled in a Health Savings Account (HSA) qualified high-deductible health plan, as applicable, and any limitations or exclusions on coverage of Covered Services, in accordance with DHCS policy. The integrity and accuracy of the eligibility file shall be the sole responsibility of the Participating Entity. CBH will rely exclusively on the data provided by the Participating Entity to determine payment eligibility and shall not be liable for any errors, omissions, or delays resulting from the Participating Entity's failure to accurately or promptly update membership information.

Notwithstanding the above, Participating Entity and CBH recognize that government agencies may be entitled to make retroactive eligibility changes and, in such cases, providers shall seek payment for retroactively disenrolled Members from the Member's new carrier, if permissible. Eligibility information shall be provided by Participating Entity in a format and manner that is agreeable to CBH and Participating Entity. The format and manner of eligibility data will be detailed in the business requirements documents during the discovery phase of the implementation. This document shall be mutually agreed upon and executed by both parties.

5.2.1.4. CBH will send Encounter Data to Participating Entity in a format and manner that is agreeable to CBH and Participating Entity. CBH will send Participating Entity a complete encounter data record for all Clean Claims paid during the Interim Clean Claims Payment Model period within sixty (60) business days once the setup for eligibility and Encounter Data is complete. The format and manner of Encounter Data will be documented in the business requirements documents during the discovery phase of the implementation.

5.2.1.5. If any Clean Claim(s) on the invoice is determined to be ineligible for payment (i.e., the member is not in an eligible plan, Participating Entity shall indicate its determination on the invoice and submit back to CBH.

5.3 CBH Reporting to Participating Entity: In addition to the Encounter Data file, CBH shall send a weekly claim report file in accordance with Exhibit B and shall include:

(a) CBH Claim Reference ID
(b) Federal Tax ID
(c) Billing NPI
(d) Billing Provider Name
(e) Billing Provider Address
(f) Servicing Provider NPI
(g) Servicing Provider Name
(h) Servicing Provider Address
(i) Rendering NPI
(j) Render Provider Name
(k) Date of Service From
(l) Date of Service To
(m) Service Code
(n) Diagnosis Code 1
(o) Diagnosis Code 2
(p) Diagnosis Code 3
(q) Diagnosis Code 4
(r) Billed/Charged Amount
(s) Coinsurance Amount
(t) Deductible Amount

(u) Copay Amount
(v) Paid Amount
(w) CARC Codes
(x) Place of Service

In the event that there are no claims for the week, no report will be sent.

5.5 Quality Monitoring. In accordance with DHCS guidance, CBH shall develop a Quality Monitoring plan with DHCS that provides oversight of the requirements outlined in this MOU.

5.6 Provider Dispute Resolution. CBH will review Provider claims disputes, including but not limited to claims disputes regarding claims that are a) paid at the incorrect rate; b) include an incorrect interest payment; and c) incorrectly denied for no coverage or not a Covered Service. In accordance with California law, CBH will timely acknowledge receipt of the dispute notice, document the determination and timely share the determination letter with the Provider. CBH will send provide dispute resolution reports to DHCS in accordance with CBH's contract with DHCS. DHCS will oversee and monitor CBH's compliance with DHCS Agreement No. 23-30348, [DHCS CYBHI Fee Schedule Program Guide], and any other California state law requirements, and associated policies and procedures for provider dispute resolution.

5.7 CBH Available Normal Business Hours. The CBH's call center for members and providers will be available from 8:00am – 5:00pm PT, Monday through Friday. The after-hours message will indicate that if this call is about a routine business matter, please call back during administrative business hours, which are 8:00 am - 5:00 pm PT, Monday through Friday.

5.7.1. CBH will assign a CBH Representative to each Participating Entity for the purposes of resolving routine business matters.

5.8 Member Grievances, Insurer Complaints and Appeals. CBH will handle member grievances, insurer complaints and appeals, as appropriate, in accordance with DHCS guidance.

5.9 Provider Complaint Process. CBH will address complaints from providers related to CBH's services or processes, including dissatisfaction with customer service or billing procedures.

5.10 Delay in Furnishing Information. Regardless of any provision to the contrary, Participating Entity and CBH will not be responsible for delay in the performance or nonperformance of services to the extent caused by or contributed to by the failure of either party or Providers to furnish any required information promptly.

5.11 Network Support. CBH shall assist DHCS with Provider network support, Provider inquiry support, Provider relations, and Provider education and communication for the CYBHI Fee Schedule program. CBH will work directly with DHCS to support Providers and Participating Entity with technical assistance.

5.12 ASO Implementation. Participating Entity and CBH shall timely coordinate activities to implement the ASO infrastructure based on DHCS-approved prioritization and sequencing of

Participating Entities. CBH and Participating Entity shall dedicate sufficient and appropriate staffing and resources to ensure all ASO implementation timelines are met.

ARTICLE 6: COMPENSATION

6.1 Payments. The parties acknowledge that DHCS shall compensate CBH for its CYBHI administrative services in accordance with the contract between CBH and DHCS. This compensation is unrelated to claims payments. Furthermore, CBH is not responsible for funding any claims. Any claims remittance activities are subject to and dependent upon appropriate and complete funding by the Participating Entity.

6.2 Taxes, Assessments & Surcharges. Each party shall be solely responsible for its respective state and/or federal tax obligations arising from or relating to this MOU. Notwithstanding the above and/or anything to the contrary in this MOU, where there is a tax, assessment, fee, or surcharge: (a) on medical, behavioral health and/or chemical dependency services, and/or claims costs, whether inpatient or outpatient; (b) surcharge imposed upon plans operating and/or claims for services rendered by providers in the state; and/or (c) for covered lives within a state, Participating Entity is and shall remain responsible for registration, calculation, payment and any associated reporting for these taxes, assessments, fees, and/or surcharges.

ARTICLE 7: TERM AND TERMINATION

7.1 Term. This MOU is in place as required by DHCS and shall run concurrently with the CYBHI Fee schedule program unless either CBH or the Participating Entity relationship to the CYBHI program terminates or a new MOU is fully executed between the parties for the ASO Payment Model. The term of this MOU shall commence concurrent with the effective date of the CYBHI Fee Schedule (the "***Commencement Date***") and continue through termination of the CYBHI Fee Schedule by DHCS, or termination of either party from its role in the CYBHI Fee Schedule by DHCS.

7.2 Termination with Cause. With written permission from DHCS, either party may terminate this MOU for cause at any time by giving the other party at least ninety (90) calendar days prior written notice of a material breach hereunder, provided that the party seeking termination for cause will allow the breaching party sixty (60) calendar days in which to cure such breach. Should the breaching party cure such breach to the reasonable satisfaction of the terminating party on or before the end of the above referenced sixty (60) calendar day period, then this MOU shall remain in full force and effect.

7.3 Termination Without Cause. DHCS oversees the CYBHI Fee Schedule program and party engagement. This MOU cannot be terminated without cause. Termination without cause is only permitted with DHCS approval

7.4 Automatic Termination. This MOU shall automatically terminate upon termination of the DHCS' agreement with CBH, upon the effective date of a successor contract between the parties such as an administrative services agreement for this same DHCS CYBHI Fee Schedule program, or upon the revocation, suspension or restriction of any license, certificate, or other authority required to be maintained by CBH or Participating Entity in order to perform the services required under this MOU or upon the CBH's or Participating Entity's failure to obtain such license, certificate or authority.

7.5 Termination Resulting from Insolvency. At the option of a party, on the date or within sixty (60) calendar days of the other party becomes insolvent, is adjudicated as a bankrupt entity, has its business come into the possession or control of a trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of creditors. If any of these events occurs: (a) no interest in the MOU may be deemed as an asset of creditors; (b) no interest in this MOU may be deemed an asset or liability of Participating Entity; and (c) no interest in this MOU may pass by the operation of law without the consent of the other party.

7.6 Notice to Members. Following notice of termination of this MOU, in accordance with terms hereof, DHCS will determine which party will notify Members and Providers, and other persons and entities that DHCS deems to have an interest herein of such termination. Each party agrees to provide the other party with an advance copy of such Member notice(s).

Article 8: Governing Law & Compliance

8.1 Governing Law. This MOU shall be governed by, and construed in accordance with, the laws of the State of California and federal law, including regulatory guidance issued by applicable State Regulators.

8.2 Operations of Parties. Participating Entity and CBH agree to comply with all applicable state and/or federal laws, rules, regulations, as may be amended, including without limitation: (a) those applicable requirements of the Americans with Disabilities Act; and (b) those designed to prevent or ameliorate fraud, waste and abuse, and (c) applicable policy guidance issued by State Regulators.

8.3 Member Hold Harmless. CBH and Participating Entity acknowledge and agree that in no event, including but not limited to, the insolvency of Participating Entity, breach of the MOU and/or non-payment for services by Participating Entity, shall CBH or Participating Entity bill, charge or seek compensation, remuneration or reimbursement from, or assert any legal action against members for payment of any fees or amounts that are the legal obligation of Participating Entity. Members shall be held harmless from and shall not be liable for any such amounts.

8.4 Participating Entity and CBH Compliance .

(a) Each party is responsible for compliance with all applicable state and federal laws, rules, and regulations governing its own licensure, certification, and accreditation, as well as its

respective rights, duties, and obligations, except where this MOU assigns specific responsibilities to the other party. Participating Entity is responsible for compliance with all applicable provisions of state and federal law, rules and/or regulations governing, affecting and/or regarding Participating Entity licensure, certification and/or accreditation, Participating Entity rights, duties and/or obligations, except to the extent the same are responsibilities or obligations of CBH under this MOU. This includes compliance with all legal reporting and disclosure requirements, adoption and approval of all required documents respecting the Participating Entities.

(b) In addition, Participating Entity and CBH, espectively, shall: (i) ensure that it is duly organized, validly existing and in good standing under the laws of the State of California; (ii) maintain all requisite federal, state and local authority, permits and licenses necessary or appropriate to operate and to carry out its obligations hereunder;; and (III) anything contained herein to the contrary notwithstanding, Participating Entity shall remain ultimately responsible for assuring that the Participating Entity is operated in accordance with all applicable federal, state and local laws, rules and regulations.

8.5 Non-Discrimination. The parties will perform their respective obligations under this MOU in manner so as not to discriminate against Members on the basis of color, race, creed, age, sex, (which includes discrimination on the basis of sex characteristics, including intersex traits, pregnancy or related conditions, gender, gender identity, sex stereotypes, and sexual orientation), disability, place of origin, source of payment, or type of illness or condition.

8.6 Excluded Individuals/Entities. Participating Entity and CBH respectively represent that neither is nor knowingly is employing nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.

8.7 Direction. Neither party shall knowingly direct the other to act or refrain from acting in any way that would violate any applicable law, rule or regulation. Neither party shall knowingly behave in any way that is intended to implicate or involve the other in a violation of these laws.

8.8 Payments. The parties agree that nothing contained in this MOU, nor any payment made by Participating Entity to CBH, or by CBH to any Provider, is a financial incentive or inducement to reduce, limit or withhold medically necessary services to Members.

Article 9: Dispute Resolution

9.1 Dispute Resolution. The parties agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this MOU promptly by negotiation between the parties. The exclusive remedy for unresolved disputes between the parties under this MOU, including without limitation a dispute involving interpretation of any provision of this MOU, questions regarding application and/or interpretation of applicable state and/or federal laws,

rules or regulations, the parties' respective obligations under this MOU, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration.

(a) The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators.

(b) The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.

(c) Any arbitration proceedings shall be held in a mutually agreed upon location in the State of California in accordance with and subject to the Commercial Arbitration Rules of the AAA then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure.

(d) To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator selected by the AAA from a list of arbitrators chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute.

(e) The arbitrator: (i) may construe or interpret but shall not vary or ignore the terms of this MOU; (ii) shall be bound by applicable state and/or federal controlling laws, rules and/or regulations; and (iii) shall not be empowered to certify any class or conduct any class-based arbitration or award any punitive or consequential damages.

(f) The decision of the arbitrator shall be final, conclusive and binding. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.

(g) Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne equally by the parties**.**

(h) Nothing contained in this provision shall be construed to give any Member any rights to arbitrate any dispute with Participating Entity or CBH regarding benefits payment or any other matter related to administration of the Participating Entity.

(i) This Section 9.1 shall survive any expiration or termination of this MOU.

ARTICLE 10: GENERAL PROVISIONS

10.1 Records. CBH agrees to maintain records related to CYBHI Services rendered by Providers for time periods as required by State Regulators or such longer period(s) of time as may be required by applicable law.

10.2 Access. Subject to any legal restrictions, CBH shall provide State Regulators, the California Department of Health and Human Services (CHHS), the Office of Inspector General (OIG), the General Accounting Office (GAO), the Comptroller General, and/or other applicable regulatory agencies, or their respective designees with timely access to any contracts, books, financial records, medical records, documents, papers and other records and information, including without limitation financial or otherwise, that are possessed in any medium, including electronic media (collectively, "Records"), and their respective facilities, as they apply to CBH's obligations under the MOU and/or as related to services rendered to Members. CBH agrees to cooperate in investigations conducted by the above noted authorized regulatory agencies, including through electronic means and any resulting legal actions. To the greatest extent feasible, all Records shall be furnished in a format that is digitally searchable.

10.3 Confidentiality of Clinical Records & HIPAA. The parties agree to comply with all applicable confidentiality and privacy laws, and to maintain processes designed to protect the confidentiality of Member medical information, personally identifiable information and PHI as required by applicable state and/or federal laws, rules and/or regulations, including, without limitation, HIPAA (including its privacy, security and administrative simplification rules and acts) (45 CFR Part 160 and Subparts A and E of Part 164) , the Confidentiality of Medical Information Act (California Civil Code Section 56 *et seq.),* the Insurance Information Privacy Practices Act (California Insurance Code Section 791, *et seq.*), and the California Consumer Privacy Rights Act (California Civil Code Section 1798.100, *et seq.*). The parties acknowledge and agree that CBH is a business associate of DHCS subject to a Business Associate Agreement ("BAA") (as that term is defined in HIPAA). With respect to the treatment of PHI by CBH, the terms of the BAA between DHCS and CBH shall control.

10.4 Confidential Proprietary Information. Each party shall hold Confidential Proprietary Information of the other in the strictest confidence and shall not disclose it to anyone other than those employees and agents performing services for or in support if this MOU and who have a need to know, and then only to the extent necessary, in order to carry out the terms of this MOU, or to accreditation authorities, to the extent necessary. Confidential Proprietary Information may not be used in any way not specifically allowed under this MOU, including in each party's own business, whether or not competitive with the other party. The party in possession of or otherwise with access to the other party's Confidential Proprietary Information shall employ such processes and take such care as to safeguard the confidentiality of such Confidential Proprietary Information. Each party will promptly notify the other of any loss or accidental or unauthorized disclosure of the other's Confidential Proprietary Information. Upon termination of this MOU, the recipient of Confidential Proprietary Information shall promptly deliver to the other party any and all such Confidential Proprietary Information of the other party in its possession or under its control, and any copies made

thereof, except as otherwise provided for by the express prior written permission of the party to whom the Confidential Proprietary Information belongs. The parties recognize that no remedy of law may be adequate to compensate a party for a breach of the provisions of this Section 10.4; therefore, the parties agree that a party may seek temporary or permanent injunctive relief against the party breaching this provision, in addition to all other remedies to which either is otherwise entitled, and this provision in no way limits such other remedies of the parties. Such temporary or permanent injunctive relief may be granted without bond, which each party waives.

10.5 Member Communications. For the avoidance of doubt, state policy governs member communication and each party must comply with existing state guidance pertaining to member communication and outreach. The parties acknowledge and agree that nothing contained in this MOU is intended to interfere with or hinder communications between Providers and Members regarding a Member's medical condition or mental health or substance use disorder or available treatment options. The parties agree that all patient care and related decisions are the responsibility of the treating Provider and that, regardless of any coverage or payment determination(s) made or to be made by Participating Entity or CBH, neither Participating Entity nor CBH dictates nor controls clinical decisions with respect to the medical and/or behavioral health care or treatment of Members. All communications with a member shall comply with confidentiality requirements set forth under state and federal law as applicable, including requirements related to sensitive services as set forth under California Insurance Code section 791.29 and California Civil Code section 56.107.

10.6 Notice. Any notice required by this MOU shall be given in writing to the liaison person designated by a party, sent by United States mail, return receipt requested, or by Federal Express, UPS, or other overnight mail service, with postage prepaid, signature required, and addressed to each party at the addresses set forth below their respective signatures to this MOU, or at any other address of which a party has given notice in accordance with this Section. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt if delivered by mail or the date upon which such notice is personally delivered in writing to the designated liaison person.

10.7 Assignment. Neither this MOU nor any right, interest or obligation hereunder may be assigned (by operation of law or otherwise) by any party without the prior written consent of the other party and any attempt to do so will be void; provided, however, that: (a) the parties may, upon notice to the other but without being obligated to obtain the other's consent, assign this MOU or any of its rights, interests or obligations hereunder to a wholly owned affiliate or subsidiary or parent company of the party; and (b) no such written consent will be required in connection with a change of control, merger or reorganization of a party, or a sale of all, or substantially all, of such party's assets. Subject to the preceding sentence, this MOU is binding upon, inures to the benefit of and is enforceable by the parties hereto and their respective successors and assigns.

10.8 Amendments. All amendments or modifications to this MOU shall be effective only upon mutual written agreement of the parties.

10.9 Waiver. Waiver, whether express or implied, of any breach of any provision of this MOU shall not be deemed to be a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision. In addition, waiver of one of the remedies available to either party in the event of a default or breach of this MOU by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy(ies) at any subsequent time if a condition of default continues or recurs.

10.10 Marketing. Except as otherwise specifically provided for herein, neither party will advertise or utilize any marketing materials, logos, trade names, service marks, or other materials created or owned by the other without their prior written consent. Neither party will acquire any right or title in or to the marketing materials, logos, trade names, service marks or other materials of the other.

10.11 Force Majeure. Neither party nor their subcontractor(s) or affiliate(s) hereto shall be held responsible for delay or failure to perform hereunder when such delay or failure is due to fire, flood, epidemic, strikes, acts of God or the public enemy, acts of terrorism, acts of war, unusually severe weather, legal acts of public authorities, or delays or defaults caused by public carriers, or other circumstances which cannot reasonably be forecast or provided against.

10.12 Disaster Recovery. Both parties have in place disaster recovery programs to preserve and protect data in the event a party's electronic information is damaged, destroyed or compromised by a malfunction/dysfunction of a mainframe or other high-end platform at the party's primary data center. The parties will make all commercially reasonable efforts to implement their disaster recovery program to restore the continuity of their business operations and reinstate the provision of services as soon as possible. A disaster as used in this section is an event as described in Section 10.11 above.

10.13 Severability. Any term or provision of this MOU that is invalid, illegal or unenforceable in any situation in any jurisdiction shall not affect the validity, legality or enforceability of the offending term or provision in any other situation or in any other jurisdiction. If such invalidity, illegality or unenforceability is caused by length of time or size of area, or both, the otherwise invalid provision shall be, without further action by the parties, automatically amended to such reduced period or area as would cure such invalidity, illegality or unenforceability; provided, however, that such amendment shall apply only with respect to the operation of such provision in the particular jurisdiction in which such determinations is made.

10.14 Ancillary Agreements. The parties agree to execute or cause to be executed such ancillary agreements as are appropriate and necessary to enable the services described in this MOU to be performed as mutually agreed upon by the parties.

10.15 Interpretation. The parties hereto agree that this MOU is the product of negotiation between sophisticated parties and individuals, all of whom were represented by, or had an opportunity to be represented by, legal counsel, and each of whom had an opportunity to participate in, the drafting of each provision hereof. Accordingly, ambiguities in this MOU, if any, shall not be construed strictly or in favor of or against any party hereto but rather shall be given a fair and reasonable construction.

10.16 Attachments & Exhibits. Incorporated into this MOU by reference are the following attachments and exhibits:

- Exhibit A – CYBHI Standard Invoice
- Exhibit B – Claim Invoice File Layout
- CYBHI Multi Fee Schedule Program Participating Entity's Companion Guide
- Exhibit B CYBHI Fee Schedule Program Participating Entity Interim Model Companion Guide
- CYBHI Cred Screening Processes Overview
    - Subject to annual review and may change, without need to revisit contract, to accommodate regulatory updates.
- CYBHI Program Manual

10.17 Counterparts; Facsimile Execution & Captions. This MOU may be executed and delivered: (a) in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument; and/or (b) by facsimile, in which case the instruments so executed and delivered shall be binding and effective for all purposes. The captions in this MOU are for reference purposes only and shall not affect the meaning of terms and provisions herein.

10.18 Entire MOU. This MOU, including all exhibits, attachments, schedules, addenda and amendments hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this MOU. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this MOU, which are not expressly set forth in this MOU, are null and void and of no further force or effect.

The authorized representatives of the parties hereto have executed this MOU to be effective as of the Commencement Date identified above.

[INSERT PARTICIPATING ENTITY NAME]

By: _____

Print Name: _____

Title: _____

Date: _____

By: _____

Address for Notice:

_____
_____
_____
_____
Attn: _____

Copy to:

_____

_____
_____
_____

Carelon Behavioral Health, Inc.

By: _____

Print Name: _____

Title: _____

Date: _____

By:_____

Address for Notice:

Legal Department
Carelon Behavioral Health, Inc.
200 State Street, 3rd floor
Boston, Massachusetts 02109

Item #7

No Attachment

Community Support & DHCS Reinvestment Program Ad-Hoc Committee Selection

Item #8
Attachment 8.A-B

2026 Quality Improvement
& Health Education

- 2026 Program Description & Change Summary
- 2026 Work Plan

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Shekinah Wright, Director, Quality Improvement

COMMITTEE DATE: March 19, 2026

SUBJECT: Quality Improvement Program Description Change Summary 2026

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated the year from 2025 to 2026.
Throughout	Multiple	Added behavioral health member experience survey to include the Experience of Care and Health Outcomes (ECHO)/Outpatient Mental Health (OPMH) surveys.
2-3	Table of Contents	Page numbering and section titles updated.
4	Introduction and Background: Health Plan Services and Membership	Added that Health Net is a subsidiary of Centene Corporation.
5	Information Systems and Analysis	Removed section since it is redundant to the Additional Resources - Information Systems section.
7	Quality Improvement Goals	Added bullet item: Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.
10	Scope: Services Covered by CalViva	Removed Health Homes Program (HHP), added Community Supports to meet social needs of all members.
13	Health Management Programs	Added description on Complex Health Needs/Care Management.
15	Care Management (CM) Program	Removed section and added Complex Health Needs/Care Management to Health Management Programs section.
16	Operations and Service	Provider Performance & Analytics team name updated to Data Strategy & Insights. Removed Sales from collaboration efforts.
16-17	Health Plan Performance	Health Equity Accreditation survey name was updated to Health Outcomes Accreditation (HOA), and Health Equity Accreditation Plus was updated to Community-Focused Care Accreditation (CFCA). Added MCAS and DMHC Health Equity and Quality measure performance to CalViva's monitoring activities. Specified that member outreach activities are conducted to close care gaps to improve outcomes and performance metrics.
19	Delegation	Removed language, "The delegates may review for medical necessity and appropriateness of care following the triage exam when there is no emergency condition or following stabilization of an emergency condition."
20	Health Equity and Cultural and Linguistic Needs	Replaced Diversity, Equity, and Inclusion training with Cultural Competency Training.

23-24	Access and Availability	Shortened first paragraph. Added “Standards are communicated through the online Provider Operations Manual and Provider Updates.” Added information on monitoring and reporting activities in the last two paragraphs.
24	Satisfaction	Revised and rephrased Satisfaction description. Added ECHO/OPMH surveys and description on Program Manager responsibilities.
25	Health Education Programs	Removed the Health Education phone number. Rephrased the Kick It California description.
26-27	Telehealth Services	Added ConferMed of CA as vendor. Removed and replaced the goals for the Telehealth Program.
35-39	Staff Resources and Accountability	Added Case/Care Management department description; Updated Health Plan Operations team to Clinical Vendor Management team; Updated Provider Performance & Analytics team name to Data Strategy & Insights: Updated HEDIS Management and Clinical Reporting team to HEDIS Measurement and Reporting team; Under Additional Resources, removed Sales, Updated Management Information Systems (MIS) summary description, revised Enterprise Data Warehouse (EDW) and Statistical Analysis Software (SAS) descriptions, and added new software descriptions including Operational Data Warehouse (ODW), Snowflake Platform, Inovalon, and Power BI.
41-42	QI Program Activities: Projects, Surveys and Audits, Incentive Programs	Added ECHO and OPMH; Revised Member and Provider Incentive Programs.
48	QI Process	Added DMHC Health Equity and Quality measure performance as areas for focused performance improvement.

CalViva Health
Quality Improvement and Health Education Program Description

2026

Deleted: *5*

March 11, 2026

Deleted: *March 12, 2025*

Table of Contents

Deleted: 5
Deleted: t
Deleted: and
Deleted:
Deleted:

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

I. Introduction and Background

A. *Health Plan Services and Membership*

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. Under California's Medi-Cal managed care program, the RHA dba CalViva Health ("CalViva") is designated as the Local Initiative. CalViva is contracting with Health Net Community Solutions (HNCS or Health Net, a subsidiary of Centene Corporation), a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for the majority of CalViva's membership.

CalViva recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Fresno-Kings-Madera Region. CalViva, in conjunction with HNCS, has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Fresno-Kings-Madera Region and meet those challenges. CalViva's collaborative health plan partner, HNCS, has over 20 years' experience in Fresno County since 1997 when the Two-Plan model was implemented. As such, CalViva is well prepared to serve Medi-Cal beneficiaries in Fresno, Kings and Madera Counties with quality care through evidence-based practices that emphasize preventive care and encourage self-management for healthy behaviors.

The RHA may also contract with other entities or health plans to provide or arrange services for CalViva members enrolled with CalViva in the Service Area.

The CalViva Quality Improvement and Health Education Program (QIHEd Program) provides members with access to network-wide safe clinical practices and services and ensures they are given the information they need to make better decisions about their healthcare choices. The QIHEd Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QIHEd Program employs an organizational structure that reports to the Quality Improvement/ Utilization Management (QI/UM) Committee and RHA Commission and is led by committed decision-makers. The QIHEd Program functions in collaboration with multiple departments that have QI-related functions. CalViva also collaborates externally with network physicians, other provider types and community partners for an effective QI integration process. This includes collaborative activities with participating provider groups (PPGs) and provider clinics to complete performance improvement projects (PIPs) and Plan, Do, Study, Act (PDSA) projects to close care gaps and improve provider performance and quality of care for members. Quarterly reports of these activities and outcomes are presented to the QI Work Group and subsequently at the QIUM Committee.

CalViva works with stakeholders in each county to develop unique programs tailored to the county's needs and continues to interact with the families, health care providers and county administrators to ensure the programs achieve their goal of providing access to needed health care services.

Deleted: ¶
<#>Membership ... [1]

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

II. Purpose and Goals

A. Mission

The CalViva mission is:

"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."

The mission of the CalViva QIHEd Program is:

To help CalViva members stay healthy, secure and comfortable by providing access to quality care and services and information to make better decisions about their healthcare choices. The vision of CalViva QIHEd Program is to:

- Provide access to quality health care that helps CalViva members achieve improved health outcomes.
- Provide understandable, reliable and affordable products and services that exceed expectations.
- Monitor and promote the delivery of accessible, appropriate, compassionate and comprehensive health care and service.
- Offer wellness services that minimize adverse outcomes or improve health care status.
- Foster member-focused partnerships with physician groups and other health care practitioners and providers.

B. Purpose

Quality Improvement Purpose

The CalViva QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

Health Education Purpose

The CalViva Health Education Department (HEd) provides accessible, no-cost health education programs, services, and resources based on the community health, cultural and linguistic needs of CalViva members and contractually required program scope. The CalViva HEd also monitors the quality and accessibility of health promotion and education resources made available by CalViva primary care physicians (PCPs) to CalViva members.

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

C. *Goals*

Quality Improvement Goals

- Support CalViva's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or standards established state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to CalViva members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving/maintaining performance of target measures, and takes action, as needed, to improve performance.
- Support a partnership among members, practitioners, providers, and regulators to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with CalViva's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and chronic condition management programs.
- Monitor and improve CalViva's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of administrative data; emphasizing administrative, primary care, high-volume specialists/specialty services, and behavioral health/chemical dependency services.
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolutions of perceived failure by practitioners/providers or CalViva personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.
- Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.

Health Education Goals

- To provide culturally and linguistically appropriate health education programs and resources at no cost to:
  - Support members and the community to achieve optimal physical and mental health.
  - Promote health equity.
  - Improve CalViva's quality performance.

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

- Enhance member satisfaction and retention.
- To engage communities, stakeholders, and partners.

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

III. Scope

A. *Overview of the QIHEd Program*

The QIHEd Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The Population Health Management (PHM) strategy provides a unifying framework to support the QIHEd Program in delivering a whole-person approach to caring for CalViva members.

Health education interventions are based on community health and cultural and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health and dental care services, and to follow self-care regimens and treatment therapies. Health education services include individual, group or community-level education and are supported by trained health educators and public health professionals to encourage immediate positive knowledge gain and healthy behavioral intentions. Health Education Programs include individual, community or population-based initiatives designed to encourage long-term behavioral changes for positive health outcomes. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

The QIHEd Program impacts the following:

- **CalViva Members** in all demographic groups and in service areas for which CalViva is licensed.
- **Network Providers** including 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 Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Health Education** by providing accessible no cost health education programs, services and resources based on the community health, cultural and linguistic needs of members and contractually required program scope and by monitoring the quality and accessibility of health promotion and education resources made available to members by Health Net's subcontracting/delegated vendors, Participating Provider Groups (PPG), and Primary Care Physicians (PCPs).
- **Communication** to meet the cultural and linguistic needs of CalViva 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

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.

- **Services Covered by CalViva** 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, Long Term Services and Supports (LTSS): long term care (LTC), Community Based Adult Services (CBAS); and CalAIM benefits and Community Supports that meet the special, cultural and linguistic, complex, social 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.

Health Net and CalViva collaboratively and continually strive to incorporate a culture of quality across their organizations and conduct operations to improve service and satisfaction for CalViva members. This philosophy also extends across the provider network to improve provider quality outcomes, as evidenced by the plan's Healthcare Effectiveness Data and Information Set (HEDIS®); provider access, availability, and satisfaction surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) rates. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

The QIHEd Program is prepared annually by the CalViva Health Senior Director of Medical Management and Chief Medical Officer for presentation to the CalViva QI/UM Committee during the first quarter of each year. The CalViva committee structure ensures that contracted network providers with various specialties participate in the oversight, monitoring, evaluation, and improvement of the QIHEd Program. Six practicing providers participate in the QI/UM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Family Medicine, behavioral health, Internal Medicine, Obstetrics and Gynecology, and general surgery. CalViva's Chief Medical Officer chairs the committees and invites the contracted network practitioners to participate. Health Net Medical Directors are involved in designing the program, establishing monitoring metrics, analyzing data, and assessing program outcomes in order to make recommendations for improvement including behavioral health components of the program. The QI/UM Committee approves or modifies the QIHEd Program annually, based on goals and initiatives for the year, taking into consideration new legislation, regulation and needs of the membership and provider community.

Once approved, the CalViva Chief Medical Officer presents the finalized QIHEd Program to the RHA Commission for its approval at its next scheduled RHA Commission meeting. After the RHA Commission has approved the QIHEd Program, the CalViva Chief Medical Officer, as a licensed physician and the QI/UM Committee Chair collaborates with the QI/UM Committee to monitor the full scope of clinical services rendered on a scheduled basis, including a full review at mid-year. During the first quarter of the next year, annual reviews of the QIHEd and UM Work Plan progress and completion are conducted by the CalViva Chief Medical Officer and QI/UM Committee following the completion of a calendar year.

Each CalViva delegate has established and implemented policies and procedures regarding approval, modification, delay or denial of services as well as the timeliness of those decisions consistent with CalViva policies/standards. As part of the pre-delegation audit and annual audit, CalViva verifies that each delegate has policies and procedures regarding authorization,

Deleted: Health Homes Program (HHP), long term care (LTC), …

Deleted: ,

Deleted: Committee,

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

modification, denial or delay of services, as well as policies regarding the timelines of those decisions.

B. *Provider Network*

In the Fresno-Kings-Madera Region, CalViva partners with HNCS and other entities to maintain contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, laboratory services, outpatient pharmacies, and hospices. HNCS and other entities also arrange health care through direct contracts with certain health care providers. In Fresno, Kings and Madera counties, all of the provider contracts are a mix of fee-for-service (FFS), capitated delegated, and capitated non-delegated models.

C. *Preventive Screening Guidelines (PSGs)*

CalViva adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease for children and adults. The guidelines are reviewed, adopted and updated on an annual basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review. CalViva along with HNCS medical directors with various medical specialties are involved in the adoption of the guidelines. New members receive the Preventive Health Screening guidelines in the new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see CalViva members. It is also available to all members and existing practitioners and providers online and by calling the Health Education Department. Updates, when applicable, are distributed to all practitioners via Provider Updates.

Deleted: the member and provider portals

Preventive services that are relevant to CalViva's membership are monitored through participation in National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) and other programs as specified in the QIHEd Work Plan. In collaboration with HNCS, physicians and providers, CalViva encourages members to utilize health promotion and preventive care services.

Deleted: A

D. *Clinical Practice Guidelines*

CalViva adopts and disseminates evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health care services, acute and chronic medical services and behavioral health services. These clinical practice guidelines assist practitioners, providers and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and to reduce unnecessary variations in care.

CalViva adopts guidelines from recognized organizations that develop or disseminate evidence-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, (through the Health Net Medical Advisory Council), and CalViva's CMO and the QI/UM

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

Committee. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

Guidelines are evaluated for consistency with CalViva's benefits, utilization management criteria, and member education materials. They are communicated to providers through provider updates and are available to providers on the Health Net website and to members upon request. CalViva monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

E. *New Technologies*

CalViva has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as American Hospital Formulary Service-Drug Information (AHFS DI®), Facts & Comparisons®, Clinical Pharmacology®, DRUGDEX®, Lexi-Drugs®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to these primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by CalViva members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

F. *Health Management Programs*

Population Health Management (PHM)
Annually, through the PHM Program, CalViva 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's PHM Program examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims and encounters, social needs data, 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 all-payer claims databases or regional health information. The data are used for:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant SDoH.

Deleted: 5
Deleted: t
Deleted: and
Deleted:
Deleted:

- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64 and ages 65 and over.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of member with severe and persistent mental illness.

Data combined with SDoH and QI data (e.g., HEDIS care gaps), are reported to facilitate an understanding of similarities and differences in health needs and status. When the data analyses are complete, they are used to determine if changes are required for PHM programs or resources. In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in members' health status or level of care and in this way, members are monitored to ensure appropriate re-stratification and connection to chronic disease management, care management, enhanced care management (ECM), complex care management (CCM), community supports (CS) and other programs. Outcomes data is stratified by race, ethnicity, language, and age on a plan-level including emergency room (ER)/inpatient (IP) utilization, ambulatory and preventative visits within a twelve-month period, enrollment into CCM, and transitions for high-risk members having connection with their assigned care manager.

The PHM operations team is a cross-unit operations team composed of talent from multiple departments and is led by a core team of a Medical Director and a Pharmacist.

Basic Population Health Management
CalViva's Basic Population Health Management (BPHM) services support the ongoing, seasonal, episodic, and occasional needs of our members to ensure appropriate care. Using a multi-pronged, non-delegated, empanelment approach to BPHM, we directly facilitate connections to primary care. New member welcome packets are sent to ask members to schedule their initial health appointment (IHA), and conduct new member outreach to facilitate appointment scheduling, and survey members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who don't select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible members are not required to select a Medi-Cal PCP).

The Plan proactively outreaches to members without a PCP visit in the past year to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach members, including those with unstable housing or no phone, are assigned to the Plan's MemberConnections Field Team for telephonic and in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant).

Chronic Condition Management
CalViva's chronic condition management programs increase awareness of self-care strategies and empower participants to better manage their disease. The program targets high-risk members identified with chronic conditions including, but not limited to

Deleted: 12

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

asthma, diabetes and heart failure and encourages them to participate in the program. This program includes a population-based identification process, interventions based on clinical need, patient self-management and disease education. Multi-disciplinary teams participate in the development of these efforts. Additional referrals to chronic condition management programs are multichannel and come through provider, Care Management and member self-referrals.

Complex Health Needs/Care Management
CalViva is committed to serving members with complex medical or behavioral health needs through coordinating services and assisting them in accessing needed resources.

CalViva provides care management for Medi-Cal including seniors and persons with disabilities. The goal of Care Management is to support members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition, and access to available resources.

Members in Complex Care Management have typically experienced a critical event or have a complex diagnosis that may be compounded by SDoH requiring oversight and coordination of care with practitioners, providers and/or community and social service agencies. Members are identified using Health Net data sources and may also be referred into the program via multiple avenues, such as:

- Health information
- Internal program
- Discharge planning referral
- Utilization management referral
- Member or caregiver self-referral
- Practitioner referral, and
- Ancillary providers (e.g., home health, physical therapy, occupational therapy).

Members undergo a comprehensive assessment, which is used to develop a care plan that meets their specific complex care needs. Care plans focus on the member's prioritized needs including monitoring the patient's understanding and adherence to the plan of care, identification and removal of barriers to care, achievement of short- and long-term goals, and restoration of the highest functional level that is possible for the patient.

Nurse Advice Line
The nurse advice line provides timely triage for health-related problems through CA-licensed Registered Nurses (RNs) using physician-approved guidelines and protocols. The service is offered 24 hours a day, seven days a week, 365 days a year, in English and Spanish with translation services available for other languages.

Using nationally recognized algorithms and world-class clinical triage guidelines, the nurse advice line Registered Nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation whether it be providing self-care guidance or recommending a visit to Urgent Care or the ER.

Deleted: ¶

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

Adult Weight Management
Members aged 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered Dietitians (RDs) and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, and tips for eating out. Members are offered unlimited inbound calls to program coaches and appropriate educational resources.

Raising Well - Pediatric Weight Management
Raising Well is a new telephonic weight management program for children and adolescents. Members ages 2–17 with a body mass index (BMI) at or above the 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight management. Coaches include Registered Dietitians (RDs), exercise physiologists and nutritionists.

Developed from nationally recognized, evidence-based practices, program components include:

- Behavioral counseling and coping skills
- Dietary counseling and physical activity education
- Parent training and modeling
- Physician visit promotion and tracking
- Printed educational materials
- Private social media/Facebook peer support group
- Readiness to change assessment
- Unlimited inbound calls to program coaches

Audio Library
Members can choose from over 1,000 health-related topics in the Audio Health Library for a concise overview of any subject of interest. Topics are available in English and Spanish.

G. *Transitional Care Services*

The purpose of Transitional Care Services (TCS) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care transition interventions are focused on coaching the member and the member's support system during an inpatient stay and the post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external resources and processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The Care Manager works to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a member-centric approach, the model incorporates three evidence-based care elements of inter-disciplinary

Deleted: ages

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

communication and collaboration, Member/participant engagement, and enhance post-acute care follow-up.

TCS includes:

- Conducting an initial outreach call within 72 hours of inpatient referral to complete an inpatient discharge risk assessment.
- A minimum of two follow-up calls are made to the member within 15 days of discharge.
- Initiating Community Supports referrals as appropriate.
- Focus on the member's goals and treatment preferences during the discharge process.
- Review of the member's disease symptoms or "red flags" that indicate a worsening condition and strategies for how to respond.
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care.
- Supporting the member's self-management role.
- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge and providing scheduling assistance if not listed on the post-discharge instructions.
- Ensuring member transition is successful, and needs are met.
- Actively engages the member in medication reconciliation including how to respond to medication discrepancies.

During the post-discharge period, staff evaluate the member to provide effective support to the member in managing their continued needs. Members are referred to Care Management, Complex Care Management programs, or ECM as appropriate for ongoing/longer term support.

H. *Behavioral Health Services*

CalViva delivers covered mental health services to its members through Health Net. Health Net contracts directly with psychiatrists as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g., credentialing, claims, utilization management, etc.).

CalViva and HNCS are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans
- Diagnosis, treatment, and referrals of members with mental health and substance use disorders to network specialists, county mental health plans, County Drug and Alcohol Programs and other resources as appropriate
- Appropriate uses of psychopharmacologic medications and treatment adherence
- Managing coexisting conditions and behavioral health preventive programs.

These areas are measured through the following sources to identify new initiatives or opportunities to enhance existing interventions.

- Member survey to assess satisfaction with and access to covered mental health services

Deleted: ***<#>Care Management (CM) Program***¶
CalViva partners with HNCS to provide Care Management (CM) services. The program targets members identified as being at high risk for hospitalizations or poor outcomes and who have barriers to their care. The program utilizes an evidence-based approach, which is member focused and goal directed in developing, implementing and monitoring an individualized care plan. Trained nurse care managers, in collaboration with a multi-disciplinary team, provide coordination, education and support to the member (family and caregiver) in achieving optimal health, enhancing quality of life and accessing appropriate services. ¶
¶
The goals of the CM program are:
¶
Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.¶
Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.¶
Accomplish the goals in the individual member's care plan.¶
Provide members and their families with the information and education that promotes self-care management.¶
Assist in optimizing the use of available benefits.¶
Improve member and provider satisfaction.¶
Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the members.¶
Provide members with tools to empower members to achieve optimal health, independence and functioning in the most proactive and effective way.¶
Ensure members with complex conditions receive support and assistance with coordination of care and access to any needed services.¶
¶
This program seeks to identify and intervene with members:
¶
Who are at risk of re-admission to hospitals¶
With declining health status¶
Whose profiles resemble other members with prior poor outcomes¶
Who are most likely to engage with care managers (demographics)¶
With extensive coordination of care needs, such as members receiving transgender services¶
¶
Members for the Care Management Program are identified proactively using utilization, claims, pharmacy, and encounter data sources. These data are stratified using a predictive modeling and care management analytic tool with a built-in proprietary risk stratification algorithm to differentiate members who have higher risk and more complex health needs from those with lower risk. In addition, data gathered through assessments and/or screenings is filtered electronically at least monthly to identify members for the program. Members may also be directly referred by sources including:¶ ... [2]

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners, along with their experience with coordination of care
- Network availability and adequacy of behavioral health providers
- Member quality of care and service complaints investigation
- Evaluation of behavioral health HEDIS measures and other QI behavioral health initiatives.

I. *Operations and Service*

The scope of CalViva's delegated entity's (Health Net Community Solutions) operational oversight is broad and is a collaborative effort among several departments that support the QIHEd Program, including but not limited to: Population Health and Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Data Strategy & Insights, Claims, Compliance, Privacy, Program Accreditation, and Marketing.

CalViva's delegated entity monitors and evaluates the effectiveness of functional areas and processes that enable the availability, timeliness, and quality of health care services. Additionally, it assesses member and provider satisfaction with several aspects of the care delivery system. In many areas, effectiveness is measured against standards established by regulatory agencies and accrediting bodies.

The program data and outcomes of these activities are routinely reported and reviewed at various internal work groups, committee and management oversight meetings that identify issues and implement opportunities for quality improvement.

J. *Health Plan Performance*

CalViva conducts ongoing monitoring of health plan performance by participating in annual HEDIS measurement, member experience and practitioner satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services.

CalViva Health ("CalViva") annually assesses the overall effectiveness of its Quality Improvement and Health Education (QIHEd) Program at improving network-wide clinical and service practices. Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for both Health Plan (HPA) Health Outcomes (HOA) and Community-Focused Care Accreditation (CFCA). As part of the CalAIM strategy, CalViva became "NCQA accredited" for HPA in 2024 and HOA in 2025.

CalViva's QI Program also has established metrics for key operational processes, such as Claims and Customer Service, and monitoring for service improvement opportunities.

CalViva maintains a broad range of key performance metrics to monitor clinical and service quality in Appeals & Grievances, Customer Service, and Population Health & Clinical Operations (PHCO) which includes Utilization Management, Care Management, Concurrent Review, and the Medical Review Unit. CalViva's QI Program also monitors key performance metrics for Pharmacy.

Deleted: Provider Performance & Analytics

Deleted: Sales

Deleted:

Deleted:

Deleted:

Deleted: Equity

Deleted: (HEA)

Deleted: Health Equity Plus

Deleted: plans to obtain HEA

Deleted: accreditation by January 1, 2026

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

CalViva monitors HEDIS rates, Medi-Cal Managed Care Accountability Set (MCAS), DMHC Health Equity and Quality measure performance, access and availability standards, quality of care incidents, and CAHPS/BH member experience survey results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns. CalViva emphasizes the importance of technology/Electronic Health Records (EHRs) enabling providers to track and remind patients about regular health screenings. Multiple activities may be in place to improve outcomes, promote safety, increase screening and improve performance metrics. Examples are included in the following list (refer to the QI and HEd Annual Work Plan section for more details):

- Practitioner and provider outreach to improve exchange of quality performance data.
- Member outreach to close care gaps.
- Provider outreach to share quality performance ratings.
- Development of tools to assist practitioners and providers to improve performance.
- Hospital quality monitoring for hospital acquired conditions.

K. *Credentialing / Recredentialing*

CalViva has established policies and standards to ensure the selection of qualified and credentialed practitioners and providers.

Compliance issues are reported to CalViva's Chief Medical Officer. CalViva's Credentialling Committee addresses such compliance issues.

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialed every three years. All providers are monitored monthly for Medicaid plan sanctions, license disciplinary actions, quality of care and service incidents, and any other adverse actions. Trendable actions and any high severity-leveled cases are reported to the Peer Review Committee where further actions are taken.

L. *Continuity and Coordination of Care*

A major focus of CalViva's QIHEd Program is ensuring that the care members receive is seamless and integrated. These activities can be divided into three main areas:

- Across medical care settings that include (but are not limited to) inpatient, residential, ambulatory and other locations where care may be rendered.
- Continuity and coordination between medical care locations and public health agencies, medical care providers, behavioral health care providers and county mental health plans
- Transition of care when benefits end or practitioners leave the network, between practitioners or changes in setting.

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Care management
- Pharmacy programs
- Utilization management
- Member Services functions

Deleted: and p

Deleted: severity

Deleted:

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations, and
- Information will be posted on the Plan website for advising providers, contractors, members, and the public on how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CalViva.

For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. The Nurse Advice Line also addresses member triage needs 24 hours a day, seven days a week. Provider groups also support members through their coordination of care programs.

CalViva, in conjunction with HNCS, identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals & Grievance data analysis
- Provider satisfaction surveys
- HEDIS measures, and
- Medical record review.

M. *Delegation*

CalViva Health has an Administrative Services Agreement ("ASA") with HNCS to provide certain administrative services on CalViva's behalf (e.g., utilization management, appeals and grievances, claims, credentialing, etc.). CalViva also has a Capitated Provider Services Agreement ("CPSA") with HNCS for the provision of health care services to CalViva members through HNCS' network of contracted providers (e.g., primary care providers, specialists, behavioral health providers, ancillary providers, etc.).

CalViva has delegated QI functions to HNCS and other entities, including QI program structure and operations (including behavioral health aspects), health services contracting for practitioners and providers, continuity and coordination of medical care and continuity and coordination between medical care and behavioral healthcare.

CalViva oversees activities performed by Health Net and its subdelegates through a variety of mechanisms including review of monthly, quarterly, semi-annual and annual data or summary activity reports, and through monthly management oversight meetings between CalViva and Health Net management staff, ongoing joint workgroups or other focused joint ad-hoc work groups when needed, oversight assessments / audits, re-assessment / re-audits and periodic focus audits as needed. Formal audits include desktop reviews of documents reports, case files, and on-site operations reviews when necessary. Through these mechanisms, HNCS must demonstrate the capability, proficiency and experience to manage the delegated responsibilities. Results and performance of delegated QI activities (Credentialing/ Recredentialing, and Peer Review) are reported at least semi-annually to the CalViva QI/UM Committee. CalViva will institute corrective action and/or may revoke delegation when it

Deleted:
Deleted:
Deleted: 5
Deleted: t
Deleted: and
Deleted:
Deleted:

determines that HNCS or its subdelegates are unable or unwilling to carry out the delegated responsibilities.

The CalViva QIHEd Program incorporates input from appropriate professionals into the designs of its corrective action plans or QIHEd Programs. Should corrective action plans (CAP) be required and implemented, CalViva utilizes physicians' and registered nurses' input and other Plan compliance staff, as applicable to the delegated function, to define the CAP, approve the CAP, and monitor progress and resolution of the CAP. Such CAP is reviewed by CalViva's Chief Medical Officer and/or Chief Compliance Officer as applicable with summary reports of actions taken and progress toward resolution reported to the QI/UM Committee or other appropriate Plan Committees.

CalViva requires that each delegate have a written description of the UM program that includes structure, scope, criteria, processes, and policies and have a designated Medical Director who is responsible for UM program oversight and holds an unrestricted license to practice medicine in California. As part of the annual delegation audit and pre-delegation audit by CalViva, CalViva verifies the status of the Medical Directors and Registered Nurses for the delegate and verifies that the delegate's UM program has oversight by medical directors licensed in California.

CalViva assesses the capability of each delegated entity by performing a capability assessment prior to delegation specifically with regard to technical expertise and review of budgetary resources. As part of the delegation audit, HNCS and other delegated entities must demonstrate they have adequate clinical staffing to provide timely determinations.

Each CalViva delegate will ensure that emergency health care services are available and accessible, that providers are reimbursed for care necessary to stabilize an emergency condition, and that denials of payment for emergency care meet requirements. As part of the pre-delegation audit and subsequent annual audits, CalViva ensures that each subcontracted delegate, including HNCS, has policies and procedures that ensure access to emergency services, and that emergency services are not subject to prior authorization or denial. Additionally, claims payment policies are reviewed to ensure that delegates are providing payment for emergency services. Delegates may review records and any other clinical information to determine emergency versus non-emergency condition as a condition of determining payment. These standards are audited during claims audits. The QI/UM Committee monitors appeal and grievance data to ensure issues involving inappropriate denial of emergency claims or inappropriate billing of members are addressed in a timely and complete manner to prevent future similar occurrences.

N. *Safety*

CalViva is committed to ongoing collaboration with network practitioners, providers and external agencies to build a safer health system. This is accomplished through quality initiatives that promote best practices, track outcomes, educate members, educate practitioners and providers, and ensure coordination of care. Measures to ensure that the goals of the member safety and quality data collection program are met include but are not limited to:

- Informing and educating health care professionals on safety issues.
- Identifying and evaluating strategies for reducing errors and improving member safety.
- Promoting the dissemination of effective strategies and best practices throughout the health care industry.

Deleted:

Deleted: meets

Deleted: . The delegates may review for medical necessity and appropriateness of care following the triage exam when there is no emergency condition or following stabilization of an emergency condition

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- Making performance data publicly available for members and practitioners.
- Current member safety activities include but are not limited to: Conducting PCP facility site/medical record reviews and physical accessibility reviews of PCP and other high-volume provider sites.
- Conducting a rigorous credentialing and recredentialing process to ensure only qualified practitioners and organizational providers provide care in the network.
- Monitoring quality of care indicators on a quarterly basis to identify patterns and/or trends.
- Working with contracted pharmacies to ensure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet CalViva's severity threshold.
- Monitoring narcotic prescribing carefully and ensuring a narcotic contract is in place for any member on narcotic medication in excess of Department of Health Care Services (DHCS) determined or nationally recommended quantity limit.
- Analysis of member quality of care complaints, potential quality of care, and provider preventable conditions cases to identify patterns and trends.
- Care coordination for high-risk patients.
- Member education.
- Assuring that affected members and providers are notified of FDA and voluntary drug safety alerts and recalls.
- Nurse advice and triage line that is available 24 hours a day, 7 days a week, every day of the year.

Mechanisms for communication may include:

- CalViva website
- Provider Updates
- Drug safety, refill history and dosage alerts
- Letters to individual practitioners, providers, or members
- Member and Provider Newsletters
- Regular provider and member communications
- Automated reminder calls to members such as interactive voice response (IVR), and
- Prior Authorization process for Medical Benefit Pharmacy Drugs and Medical Services.

O. *Health Equity and Cultural and Linguistic Needs*

CalViva is contracted with HNCS to provide cultural and linguistic services and programs for CalViva's membership. CalViva may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva. CalViva, 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 and HNCS.

The Health Equity Department, on behalf of CalViva, provides resources, materials, trainings, and in-services on a wide range of health equity and cultural and linguistic (C&L) topics that impact health and health care. The Cultural Competency Training Program adheres and implements Department of Health Care Services (DHCS), and Health and Human Services guidelines for Section 1557 of the Affordable Care Act for C&L services and requirement for non-discrimination based on national origin, race, color, ancestry, ethnic group identification,

Deleted: assure

Deleted: Diversity, Equity, and Inclusion

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information. Services offered include cultural and language information for providers and their staff, as well as for Plan staff; training on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and culturally responsive education. Health Equity also analyses the needs of its membership by reviewing various sources of data which may include membership demographic data, call center data, appeals and grievance information, and geo-access analysis of provider network language capabilities.

HNCS is aware of the diverse culture of California and is fully compliant with the contract requirements related to the DHCS regulatory agency Medi-Cal Managed Care Division (MMCD) Policy Letters and DMHC regulations for language assistance services and federal rules that require the provision of language assistance services. Additionally, it will ensure meeting contractual and regulatory cultural and linguistic requirements identified by Centers for Medicare and Medicaid Services (CMS) and other regulatory and oversight entities.

At least annually, the Health Equity Department, on behalf of CalViva, informs CalViva members, practitioners, and providers of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preference for all product lines. CalViva quality committees approve the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QIHEd Programs, follow-up actions or corrective action plans as needed.

A Geo Access assessment is conducted using member zip code data and correlated with member language preference every two years. The language capabilities of the practitioner and provider network are compared to the language needs of CalViva members. The availability of linguistic services by contracted providers for limited English proficient members is analyzed and recommendations are made to further enhance the promotion of available language services in support of members, practitioner and provider network. Contracted practitioners and providers are informed of the cultural and linguistic services available via Provider Updates and the provider operations manuals. Culturally informative materials, trainings and in-services are provided to network practitioners and internal department associates periodically. Cultural competency training addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Health Equity and C&L services are part of a continuing quality improvement endeavor. The Health Equity program description, work plan, language assistance utilization and mid-year and end of year reports are all submitted to the CalViva QI/UM Committee for review and approval.

To ensure compliance with applicable Medi-Cal contractual requirements, state and federal rules and regulations and other DHCS, DMHC, and NCQA requirements, the Health Equity Services Department:

Deleted: processes to

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

- Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services.
- Utilizes and implements the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities.
- Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities.
- Collects, analyzes and reports membership language, race and ethnicity data in reports such as the Population Needs Assessment (PNA).
- Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually.
- Obtains feedback and guidance from the Public Policy Committee (PPC) in the delivery of culturally and linguistically appropriate health care services, member health education needs, and input on the Population Needs Assessment (PNA).
- Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources.
- Engages community-based organizations, coalitions, and collaboratives in counties where CalViva members reside and be a resource for them on C&L issues.
- Participates actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE) and America's Health Insurance Plans (AHIP).
- Provides health equity and C&L services that support member satisfaction, retention, and growth.
- Conducts English material reviews through the EMR database. EMRs are conducted on all member informing materials to ensure that the information received by members is culturally and linguistically appropriate. Readability levels are assessed on the original document and revised accordingly to ensure they comply with the required readability levels mandated by regulatory agencies.

Additionally, Health Equity staff perform the following activities to ensure staff and providers have C&L resources available to provide culturally competent services to CalViva members:

- Provide C&L information and support for HNCS and CalViva staff in their efforts to provide excellent customer relations and services.
- Collaborate with other departments, where appropriate, to further the mutual attainment of culturally and linguistically appropriate healthcare services received by members, e.g., work with the Appeals and Grievance department on culture and language related grievances.
- Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services.
- Promote effective communication by staff and contracted providers with LEP members by providing them with easy access to culturally and linguistically appropriate materials, high quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers.
- Deliberately address health equity through collaborating to identify, develop and implement interventions at the member, community and provider levels to improve health disparities.

Deleted: 5

Deleted: t

Deleted: and

Deleted:

Deleted:

- Sustain efforts to address health literacy in support of CalViva members.
- Assess bilingual capabilities of bilingual staff and provide ongoing education and support.
- Increase cultural awareness of plan staff through trainings, newsletter articles, annual "Heritage/CLAS Month" activities, and other venues.

P. *Access and Availability*

CalViva maintains a network designed to ensure members have timely and appropriate access to practitioners, providers and healthcare services. Access standards cover primary, specialty, and behavioral health appointments; after-hours care emergency services; telephone access and provider availability, including PCPs, specialists, hospitals, pharmacies, laboratories, radiology facilities, skilled nursing, home health and ambulatory clinics.

CalViva does not pressure providers or facilities to render care beyond the scope of their training or experience. Standards are communicated through the online Provider Operations Manual and Provider Updates.

CalViva measures, evaluates, and reports compliance with access and availability standards using the following methods:

- Provider Appointment Availability Survey (PAAS): Annual provider appointment survey to assess members' access to care and service, including specific elements of urgent and non-urgent care for medical and behavioral.
- Provider After-Hours Access Survey (PAHAS): Annual provider telephone survey assessing after-hours ER information and physician after-hours access.
- Telephone Access Survey: Annual provider telephone survey to assess how long it takes a provider's office to answer the phone and return calls to members.
- Member Satisfaction Surveys: HEDIS, CAHPS, and behavioral health member experience survey.
- Provider Satisfaction Survey (PSS): Annual provider survey to assess provider perspectives and concerns regarding compliance with the Timely Access standards.
- Member Grievances: Tracks and trends of access-related complaints.
- Geo Access Analysis: Evaluates geographic distribution of PCPs, SCPs, hospitals, emergency services, ambulatory clinics, laboratories, and radiology providers.
- Hospital Bed Capacity: Ratio of members per hospital bed in the contracted hospital network.
- Ratio of Members to Practitioner/Provider: Assessment of the ratio of members to PCPs, SCPs, and high-volume SCPs.
- Network Open Access Report: Tracks PCP availability for new members.

CalViva utilizes a dashboard to address several access reporting metrics at the delegated group level. Results are analyzed to identify improvement opportunities and corrective actions. Findings and recommendations are shared with the QI/UM Committee, Access Workgroup, or appropriate CalViva or HNCS staff for review and approval, and communicated to practitioners and providers as appropriate through the CalViva QI/UM Committee.

Ensuring timely access is essential for quality care. CalViva meets regulatory requirements through ongoing monitoring and annual assessments of appointment access, member services, provider satisfaction, grievances, and triage services. Metrics include compliance rates

Deleted: *5*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

mandated by DMHC and DHCS as well as additional internal measures to support continuous improvement.

As waiting times for routine healthcare have lengthened over time, potentially impacting health outcomes and leading to emergency department overuse, CalViva has implemented the Advanced Access Program (also known as Same-day-Scheduling) to assist providers in maintaining compliance with timely access standards. Advanced Access is a way of scheduling appointments that allows members to seek and receive care from a qualified health care provider the same or next business day. Advanced Access has the potential to reduce patient wait times, improve continuity of care, and reduce missed appointments.

Q. *Satisfaction*

In 2026, the health plan will conduct the regulatory CAHPS survey. CalViva continuously monitors member experience year-round by monitoring member satisfaction data, including resolved member appeals and grievances. Results from the CAHPS surveys conducted by DHCS (via HSAG) are also reviewed to assess progress and are included in the Population Analysis Report. Additionally, CalViva conducts a behavioral health member experience survey, with results analyzed to identify trends and improvement opportunities.

Quarterly Root Cause Analysis Reports on member satisfaction data are conducted throughout the year to help identify improvement opportunities. The annual CAHPS and the Experience of Care and Health Outcomes (ECHO)/Outpatient Mental Health (OPMH) Survey results, along with the quarterly root cause analysis findings, are shared with the A&G Workgroup for review. This group analyzes the data to assess how well interventions are working and to spot new opportunities for improvement. These findings and results are then reported to the QI/UM Committee and RHA Commission at least once a year. Member experience, especially CAHPS awareness and education, is a key focus since many stakeholder teams interact directly with members and can influence experience scores.

Improvement efforts focus on educating CAHPS stakeholders and measure owners, offering focused provider webinars, partnering with operational teams to implement initiatives, and leading quarterly CAHPS Steering Committees. CAHPS Program Managers meet with several business areas including Quality Improvement (with the behavioral health team), Population Health & Clinical Operations, Member Services, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Engagement (both provider and PPG facing teams), Delegation Oversight, and Marketing. Annually, Program Managers review data, documents, and reports to provide stakeholders with Integrated Member Satisfaction reports and CAHPS survey disparity reports, which are required for NCQA accreditation. These efforts aim to support and enhance member experience.

Member materials are reviewed to ensure they clearly explain key information for prospective members, including benefit details, how to access primary and specialty care, and how to file complaints or appeals. In addition, members receive various communications throughout the year that share general health information and highlight specific programs or initiatives.

Deleted: For…20265… the health plan will be conducting…the rR…gulatory CAHPS survey. HSAG will stop conducting the DHCS CAHPS survey after this year and the health plan will be required to administer its own annual Regulatory CAHPS survey moving forward. ... [4]

Deleted:

Deleted: throughout the …ear-round by monitoring member pain points…atisfaction data, including (…esolved member appeals and grievances)… Results from the CAHPS surveys conducted by DHCS (via HSAG) are also reviewed to track …ssess progress member experience improvement …nd are included in the Population Analysis Report. Additionally, CalViva also …onducts a member experience survey for ... [5]

Deleted: B…havioral hH ... [6]

Deleted: . R…sults analyzed are reviewed …o identify any trends and improvementor ... [7]

Deleted:

Deleted: pain point …atisfaction data are conducted throughout the year to help identify improvement opportunities. The annual CAHPS survey results from CAHPS …nd the Experience of Care and Health Outcomes (ECHO)/the ... [8]

Deleted: behavioral health…utpatient Mental Health (OPMH) member…Ss ... [9]

Deleted: as well as…long with the quarterly root cause analysis reports …indings, are shared with and analyzed by the A … … Workg G…oup for review. This group analyzes analyzes the data to assess how well to evaluate the success of …nterventions are working and identify …o spot new opportunities for improvement. These findings and results are then reported to the QI/UM Committee and RHA Commission at least annually…nce a year. Member experience, especially CAHPS and member experience awareness and education, is a key are a major…focus since there are multiple…any stakeholder teams interact directly with members and can influence that are member-facing and have the potential to impact member ... [10]

Deleted: ¶

Deleted: activities are…fforts focused…on educating CAHPS stakeholders and measure owners, offering focused provider webinars, partnering with operational areas …eams to implement initiatives, and leading quarterly CAHPS Steering Committees. The …AHPS Program Managers meet with several business areas including Quality Improvement (including …ith the behavioral health team), Population Health & Clinical Operations, Customer Contact Center…ember Services, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Engagement (both pP…ovider and PPG fF…cing tT ... [11]

Deleted: Sales,

Deleted: assessed …eviewed to ensure that …hey clearly explain key information for prospective members, and enrollment information …ncludinges…details on the benefit plan…etails, how to accessobtaining…primary and specialty care, and how to voice …ilea…complaints and submit an…r appeals. In addition, members receive various communications throughout the year that highlight …hare general medical …ealth information and highlight specific programs or initiatives.other focused activities. ... [12]

Deleted: *5…CalViva Health Quality Improvement andt…and …ealth Education …Program Description* ... [3]

R. *Health Education Programs*

CalViva provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the members' clinical, cultural and linguistic needs.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more information by contacting the toll-free Member Services Line. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7. The Plan sends health education materials to members in their preferred threshold language or alternative format. Content will also be promoted using QR codes to improve accessibility to information.

- Weight Management Resources: Members have access to weight management resources through our Krames Library.
- CalViva Pregnancy Program - The pregnancy program incorporates the concepts of care management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy through 60 days postpartum. In addition, the program supports the following:
    - Information about pregnancy and newborn care.
    - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
    - Breastfeeding support and resources.
    - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
    - Resources for members who feel down during or after their pregnancy.
    - Methods to help pregnant members quit smoking, alcohol, or drug use.

  The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for the baby. High-risk pregnancies receive additional care management services.
- Kick It California - Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a text messaging program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Members can learn more by calling Kick It California at 1-800-300-8086 Monday-Friday, 7am-9pm, and Saturday, 9am-5pm (excluding holidays) or by visiting www.kickitca.org.
- Diabetes Prevention Program – The Diabetes Prevention Program (DPP) is a 12-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include any member 18 years of age and older at risk for developing type 2 diabetes.

Deleted: '

Deleted: at (888) 893-1569

Deleted: website

Deleted: member informing

Deleted:

Deleted: textingmessaging

Deleted: Telephonic coaching is available

Deleted: by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.…

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- The Teladoc Mental Health (Digital Program) offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic condition, pain management and many other conditions. This program is available for members ages 13 and older.
- Health Promotion Incentive Programs - The Quality Improvement/Health Education Department develops, implements and evaluates incentive programs to encourage members to receive health education and to access HEDIS related preventive health care services. CalViva Health follows MMCD Policy Letter 16-005 to develop, implement and evaluate appropriate incentive programs to promote positive health behaviors among members.
- Community and Telephonic Health Education Classes - No-cost health education classes and webinars are available for members and the community. Classes are available in various languages. Topics vary and are determined by the community's needs and topic availability.
- Community Health Fairs - The Health Education partners with Community Engagement to participate in health fairs and community events to promote health awareness to members and the community.

The following resources are also available to members:

- Health Education Resources - Members or the parents of children and adolescent members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.calvivahealth.org.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages: English, Spanish, and Hmong. They are mailed to new members and are also available on www.CalvivaHealth.org.
- Member Newsletter - The CalViva Whole You newsletter is mailed to head-of-household members once a year to notify members of: NCQA, health equity, and other regulatory articles; promotion of health education resources and wellness programs; and quality improvement interventions.

S. *Telehealth Services*

CalViva supports members' access to their care through telehealth programs by connecting them to licensed clinicians through leading and global providers of virtual care such as Teladoc Health. Members can schedule general medical and behavioral health virtual visits with various pediatric and adult primary care providers. ConferMed of CA connects providers with California-licensed specialty care experts through secure, digital dialogues.

Members receiving services from Teladoc can access mobile apps to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and

Deleted: Ed

Deleted: youth

Deleted: s

Deleted: These are available in English, Spanish and Hmong.

Deleted: -

Deleted: ***<#>Access and Availability***¶
¶
¶

Deleted: **<#>**To ensure CalViva has a network that is sufficient and adequate to provide its members appropriate access to, and availability of, practitioners, providers, and health care services and to ensure CalViva's members have appropriate access to health care services within a reasonable period of time, CalViva has established access to care standards for medical services. The access to care standards include primary, specialty, and behavioral health care appointment access; after-hours access and instruction; emergency care and telephone access; and standards for availability of practitioners, providers and health care facilities, including primary care physicians, specialty care physicians, high volume specialty care physicians, hospitals, ERs, pharmacies, laboratory/radiology facilities, skilled nursing facilities, home health agencies and ambulatory clinics. ¶
¶
CalViva does not pressure providers or facilities to render care beyond the scope of their training or experience.¶
¶
Access standards are communicated to network practitioners and providers via the online Provider Operations Manual, and Provider Updates. ¶
¶
CalViva measures, evaluates, and reports compliance with access and availability standards using the following methods: ¶
¶
Member Satisfaction Surveys: HEDIS, CAHPS (DHCS administered), behavioral health member experience survey, and Enrollee Experience Survey.¶
Provider After-Hours Access Survey (PAHAS): Annual provider telephone survey assessing after-hours ER information and physician after-hours access.¶
Provider Appointment Availability Survey (PAAS): Annual provider appointment survey to assess members' access to care and service. Specific elements include preventive care, routine care, and urgent care for medical and behavioral care.¶
Provider Satisfaction Survey (PSS): Annual provider survey to assess provider perspective and concerns regarding compliance with the access standards and to evaluate satisfaction with the time-elapsed standards.¶
Telephone Access Survey: Annual provider telephone survey to assess how long it takes a provider's office to answer the phone and return calls to members.¶
Member Grievances: Grievance data related to access is tracked and trended to identify issues with access. ¶
Geo Access Analysis: Geographic distribution of PCPs, SCPs, high volume SCPs, hospitals, emergency services, ambulatory clinics and ancillary (laboratory, radiology) ... [13]

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across high demand and threshold languages including Spanish and American Sign Language.

ConferMed of CA provides an asynchronous, electronic consultation that offers PCPs rapid access to California-licensed specialty care experts through secure, digital dialogues. PCPs use eConsults at their discretion for non-urgent, non-procedural specialty care referrals. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist. In 70%-75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists. Most eConsults are reviewed by the specialist and responded to within 72-hours, which improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

The goals of the telehealth program are to:

- Enhance member and provider experiences.
- Address critical provider shortages.
- Optimize care coordination.
- Reduce overall health care costs.
- Provide equal health care access to Limited English Proficiency members.
- Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.
- Reduce the incidence of unnecessary emergency room utilization.

T. *MemberConnections® Program*

MemberConnections is an educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and Population Health Team efforts by making telephonic and home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan and providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the Health Risk Screening, Post Partum Assessment / Edinburgh Postnatal Depression Scale, Notification of Pregnancy and SDoH needs.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect and reconnect members to clinical pharmacy, care management and chronic condition management to better manage their chronic and/or complex health conditions.
- Identify and address SDoH needs by linking members to county, CalAim Programs and community-based organizations.

Deleted: The goals of the telehealth program are to:
¶
Enhance member and provider experiences.¶
Address critical provider shortages.¶
Optimize care coordination.¶
Reduce overall health care costs.¶
Provide equal health care access to Limited English Proficiency members.¶
Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.¶
Reduce the incidence of unnecessary emergency room utilization.
¶
Electronic Consultation Services – Provider to Specialist¶

Deleted: Electronic Consultation is an asynchronous concurrent exchange between a primary care physician (PCP) and a specialist. consultation that offer PCPs rapid access to California-licensed specialty care experts through secure, digital dialogues. PCPs use eConsults at their discretion for non-urgent, non-procedural specialty care referrals.¶

Deleted: A PCP can consult with a specialist through a secure electronic message to initiate care for a non-urgent, non-procedural patient needs.

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. Having “eyes on the member” to do visual assessments while in the member’s home.
- Follow-up and monitor the status of high-risk member referrals.
- Help with utilizing telehealth services.
- Completing emergency outreach during natural disasters.
- Engage members based on Population Health Prioritization Reporting and HEDIS Care Gap Reports to connect members to PCP and to refer into clinical pharmacy and care management.

U. *Member Rights and Responsibilities*

CalViva has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are reviewed and approved annually by the appropriate CalViva staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include the right to:

- Be treated with respect, dignity, and courtesy.
- Privacy and confidentiality.
- Receive information about their health plan, its services, its doctors and other providers.
- Choose a primary care physician and get an appointment within a reasonable time.
- Participate in making decisions and have a candid discussion with practitioners regarding appropriate or medically necessary treatment options.
- Decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
- Voice complaints or other feedback about the Plan or the care provided without fear of losing their benefits.
- Appeal if they don’t agree with a decision.
- Request a State Fair Hearing.
- Receive emergency or urgent services whenever and wherever they need it.
- Services and information in their language.
- Receive information about your rights and responsibilities.
- Make recommendations regarding the organization’s members’ rights and responsibilities policies.

Member responsibilities include:

- Acting courteously and respectfully toward doctors and staff and being on time for visits.
- Providing up-to-date, accurate and complete information.
- Following the doctor’s advice and participating in the treatment plan.
- Using the Emergency Room only in an emergency.
- Reporting health care fraud or wrongdoing.

Deleted: P

Deleted: C

Deleted: P

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

CalViva has established policies that address member grievances and appeals. Grievances and appeals are resolved in a timely manner. Trends are monitored on a regular basis to assess opportunities to improve health plan processes.

V. *Medical Records*

CalViva requires its practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

CalViva's documentation standards address format, documentation, coordination of care and preventive care and includes, but is not limited to, the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers.

Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record keeping practices.

CalViva monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits. This occurs during the HEDIS process, Department of Managed Health Care (DMHC) and CMS surveys, during routine DHCS audits, and as part of the Managed Care Quality and Monitoring Division of DHCS PCP Full Scope Facility Site and Medical Record Review process.

Annually, the data are aggregated and analyzed to evaluate effectiveness of interventions and identify opportunities for improvement. Actions are taken when compliance issues are identified, and interventions are implemented based on compliance rates established for each standard. Interventions may include sending Medical Record review CAPs, Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, creating template medical record forms, and face to face instructions with a QI Compliance Nurse. Follow up may be conducted to evaluate the effectiveness of corrective actions implemented.

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

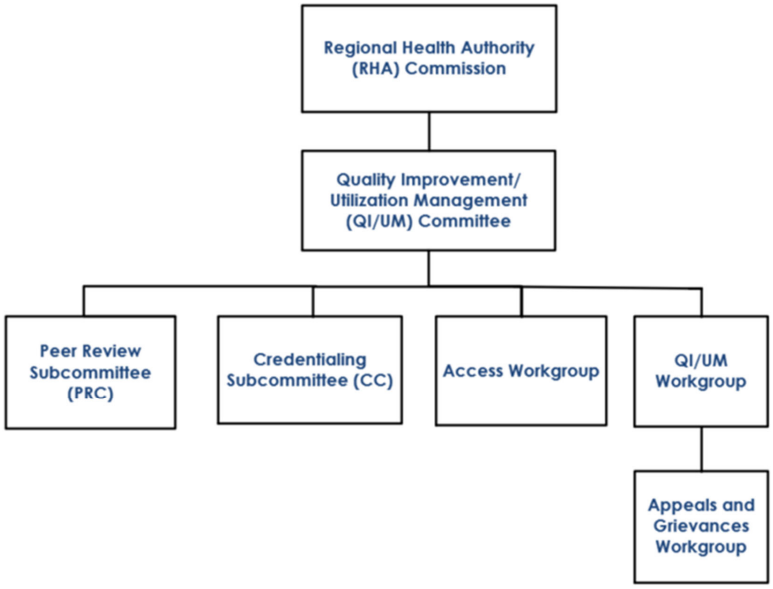
IV. Program Structure and Resources

A. QI Committees

Governing Body/RHA Commission
The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of the CalViva QIHEd Program. The RHA Commission has delegated the authority and responsibility for development and implementation of the QIHEd Program to the CalViva QI/UM Committee.

RHA Commission functions:

- Establish strategic direction for the QI/Utilization Management/Credentialing/ Peer Review Program.
- Annually review and approve the QIHEd Program Description, QIHEd Work Plan and QIHEd Work Plan Evaluation.
- Review quarterly reports regarding the QIHEd Program, delineating actions taken and improvements made.
- Ensure the QIHEd Program and Work Plan are implemented effectively to provide improvements in care and service.
- Provide feedback to the CalViva QI/UM Committee, as appropriate following each review.
- Assess and recommend resources, as needed, to implement QI activities.



Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

CalViva Quality Committees: CalViva Quality Improvement/Utilization Management (QI/UM) Committee and its Peer Review and Credentialing Subcommittees
The CalViva QI/UM Committee is chaired by CalViva's Chief Medical Officer and meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its delegated and non-delegated, and collaborative quality improvement activities.

Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends and oversees policy decisions and changes, evaluates the results of delegated and non-delegated, and collaborative QI activities, institutes needed actions, and ensures follow up as appropriate.

The Committee also ensures external providers, who are representative of specialties in the network (i.e.; behavioral health, SPD and members with chronic conditions), participate in the planning, design, implementation and review of the CalViva QIHEd Program, and are included as members of the Committee. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis.

Representatives from CalViva and HNCS who report to the QI/UM Committee include the Quality Improvement Department (including behavioral health), Health Equity and CAHPS teams, Pharmacy Department, Provider Network Management, Delegation Oversight, Customer Service Center, Credentialing, Peer Review, Appeals and Grievances, and PHCO. Refer to the CalViva QI/UM Charter for more information on committee members, roles and functions.

QI/UM Operational Workgroup
The QI/UM Operational Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and QI/UM related services on a continuous and systematic basis. The QI/UM Workgroup supports the QI/UM Committee in the identification and pursuit of opportunities to improve health outcomes, safety, access, services and member and provider satisfaction. The Workgroup consists of CalViva and Health Net Community Solutions core staff including CalViva's Chief Medical Officer, Senior Director of Medical Management, Chief Compliance Officer, and Medical Management Manager. Health Net Community Solutions staff includes designated Medical Directors, Quality Improvement staff, Utilization Management staff, Appeals and Grievance staff, Credentialing, Provider Network, and ad-hoc members pertinent to the report or discussion topic. The Workgroup process includes performance improvement review and discussion of monitoring activities, findings, barriers, and interventions to develop and implement actions. The QI Operational Workgroup meets weekly and reports significant findings and ensures follow-up to the QI/UM Committee.

Access Workgroup
The CalViva Access Workgroup brings together representatives from CalViva and multiple HNCS departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services. The Workgroup submits quarterly reports to the QI/UM Committee and/or RHA Commission for approval of recommended actions.

Deleted:

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

Appeals and Grievances Workgroup
CalViva has an Appeals and Grievances Workgroup which processes, tracks and trends member grievances and appeals at the practitioner and plan level. CalViva identifies patterns and/or trends of potential risk exposures via the Potential Quality Incident Referral Form. The Appeals and Grievances Workgroup will submit reports to the CalViva QI/UM Work Group and as indicated its Peer Review Subcommittee to ensure and allow CalViva the ability to review, act, and follow-up on identified clinical and/or service events or trends that are significant at the practitioner or plan level.

Refer to the CalViva QI/UM Charter for more information on committee members, roles and functions.

The CalViva QI/UM Committee has the following subcommittees:

Credentialing Subcommittee
The RHA Commission has final authority for the Credentialing Program. The CMO receives recommendations regarding policies, processes and standards from the Credentialing Subcommittee. The chairperson of the Credentialing Subcommittee, the CalViva Chief Medical Officer, is responsible for the Credentialing Subcommittee operations, including, but not limited to, communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting credentialing policies. The CalViva QI/UM Committee provides program oversight through annual review and approval of the Credentialing Program and quarterly reports supplied by the Credentialing Subcommittee. Membership of the Credentialing Subcommittee includes participating practitioners.

The RHA Commission and the QI/UM Committee provides oversight of the Credentialing Subcommittee, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing Subcommittee. The RHA Commission has final decision-making responsibility and authority to monitor, suspend, terminate or deny practitioners or organizational providers who have a direct contract with CalViva. CalViva retains the right to request in writing any modifications to a Health Net contracted participating providers' status in the CalViva network, including, without limitation, a request to terminate a participating provider's contract.

If the Credentialing Subcommittee decides to take disciplinary action against a practitioner that would be reportable to any outside agency, as a result of a practitioner's professional competence and/or conduct not meeting participation criteria or community care standards, all case materials are handled in accordance with CalViva Credentialing policies and procedures.

Peer Review Subcommittee
The RHA Commission and the QI/UM Committee provides oversight of the Peer Review Subcommittee, through annual approval of the Peer Review Program and quarterly reports supplied by the Peer Review Subcommittee. The chairperson of the Peer Review Subcommittee, the CalViva Chief Medical Officer, is responsible for the Peer Review Subcommittee operations, including, but not limited to, communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting Peer Review policies. The CalViva QI/UM Committee provides program oversight through annual review and approval of the Peer Review Program and quarterly reports supplied by the Peer Review Subcommittee. Membership of the Peer Review Subcommittee includes participating practitioners.

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

The RHA Commission provides oversight of the QI/UM Committee and Peer Review Subcommittee, through annual approval of the Peer Review Program and quarterly reports supplied by the Peer Review Subcommittee. The RHA Commission has final decision-making responsibility and authority to monitor, suspend, terminate or deny practitioners or organizational providers who have a direct contract with CalViva. CalViva retains the right to request in writing any modifications to a Health Net contracted participating providers' status in the CalViva network, including, without limitation, a request to terminate a participating provider's contract.

Furthermore, in the interest of protecting the safety and welfare of CalViva members, the Peer Review Subcommittees also review summary reports of member Quality of Care (QOC) grievances and Potential Quality Issues (PQIs) cases that may be initiated by members, providers, CalViva or HNCS staff, or other sources. The Peer Review Subcommittee may conduct an assessment of a practitioner's professional competence and conduct. If the Peer Review Subcommittee decides to take disciplinary action against a practitioner that would be reportable to any outside agency, as a result of a practitioner's professional competence and/or conduct not meeting participation criteria or community care standards, all case materials are handled in accordance with CalViva Peer Review policies and procedures.

B. *Staff Resources and Accountability*

CalViva Chief Medical Officer
The CalViva Chief Medical Officer's responsibilities include chairing the QI/UM Committee and work group, providing oversight of QIHEd, Health Equity, and PHCO/UM Programs, and assuring that the QIHEd, Health Equity and PHCO Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/PHCO operations. This position makes recommendations to the RHA Commission to initiate major program revisions and communicates the RHA Commission's directives to both internal and external stakeholders.

Supervisory (Regional) Medical Director
The Supervisory (Regional) Medical Directors (RMDs), who are provided through HNCS, assist in the clinical focus of the QI, Utilization Management, and Care Management Programs for CalViva's Medi-Cal members. The RMDs communicate with providers on a day-to-day basis to ensure the provider performance meets established CalViva, DHCS, DMHC, and NCQA standards. The RMDs will participate in DHCS clinical improvement workgroups and other CalViva QI activities, such as provider training, grievance and appeals review, and collaboration with network physicians and other providers to facilitate improved health outcomes for Medi-Cal members.

Behavioral Health Medical Director
A Behavioral Health Medical Director, who is a board-certified psychiatrist, is involved with the delegated behavioral health care aspects of the QI clinical program for CalViva members, including reviewing all potential quality concerns and functions in an advisory capacity to the QI/UM Committee. He is responsible for ensuring delegated behavioral health clinical services for members are administered in a manner consistent with accepted standards of care and provides direction and oversight for clinical quality improvement activities. Results are reported to CalViva's QI/UM Committee.

Deleted:

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

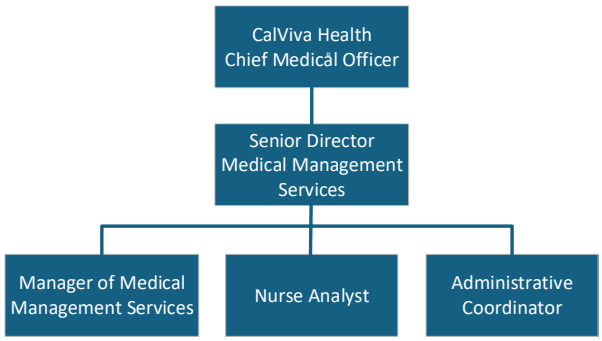
Deleted: and

Deleted:

Deleted:

QIHEd Program Resources
CalViva staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CalViva QIHEd Program. These administrative and clinical staff work with CalViva's Chief Medical Officer to carry out QIHEd activities for CalViva's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the QIHEd process are described below.

QI Team
The QI team includes a Chief Medical Officer, Senior Director of Medical Management Services, who is a Registered Nurse, a Manager of Medical Management Services, a Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Quality Program are appropriately trained and experienced in Quality Improvement and Safety, Public Health, Health Administration, and Care Management.



Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)
CalViva delegates DHCS's required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per APL 22-017, PL 12-006, APL 15-023. HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high-volume specialists (including behavioral health), ancillary providers, Community-Based Adult Services (CBAS) providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

The FSR team will include at least one Quality Compliance nurse, who must be a registered nurse, who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting an initial evaluation, conducting annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CalViva

Deleted: 5…CalViva Health Quality Improvement andt
Deleted: t
Deleted: and
Deleted:
Deleted:

Chief Medical Officer and the CalViva QI/UM Committee.

Health Education
CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support by trained health educators. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

Utilization Management/Population Health & Clinical Operations
CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and PHCO programs. A systematic approach is used by CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. The HNCS Medical Affairs and PHCO Departments partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CalViva's members. PHCO staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CalViva members. HNCS UM Department prepares and presents reports to the CalViva QI/UM committee at each meeting and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CalViva QI/UM committee and RHA Commission prior to preparing the annual Work Plan.

Case/Care Management
Case/Care Management (CM), delegated to HNCS, is responsible for the design, implementation and monitoring the effectiveness of the care management program and member outcomes. CM uses a systematic approach to identify and manage members who are currently accessing inpatient, ambulatory health care services, and may have compounding social drivers of health issues. Health Net's CM team partners with contracted practitioners, and member/family and/or caregivers to monitor, evaluate and facilitate continuity and coordination of care among its members, to improve care transitions and outcomes, and decrease readmission rates.

CM supports the integration of both physical and behavioral health services by ensuring that members who need behavioral health services are referred to the appropriate behavioral health provider to obtain medically necessary services. CM may refer these cases to a behavioral health Care Manager who works in tandem with a physical health Care Manager on the member's care plan, as needed.

Clinical Vendor Management
Clinical Vendor Management works in conjunction with Population Health and Clinical Operations for the monitoring and oversight of clinical performance metrics and operations for programs such as the Nurse Advice Line, SPD HRA, Teladoc virtual general medical and behavioral health services for members, and the specialty UM/prior authorization vendor for musculoskeletal procedures.

Deleted: the

Deleted: lied

Deleted: O

Deleted: perations

Deleted: H

Deleted: ealth Plan Operations

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

Credentialing/Recredentialing
CalViva delegates credentialing/recredentialing of practitioners and organizational providers to HNCS but retains oversight and ultimate authority for such function.

Appeals and Grievances
The Appeals and Grievance Department is responsible for conducting full investigation and fair review of all member concerns and/or reconsideration requests. This includes reasonable efforts to gather all information needed to make accurate decisions and provide the member with a resolution in writing within applicable regulatory timeframes. If an appeal has been upheld by the plan, the member is provided with their next level of appeal rights of an independent third-party review and the option to request a State Fair Hearing.

Appeals and grievances are monitored and trended to identify opportunities for improvements in service and quality of care. Appeals and Grievance Department will provide monthly operational and quarterly reporting to CalViva. These reports are to ensure and allow the departments the ability to review, act and follow-up on services, quality events or trends that are significant at the practitioner, provider, or plan level. Initiatives are put in place, as needed to address any identified deficiencies.

Customer Contact Centers
The Customer Contact Centers, operated by HNCS on CalViva's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CalViva and HNCS Appeals and Grievances department for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports on trended member/ practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CalViva's Chief Medical Officer to directly identify and/or confirm opportunities for improvement.

Provider Network Management
CalViva delegates provider network management to HNCS. HNCS Provider Network Management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network Management staff liaison collaborate with the hospitals, practitioners and other providers for the resolution of contractual issues related to the terms and conditions and/or payment rate(s) for certain services.

Provider Engagement and Data Strategy & Insights
The Provider Engagement and Data Strategy & Insights departments provides oversight and capabilities in support of improving and maintaining performance with providers and their membership across all lines of business. Collaboration between the departments involve the Provider Relations, Practice Transformation, Encounters, risk assessment forms (RAF), and Data Analytics and Solutions teams. The Provider Engagement and Data Strategy & Insights departments' success is dependent on both "internal" and "external" alignment to improve practitioner and provider performance and satisfaction.

Key responsibilities of the Provider Engagement and Data Strategy & Insights departments include:

Deleted: to conduct

Deleted: provided

Deleted: which provides the member

Deleted: of

Deleted: Provider Performance & Analytics

Deleted: Provider Performance & Analytics

Deleted: Provider Performance & Analytics

Deleted: Provider Performance & Analytics

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- Monitor and maintain and/or improved provider compliance (HEDIS, CAHPS, practitioner/provider satisfaction, UM metrics, RAF and encounter submissions) through provider outreach, training and education.
- Oversee and evaluate provider effectiveness.
- Assure business capabilities meet and support provider and member needs.
- Improve technical support, bi-directional data exchange, and communication channels or methodologies.
- Identify trends, issues, and opportunities to form and adopt best practices and meet or exceed performance targets.
- Engage and collaborate with targeted practitioners and providers through performance improvement projects.
- Collaborate with practitioners, providers and cross-functional departments to build and align incentives based on performance goals.

Delegation Oversight
CalViva staff is responsible for the development, implementation and monitoring of the delegation program for functions (e.g., utilization management, credentialing, claims and claims administration, etc.) delegated to HNCS and other entities as specified in written agreements between CalViva and the entities. CalViva staff maintains responsibility for the implementation and monitoring of corrective action plans resulting from oversight recommendations.

Vendor Management Office (VMO)
The core responsibilities of the VMO are oversight, monitoring, and auditing of vendor delegates. Regular Joint Oversight Committees (JOCs) are led by the VMO in which performance metrics, member experience, complaints and grievances and the status of corrective actions are reviewed. Corrective actions are issued for non-compliance with service level requirements or for audit findings and are tracked through remediation.

Pharmacy Services
CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the Pharmacy Medical Drug Benefit. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and prior authorization of medical benefit drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

HEDIS Measurement and Reporting
HNCS provides CalViva with the HEDIS Measurement and Reporting Team which is responsible for HEDIS data collection and reporting. This team works collaboratively with CalViva staff to collect and report data.

Public Programs
The Public Programs department monitors and acts as a resource for the LTSS (CBAS, MSSP, in-home support services (IHSS), and LTC) services for members. The department is engaged in the following activities:

- Support access to care initiatives through member outreach, coordination of care, and nursing home transitions.

Deleted:
Deleted: Management and Clinical Reporting
Deleted: Management and Clinical Reporting
Deleted: {
Deleted: }
Deleted: 5…CalViva Health Quality Improvement andt
Deleted: t
Deleted: and
Deleted:
Deleted:

- Early identification and referral to California Children's Services (CCS), and outreach to members aging out of program twelve (12) months before their twenty-first birthday to avoid interruption in care.
- Referral/connection to carved out Medi-Cal benefits and providers.

Program Accreditation
The HNCS Program Accreditation (PA) team supports and promotes activities to assess and monitor CalViva ongoing compliance with requirements of accrediting bodies (NCQA). Responsibilities include managing the accreditation timelines, coordination and submission of documents and implementation of any identified actions based on survey outcomes. PA works with CalViva staff to ensure all aspects of survey submission. The PA team also manages collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality Evaluating Data to Generate Excellence (EDGE) efforts.

Additional Resources
Additional resources available to the CalViva QI Program:

- Marketing
- Compliance
- Privacy
- Legal
- Web Development
- Strategic Sourcing and Procurement
- Claims/Encounters
- Provider Communications, and
- Member Communications.

Management of Information Systems (MIS)
The Management of Information Systems supporting CalViva's QI Program allows key personnel the necessary access and ability to manage the data required to support the measurement aspects of the QI activities. Analytic resources within the HNCS QI Department are available to support CalViva efforts, including expertise from the Director of QI Research and Analytics, who holds a master's degree and has SAS and programming experience. Additional analytic and operational support is provided by regional and corporate departments such as Information Systems, Health Care Services, Pharmacy Operations, Medical Informatics, HEDIS Measurement and Reporting, Actuary, Finance, Strategic Planning, and Marketing. Data sources include HEDIS, CAHPS, ECHO/OPMH surveys, appointment access and provider availability surveys, provider satisfaction surveys, and practitioner after-hours access surveys.
Computer systems used by Health Net to support Quality Management includes:

- **Centelligence™**: A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal and external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports.
- **Centelligence Enterprise Data Warehouse (EDW)**: Supporting both Insight and Foresight, EDW receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results,

Deleted: /Sales

Deleted: (MIS)

Deleted: the CalViva's

Deleted: ™

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

health assessments, service authorizations, and enrollee and provider information as required for QI Programs.

- **Statistical Analysis Software (SAS)**: an integrated software suite for advanced analytics, business intelligence, data management, and predictive analysis.
- **R**: an open-source software environment for statistical computing and graphics. QI utilizes the R-Shiny package within R to build and display interactive dashboards.
- **Power BI**, a Microsoft product that transforms raw plan data from multiple sources into actionable insights through interactive dashboards, real-time analytics, and secure, collaborative sharing. It boosts efficiency by enabling data-driven QI decision-making, streamlining data visualization, and offering, mobile accessibility for quick, informed actions driving QI programs.
- **MicroStrategy**: MicroStrategy is an enterprise business intelligence (BI) application software vendor. The MicroStrategy platform supports interactive dashboards, scorecards, highly formatted reports, ad hoc query, thresholds and alerts, and automated report distribution.
- **Inovalon's Converged Analytics**: A HEDIS-certified software system used to optimize quality measurement, reporting, and improvement initiatives. Converged Analytics is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. Enables the Plan to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.
- **Cozeva®**: A value-based NCQA-certified care operating system with reporting and analytics functionality, offers up-to-date information on quality and risk measures to plan providers. Cozeva gives providers visibility to provider-level incentives, and supports supplemental data submissions, data integrations with EMRs, and biweekly data syncs to CAIR and various EHR systems. Provider groups have the ability to track and trend performance of their providers to better monitor, understand, and take action on performance gaps through customizable dashboards.
- **Tableau**: Tableau is a data visualization tool which connects easily to several data sources and allows for rapid insight by transforming data into dashboards and are also interactive. Quality uses this software for plotting data on maps and displaying outcomes through dash-boarding.
- **Quest Analytics**: Quest analytics allows geo-mapping to conduct analysis on provider and facility access and compliance for our membership.
- **Operational Data Warehouse (ODW)**, a hardware that supports the Plan's claims payment system called Automated Benefits System (ABS). Claims, encounters, member and provider information that are processed in ABS are stored in ODW. (Decommissioning and migration to Snowflake Cloud Platform started in 2023) AMISYS Advance, a claims processing engine with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate enrollee and provider data systematically; receives service authorization information in near real time from TruCare; and is integrated with our encounter production and submission software.
- **Snowflake Platform,** is the next generation of the Enterprise Data Warehouse built on top of the Snowflake platform. The platform allows the organization to unify, analyze, and share health plan data securely through a cloud-native platform. It consolidates data from disparate sources into a single, managed platform for data warehousing, data lakes, and AI/ML, enabling advanced analytics, while providing built-in security, compliance, and auditing tools to monitor data quality and manage access.

Deleted: ¶

Deleted: <#>¶ ... [14]

Deleted: Cotiviti

Deleted:

Deleted: (Verscend)

Deleted: to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns…

Deleted: otiviti

Deleted: Health Net's

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- **TruCare**: Enrollee-centric health management platform for collaborative care coordination and management; and behavioral health, disabling condition, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows Population Health and Clinical Operations staff to capture utilization, care and population-based chronic conditions data; proactively identify, stratify, and monitor high-risk enrollees; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions.
- **OMNI**: The call center application with guided workflows and business process drivers that allow the business better flexibility and integration with other systems and with changing environments. OMNI application is used to research, record and share information between providers and members.
- **PRIME**: A system application used by employees to handle complaints, grievances and appeals. PRIME includes business process management features that integrate with upstream applications, including Membership, Provider Authorizations and OMNI.

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

V. QI Program Activities

QI Program activities are selected based on their relevance to CalViva's membership, the ability to affect a significant portion of the population or the population at-risk and their potential impact on high-volume, high-risk or high-cost conditions or services. Morbidity, mortality and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities.

CalViva fosters a multi-disciplinary approach to the quality improvement process and involves all functional areas with direct impact on quality and safety of care and service. Activities involve HNCS departments and collaborations with network providers, community entities including public health, quality improvement organization and behavioral health (see QIHEd Work Plan for details of performance improvement goals, objectives, and activities). The QI Program uses PDSA cycles as one method for monitoring quality improvement activities. Progress and results of the following activities are reported up to CalViva through various mechanisms including the CalViva QI/UM Workgroup and QI/UM Committee.

1. **Projects, Surveys and Audits**

   Issues/topics are selected based on identified opportunities for improvement through member and provider input, nationally and regionally identified or mandated projects, HEDIS, CAHPS/ECHO/OPMH Survey measurement and participation in regional and national coalitions. This includes:

   - Quality Improvement Activities (QIAs), Quality Improvement Projects (QIPs), and Performance Improvement Projects (PIPs) to improve an aspect of clinical care or service. These may include activities to improve HEDIS and/or CAHPS indicators, activities for disease conditions, or other identified areas for improvement by regulators such as CMS, DHCS, and NCQA.
   - Data collection improvement projects: Includes deploying contracts with health information exchanges and vendors that receive or process claims, encounters, member demographics or clinical data to improve efficiency of operations.
   - Behavioral health projects to monitor behavioral health care using data from HEDIS indicators, and member, practitioner and provider surveys.
   - Audits, both internal and external reviews, to ensure that CalViva maintains compliance with all regulatory and accreditation requirements.
   - Surveys including HEDIS, CAHPS/behavioral health member experience survey, health risk assessments, and provider satisfaction surveys, full scope facility site review surveys, and physical accessibility review surveys.
   - Mobile mammography units to improve access to services to complete breast cancer screenings.
   - Provider resources including report cards, gap reports, provider portal, educational resources, and trainings.
   - Pediatric and Maternal Health Programs promoting provider and member engagement with projects to improve immunizations, well-child visits, prenatal and postpartum care, lead screenings, and maternal health equity. Providers are supported to engage with immunization registries and the Vaccines for Children Program.

Deleted: behavioral health member experience survey

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

- Projects to improve hospital quality, including collaboration with leading external stakeholders to address priority metrics, s patient safety and maternal health indicators.
  Promote evidence-based preventive care and chronic disease management to improve self-management skills for individuals with chronic diseases.

2. Incentive Programs

CalViva rewards targeted members for healthy behaviors and collaborates with providers to build performance-based incentive programs. Development and implementation of incentives are aligned with CalViva's provider partnership, and strategies.

Member:

- CalViva rewards targeted members for healthy behaviors and engagement with their providers through the Quality EDGE program. The development and implementation of these incentives align with CalViva's provider partnership strategies and the principles of the Patient-Centered Medical (PCM) model.

Provider:

- CalViva offers tailored provider and PPG incentive programs that drive quality improvement through enhanced HEDIS performance and complete encounter submissions.

Deleted: Tailored member incentives offered to target CalViva populations to assist in closing care gaps for priority HEDIS measures including breast cancer screening, cervical cancer screening, diabetes management, well-child visits and childhood immunizations.¶

Deleted: <#>Tailored provider and PPG incentive programs for CalViva providers for HEDIS outcomes and encounter submissions.¶

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

VI. Provider Communications

Effective communication with network providers and subcontractors is crucial in advancing CalViva Health's quality improvement initiatives, studies, and fulfilling contractual obligations. Engagement with the Quality Improvement Health Education (QIHEd) Program is facilitated through various methods, including:

- Practitioner and provider office visits: Conducted by Provider Engagement team members to ensure direct and personalized communication.
- Online training and educational webinars: These resources provide continuous learning opportunities and keep participants informed about the latest guidelines and best practices.
- Joint Operation Meetings (JOMs) and work groups: These collaborative forums foster active participation and dialogue, ensuring alignment with quality improvement goals.

This structured approach ensures that all participants are well-informed and actively contributing to CalViva Health's mission of enhancing health care quality and efficiency.

To keep health care providers informed about QIHEd and Wellness program activities, modifications and outcomes, as well as available quality resources and programs, several key methods are utilized. The resources described below can be accessed through the Provider Library at providerlibrary.healthnetcalifornia.com or on other provider resource pages available on the provider portal. Additionally, CalViva's provider resource webpage (www.calvivahealth.org/providers) also includes provider resources and communications.

Available Resources:

- Provider Operations Manuals and Medi-Cal Operations Guides: Comprehensive manuals and guides outlining the operational policies and procedures necessary for providers to effectively deliver services.
- Provider Updates and Letters: Regular updates and communications sent to providers to keep them informed about important changes and developments.
- Provider Newsletters: Quarterly newsletters offering insights and updates about various health programs, initiatives, engagement in our communities, and best practices.
- Forms and Reference Documents: Essential forms and reference materials needed for administrative and operational purposes.
- Educational Materials and Resources: Resources aimed at enhancing provider knowledge and skills related to QIHEd and Wellness programs.

Communication Channels:

Provider updates, letters, and educational materials and resources are distributed via multiple channels including fax, mail and email. Additionally, these communications and materials are available in the Provider Library under the "Updates and Letters" section, or on other provider resource pages.healthnet.com. Additionally, CalViva's provider resource webpage (www.calvivahealth.org/providers) also includes provider resources and communications.

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

VII. Corrective Actions

CalViva takes timely and appropriate action to correct any significant or systemic problems identified through audits, internal reports, complaints, appeals, grievances, and delegation oversight activities.

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

VIII. Program Evaluation and Work Plan

A. *Review and Oversight*

The RHA Commission is responsible for QIHEd Program and annually receives reviews and approves the CalViva QIHEd Program Description, Work Plan and Program Evaluation. The CalViva QI/UM Committee submits regular reports to the Commission on quality findings related to monitoring and quality issues identified and activities initiated.

B. *Annual QIHEd Evaluation*

The evaluation of the QIHEd Program and Work Plan is based on the results of systematic monitoring and assessment of QI efforts. It includes a summary of completed and ongoing QI activities, trending of measures to assess performance (quality of service and clinical care, and safety of clinical care), analysis of the results of QI initiatives (including barriers), and evaluation of the overall effectiveness of the QIHEd Program, which is conducted during the year. The process identifies program strengths and limitations, improvement opportunities, and unfinished business. The QI Evaluation assesses the adequacy of resource allocations needed to plan and implement the QI activities and programs for the upcoming year. The annual QIHEd Program Evaluation and Work plan are reviewed and approved by CalViva QI/UM Committee during the first quarter each year.

C. *Annual QIHEd Work Plan*

The work plan documents the annual QIHEd initiatives and defines goals, objectives, specific actions, responsible parties and time frames targeted for completion or resolution of activities that address quality and safety of clinical care and quality of service. The work plan builds on the recommendations and findings of the previous year's program evaluation. The work plan allows integration of QI reporting and studies from various CalViva and HNCS departments and includes the requirements for both internal and external reporting. The CalViva and HNCS staff, CalViva QI/UM Committee, and RHA Commission utilize the work plan as a tool for monitoring the effectiveness of the CalViva QIHEd Program. The structure of the work plan outlines the steps necessary to complete the QI cycle: monitoring, planning, implementation, action, assessment and evaluation of outcomes. Each individual department or functional unit retains responsibility for the implementation and evaluation of their specific activities. It is a dynamic document that CalViva, with HNCS's assistance, updates regularly to reflect progress on QI activities throughout the year. The QIHEd Work Plan documents the annual QIHEd Program initiatives and delineates:

- Objectives, scope and population demographics
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported
- Responsible department(s) and/or person(s) for each activity
- Goals and benchmarks for each activity
- Number of objectives met
- Number of activities met
- Planned monitoring of previously identified issues

Deleted: a systematic

Deleted: the responsibility

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

- Barriers identified when goals are not achieved, and
- Follow-up action plan, including continuation status (close, continue, or continue with modifications).

D. *QIHEd Program Information Availability*

Information about CalViva's QIHEd Program including program description, activities and progress toward goals is available upon request, to members, prospective members and providers. CalViva notifies members of the availability of information about the QIHEd Program through the member's evidence of coverage and through the annual member newsletter highlighting CalViva's QIHEd Program. Network providers and subcontractors are notified of the availability of information about the QIHEd Program through committee meetings, JOMs, new practitioner/provider welcome letters, Provider Updates (including updates regarding quality improvement findings and outcomes), and through the operations manuals available electronically in the Provider Library on Health Net's online provider portal.

Deleted: *5…CalViva Health Quality Improvement andt*

Deleted: *t*

Deleted: *and*

Deleted:

Deleted:

IX. QI Process

A. *Confidentiality / Conflict of Interest*

CalViva's Compliance Department is responsible for reviewing, approving and disseminating confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. CalViva and Health Net contracts require that providers and practitioners maintain the confidentiality of member's information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

As a public entity, the Plan's QI/UM Committee is subject to the "open meeting" rules of the California Brown Act. Confidential matters presented to the Committee are discussed in a closed session, otherwise all other matters discussed at Committee meetings are open to the public and materials presented in the public portion of meetings are available to the public. Within CalViva's internal operations, QI activities that will not be presented in the public Committee meetings are conducted and discussed under a code of confidentiality. All documents created as part of the QIHEd Program are maintained in accordance with federal and state law. Materials pertaining to confidential QI Review will be marked "confidential" and kept in a locked area. CalViva, its providers, vendors and contracted or delegated entities are responsible for safeguarding all confidential materials.

CalViva fully complies with the Health Insurance Portability and Accountability Act (HIPAA), which regulates the privacy of protected health information (PHI). CalViva strictly prohibits any unlawful and unauthorized access to, use or disclosure of member or provider information. Members are informed of these rights through the distribution of the Notice of Privacy Practices.

CalViva has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. Prior to participation in the QIHEd Program or its non-public committees (Credentialing and Peer Review Subcommittees), participants are educated regarding confidentiality requirements. The CalViva Chief Compliance Officer is responsible for reviewing, approving and disseminating confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Conflict of Interest

No person(s) will be assigned or selected for a QIUM Committee where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other practitioners they are in direct competition with or are associated with through financial arrangements. All Peer Review case presentations are blinded as to member and practitioner identification prior to committee review.

Deleted: to review
Deleted: e
Deleted: e
Deleted: to review
Deleted: e
Deleted: e
Deleted: 5…CalViva Health Quality Improvement andt
Deleted: t
Deleted: and
Deleted:
Deleted:

B. *QI Process*

CalViva's quality and performance improvement activities are implemented and documented in accordance with applicable state, federal, and accreditation regulations and standards. CalViva, in conjunction with HNCS, identifies opportunities for improvement through continuous monitoring of important aspects of care and service. CalViva's QI process includes the following:

- Establishment of quantitative and qualitative measures to assess performance and identify and prioritize areas for improvement.
- Establishment of goals or benchmarks for each measure using nationally recognized, evidence-based standards of practice if applicable.
- Identification of appropriate methodology to identify the targeted population or sample and ensure the validity and reliability of the collected data.
- Performance of a quantitative and qualitative (identification of barriers) analysis of the data collected for each measure.
- Identification of opportunities for improvement.
- Implementation of appropriate interventions to improve practitioner, provider, and plan performance.
- Measurement of the effectiveness of the interventions and corrective actions.
- Quality of care problems or grievances are identified and can be submitted by the member, member's family, or provider on behalf of the member and can include problems or grievances about any type of medical or behavioral health service including, without limitation, care in a physician's office, clinic, hospital, ER, outpatient facility, home health agency, rehabilitation office, dialysis center, laboratory facility, hospice, imaging center. The full range of medical providers and their facilities under contract or providing medical care to CalViva members are included in and covered by the Appeal and Grievance process.

Areas for focused performance improvement are identified based on but not limited to the following:

- HEDIS, CAHPS/behavioral health member experience surveys, DMHC Health Equity and Quality measure performance, and national and regional benchmarks and goals.
- Local and state required improvement projects.
- Concordance with plan initiatives (e.g., chronic condition management programs).
- QI programs identified through community collaborative activities.
- Patterns of inappropriate utilization.
- Cultural or linguistic makeup of membership causing gaps in care.
- Health outcome disparities.
- Appeals and grievance/customer service rates.
- Member and provider survey results regarding satisfaction, access and availability, and coordination of care.

Selection of topics takes into account:

- Relevance to the health plan population
- Prevalence of a condition among, or need for a specific service, by plan membership, and

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

- Demographic characteristics and health risks.

Data collected to support the CalViva QI process include:

- Claims and encounter data
- Membership and Medical Benefit Pharmacy data
- Reports of key performance indicators and sentinel events
- Demographic factors generally associated with risk such as race, ethnicity, language, age, gender identity, sexual orientation or special health care or social needs status
- Cultural and linguistic makeup of membership
- Federal and state-reported quality and administrative data
- Clinical quality data collected by the plan, including recognized quality indicators such as HEDIS and HEDIS-like measures
- CAHPS Survey
- Behavioral health member experience survey
- Medical Record Review
- Member & Practitioner Complaint & Inquiry Reports, and
- Appeals Reports.

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

X. Approval

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

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

Deleted: ¶ ... [15]

David Hodge, MD, Fresno County Regional Health Authority Commission Chairperson

Date

Deleted:

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

Date

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

B. *Health Net Medi-Cal Quality Management Program Approval*

The Chief Medical Officer and Vice President of Quality Management have reviewed and approved this Work Plan.

Alex Chen, MD
Chief Medical Officer

Date

Cathrine Misquitta, Pharm.D.
Vice President of Quality Management

Date

Deleted: Alex Chen

Deleted: <object>¶

Deleted:

Deleted: 5…CalViva Health Quality Improvement andt

Deleted: t

Deleted: and

Deleted:

Deleted:

Page 4: [1] Deleted	Tuyen T. Pham	1/28/2026 6:17:00 PM
Page 15: [2] Deleted	Tuyen T. Pham	1/28/2026 7:58:00 PM
Page 1: [3] Deleted	Tuyen T. Pham	10/20/2025 9:14:00 AM
Page 1: [3] Deleted	Tuyen T. Pham	10/20/2025 9:14:00 AM
Page 1: [3] Deleted	Tuyen T. Pham	10/20/2025 9:14:00 AM
Page 1: [3] Deleted	Tuyen T. Pham	10/20/2025 9:14:00 AM
Page 1: [3] Deleted	Tuyen T. Pham	10/20/2025 9:14:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [4] Deleted	Guille V. Toland	11/5/2025 9:13:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM
Page 24: [5] Deleted	Guille V. Toland	11/5/2025 9:14:00 AM

Page 24: [5] Deleted	**Guille V. Toland**	**11/5/2025 9:14:00 AM**
Page 24: [5] Deleted	**Guille V. Toland**	**11/5/2025 9:14:00 AM**
Page 24: [6] Deleted	**Tuyen T. Pham**	**12/18/2025 4:56:00 PM**
Page 24: [6] Deleted	**Tuyen T. Pham**	**12/18/2025 4:56:00 PM**
Page 24: [7] Deleted	**Guille V. Toland**	**11/5/2025 9:18:00 AM**
Page 24: [7] Deleted	**Guille V. Toland**	**11/5/2025 9:18:00 AM**
Page 24: [7] Deleted	**Guille V. Toland**	**11/5/2025 9:18:00 AM**
Page 24: [7] Deleted	**Guille V. Toland**	**11/5/2025 9:18:00 AM**
Page 24: [8] Deleted	**Guille V. Toland**	**10/28/2025 10:18:00 PM**
Page 24: [8] Deleted	**Guille V. Toland**	**10/28/2025 10:18:00 PM**
Page 24: [8] Deleted	**Guille V. Toland**	**10/28/2025 10:18:00 PM**
Page 24: [9] Deleted	**Tuyen T. Pham**	**1/15/2026 4:49:00 PM**
Page 24: [9] Deleted	**Tuyen T. Pham**	**1/15/2026 4:49:00 PM**
Page 24: [9] Deleted	**Tuyen T. Pham**	**1/15/2026 4:49:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**
Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [10] Deleted	**Guille V. Toland**	**10/28/2025 10:20:00 PM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [11] Deleted	**Guille V. Toland**	**11/5/2025 9:26:00 AM**

Page 24: [12] Deleted	**Guille V. Toland**	**11/5/2025 9:20:00 AM**

Page 24: [12] Deleted	**Guille V. Toland**	**11/5/2025 9:20:00 AM**

Page 24: [12] Deleted	**Guille V. Toland**	**11/5/2025 9:20:00 AM**

Page 24: [12] Deleted	**Guille V. Toland**	**11/5/2025 9:20:00 AM**

Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 24: [12] Deleted	Guille V. Toland	11/5/2025 9:20:00 AM
Page 26: [13] Deleted	Paul Allen Fuentes	12/11/2025 11:30:00 PM
Page 39: [14] Deleted	Tuyen T. Pham	2/6/2026 12:02:00 PM
Page 50: [15] Deleted	Tuyen T. Pham	3/11/2026 10:58:00 AM

Quality Improvement and Health Education 2026 Work Plan

Purpose

The purpose of the CalViva Quality Improvement (QI) and Health Education (HEd) Program Work Plan is to integrate operational systems to both review clinical, service, access, and safety related outcomes against the priorities and objectives established by the Quality Improvement Program as well as provide a systematic plan of health education activities for the calendar year. It also documents the outcomes of proposed health education initiatives, programs and services. An assessment of critical barriers is made when objectives have not been met. The results of this Quality Improvement Program Evaluation provide evidence of the overall effectiveness of the QI Program and identify barriers and opportunities for improvement.

Mission

1. We will anticipate, understand and respond to customer needs and be customer-driven in everything we do.
2. We will hire and retain the best people, create the best climate, provide the best tools to do the best job and build a spirit of warmth, friendliness and pride throughout the company.
3. We will dedicate ourselves to a standard of excellence in all of our customer relationships.
4. We will promote better outcomes for our customers through improved provider relationships and through the promotion of evidence-based health care.
5. We will provide efficient, simple and high-quality administrative services that get things right the first time.
6. We will build excellent business systems and processes and demonstrate the highest degree of integrity in all aspects of the operation of our business.

Scope

The CalViva Health Quality Improvement and Health Education Work Plan encompasses quality improvement and health education activities for 2026. The development of this document requires resources of multiple departments. Section I includes program objectives, monitoring and evaluation for the year. Section II includes ongoing monitoring of cross-functional activities across the organization. Section III lists Quality Improvement Tracking System activities that support meeting QI and HEd program objectives for the year.

Submitted by:

Patrick Marabella, MD	Chief Medical Officer
Amy Schneider, RN, BSN	Senior Director, Medical Management

Glossary of Abbreviations/Acronyms

Acronym:	Description
A&G:	Appeals and Grievances
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CA:	California region
CAHPS®:	Consumer Assessment of Healthcare Providers and Systems
CAIR:	California Immunization Registry
CAP:	Corrective Action Plan
CH&W:	California Health & Wellness
CS:	Community Solutions
CDI:	California Department of Insurance
CM:	Case Management
DHCS:	Department of Health Care Services
DMHC:	Department of Managed Health Care
DN:	Direct Network
DM:	Disease Management
ECHO:	Experience of Care and Health Outcomes survey
FFS:	Fee-for-Service
HEDIS®:	Healthcare Effectiveness Data and Information Set
HPL:	High Performance Level
HRQ:	Health Risk Questionnaire
IHA:	Initial Health Appointments
IVR:	Interactive Voice Response
LTSS:	Long Term Services and Supports
MCAS:	Managed Care Accountability Set

Acronym:	Description
MCL:	Medi-Cal
MPL:	Minimum Performance Level
MSSP:	Multipurpose Senior Services Program
MY:	Measurement Year
N/A:	Not Available
N/R:	Not Reportable due to small denominator (<30)
NCQA:	National Committee for Quality Assurance
PAS:	Patient Assessment Survey
PCP:	Primary Care Physician
PEPM:	Provider Engagement Performance Management
PIP:	Performance Improvement Project
PDSA:	Plan, Do, Study, Act Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
POD:	Program Owners and Drivers
PNM:	Provider Network Management
PPG:	Participating Provider Group
PTMPY:	Per Thousand Members Per Year
QC:	Quality Compass
QI:	Quality Improvement
QIP:	Quality Improvement Project
RY:	Reporting Year
SPD:	Special Persons with Disabilities
UM:	Utilization Management

Glossary of Abbreviations/Acronyms (Measure Specific)

Acronym:	Description
AISE	Vaccine Adult Immunization Status
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
AMM	Antidepressant Medication Management (
AMO	Annual Monitoring for Persons on Long-Term Opioid Therapy
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CBP	Controlling Blood Pressure
CCO	Cervical Cancer Overscreening
CCS	Cervical Cancer Screening
C.Diff	Clostridioides difficile
CAUTI	Catheter-associated Urinary Tract Infection
CHL	Chlamydia Screening in Women
CIS-10	Childhood Immunization Status - Combination 10
CLABSI	Central line-associated bloodstream infection
COA-FA	Care of Older Adults-Functional Assessment
COA-MR	Care of Older Adults –Medication Review
COA-PA	Care of Older Adults- Pain Assessment
COB	Concurrent Use of Opioids and Benzodiazepines
COL	Colorectal Cancer Screening
CWP	Appropriate Testing for Pharyngitis
DEV	Developmental Screening in the First Three Years of Life
DSF	Depression Screening and Follow-up for Adolescents and Adults
EED	Eye Exam for Patients with Diabetes
FMC	Follow up After Emergency Dept Visit/Chronic Condition
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days
FUM	Follow-Up After ED Visit for Mental Illness – 30 days
FVA	Flu Vaccinations for Adults

Acronym:	Description
GSD	Glycemic Status Assessment for Patients with Diabetes (>9%)
HBD	Diabetes Care -Blood Sugar Controlled (>9%)
HDO	Use of Opioids at High Dosage
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMA-2	Immunizations for Adolescents – Combo 2
IMMH	Improving Mental Health
IMPH	Improving Physical Health
KED	Kidney Health Evaluation for Patients with Diabetes
LSC	Lead Screening in Children
MAC	Medication Adherence for Cholesterol (Statin) (MAC)
MAD	Medication Adherence for Diabetes Medications (MAD)
MAH	Medication Adherence for Hypertension (RASA) (MAH)
MPA	Monitoring Physical Activity
MRSA	Methicillin-resistant Staphylococcus aureus
MTM-CMR	MTM Program Completion Rate – Comprehensive Medication Review
MUI-OA	Improving Bladder Control
NTSV	Nulliparous, Term, Singleton, Vertex
OMW	Osteoporosis Management in Women who had a Fracture
OED/OEV	Oral Evaluation, Dental Services
OMW	Osteoporosis Management in Women who had a Fracture
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
PCR	Plan All Cause Readmission
PDC-DM	Proportion of Days Covered - Diabetes
PDC-RAS	Proportion of Days Covered - Renin Angiotensin System
PDC-Statin	Proportion of Days Covered - Statin
POD	Pharmacotherapy for Opioid Use Disorder

Glossary of Abbreviations/Acronyms (Measure Specific) - continued

Acronym:	Description
PPC-Pre	Prenatal and Postpartum Care: Prenatal Care
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care
RRF	Reducing Risk of Falls
SPC-RCV	Statin Therapy for Patients with Cardiovascular Disease - Received Therapy
SPD-RCV	Statin Therapy for Patients with Diabetes - Received Therapy
SSI-Colon	Surgical site infection following colorectal surgery
SUPD	Statin Use in Persons with Diabetes
TFL-CH	Topical Fluoride for Children
TRC	Transitions Of Care- Average
URI	Appropriate Treatment for Upper Respiratory Infection
W30	Well-Child Visits in the First 30 Months of Life
W30+6	Well-Child Visits 0-15 months – Six or more visits
W302+	Well-Child Visits 15-30 months – 2 or more visits
WCC	Children/Adolescents: BMI Percentile Documentation
WCV	Child & Adolescent Well-Care Visits

Acronym:	Description

Section I: Work Plan Initiatives

Goal: Implement activities to improve performance measures.

Section I includes program objectives, monitoring and evaluation for the year.

Program Initiative Details	Responsible Party	Objectives	2025 (MY 2024) Objectives Met (%, ratio):	2026 (MY 2025) Objectives Met (%, ratio): (Populate at Mid-Year)	2026 Activities Completed (%, ratio):	Program Continuation (Populate at year-end)
1. Behavioral Health – Improving Behavioral Health (Mental Health and Substance Use) Outcomes **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) **Type of program:** • Quality of Care • Safety	Adrianna Shoji, Program Manager III, Behavioral Health Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure (2 rates): FUA-30, FUM-30. • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA-30): MPL is 39.10% • Follow-Up After ED Visit for Mental Illness – 30 days (FUM-30): MPL is 57.13%.	MY 2024: • FUA-30: (100% 3/3) Fresno: 29.48% Kings: 36.65%* Madera: 30.7% • FUM-30: (100% 3/3) Fresno: 42.94% Kings: 64.97%* Madera: 47.71% *Measures that met MPL: (33.33%, 2/6)	MY 2025: • FUA-30: (X% X/3) Fresno: X% Kings: X% Madera: X% • FUM-30: (X% X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/6)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
2.A. Chronic Conditions - Diabetes (CDC/GSD/HBD >9%) **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) **Type of program:** • Quality of Care • Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure: • Glycemic Status Assessment for Patients with Diabetes: GSD: MPL is 30.41% (inverted rate).	MY 2024: •HBD >9: (100%, 3/3) Fresno: 24.04%* Kings: 28.00%* Madera: 23.00%* *Measures that met MPL: (100%, 3/3)	MY 2025: •GSD>9: (X%, X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/3)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
2.B. Chronic Conditions – Heart Health/Blood Pressure (CBP) **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) **Type of program:** • Quality of Care • Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure: • Controlling Blood Pressure (CBP): MPL is 64.48%.	MY 2024: •CBP: (100%, 3/3) Fresno: 68.92%* Kings: 79.00%* Madera: 72.00%* *Measures that met MPL: (100%, 3/3)	MY 2025: •CBP: (X%, X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/3)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
3.A Hospital Quality/Patient Safety **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – address quality/ safety of care priority) **Type of program:** • Quality of Care • Safety	Barbara Wentworth, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	• Hospitals with sufficient reportable data: Directional improvement, based on appropriate scores (SIR=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (CAUTI, CLABSI, C.Diff, MRSA, and SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status. • Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates.	MY 2024 (8/11, 73%) • CAUTI: SIR=<1.0: 100%; SIR>2.0: 0% • CLABSI:SIR=<1.0: 100%; SIR>2: 0% • C.Diff: SIR=<1.0: 80%; SIR>2: 0% • MRSA: SIR=<1.0: 75%; SIR>2: 0% • SSI-Colon: SIR=<1.0: 75%; SIR>2: 0% • NTSV C-sections: Rate=<23.6%: 40%	MY 2025: (X/11, X%) • CAUTI: SIR=<1.0: X%; SIR>2.0: X% • CLABSI:SIR=<1.0: X%; SIR>2: X% • C.Diff: SIR=<1.0: X%; SIR>2: X% • MRSA: SIR=<1.0: X%; SIR>2: X% • SSI-Colon: SIR=<1.0: X%; SIR>2: X% • NTSV C-sections: Rate=<23.6%: X%	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
3.B. Hospital Quality/ Patient Safety/Maternal Health: PPC-pre, PPC-pst, PND-E, PDS-E **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MPL, coordination of care priority)New Activity **Type of program:** • Quality of Care • Quality of Service	Barbara Wentworth, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measures: PPC-pre and PPC-Pst • Prenatal and Postartum Care: Prenatal Care (PPC-pre): 50th percentile MPL is 86.37% • Postpartum Care (PPC-pst): 50th percentile MPL is 82.48%.	MY 2024: • PPC-pre: (100%, 3/3) Fresno: 90.4%* Kings: 92.00%* Madera: 93.00%* • PPC-pst: (100%, 3/3) Fresno: 83.9%* Kings: 87.00%* Madera: 87.00%* *Measures that met the MPL: (100%, 6/6)	MY 2025: • PPC-pre: (X%, X/3) Fresno: X% Kings: X% Madera: X% • PPC-pst: (X%, X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/6)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	

Program Initiative Details	Responsible Party	Objectives	2025 (MY 2024) Objectives Met (%, ratio):	2026 (MY 2025) Objectives Met (%, ratio): (Populate at Mid-Year)	2026 Activities Completed (%, ratio):	Program Continuation (Populate at year-end)
4. Member Engagement and Experience – Initial Health Appointments **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – DHCS regulatory activity, audit non-compliance) **Type of program:** • Quality of Care	Miriam Rosales, Program Manager III, QI Sia Xiong Lopez CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement from prior year. IHA does not have HEDIS benchmark but is a DHCS compliance measure. * Required by DHCS for NEW Medi-Cal members within 120 days of enrollment. * Goal: To ensure newly enrolled Medi-Cal members connect with a medical home/PCP, receive a comprehensive evaluation of health needs and receive needed care services across the care continuum.	MY 2024 • IHA: (100%, 2/2) The current IHA rate is 59.40%.	MY 2025 • IHA: (X%, X/2) The current IHA rate is X%.	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
5.A. Pediatric/Dental – Dental: (TFL-CH) **Type of activity:** • Ongoing activity - (monitoring of previously identified issue) **Type of program:** • Quality of Care • Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure: • Topical Fluoride for Children (TFL-CH): MPL is 19.00%. Two fluoride applications each measurement year for all children 1 to 20 years of age.	MY 2024 • TFL-CH: (100%, 2/3) Fresno: 23.77%* Kings: 19.46% Madera: 33.83%* *Measures that met MPL: (66.67%, 2/3)	MY 2025: • TFL-CH: (X%, X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/3)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
5.B. Pediatric/Dental – Pediatric Measures for Children under 3 years of age: CIS-10-E, LSC, DEV, W30-6+, W30-2+ **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority) **Type of program:** • Quality of Care • Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measures: CIS-10-E, LSC, CDEV, W30-6+, W30-2+. • CIS-10-E 50th percentile MPL = 23.89% • LSC 50th percentile MPL = 69.96% • CDEV 50th percentile MPL = 35.70% • W30-6+ 50th percentile MPL = 63.38% • W30-2+ 50th percentile MPL = 72.32%	MY 2024: • CIS-10: (66.67%, 2/3) Fresno: 29.17%*, Kings: 14%, Madera: 39%* • LSC: (100%, 3/3) Fresno: 68.66%*, Kings: 64%*, Madera: 93%* • CDEV: (66.67%, 2/3) Fresno: 41.4%*, Kings: 7.48%, Madera: 66.65%* • W30-6+: (66.67%, 2/3) Fresno: 59.39%, Kings: 58.25%, Madera: 72.89%* • W30-2+: (100%, 3/3) Fresno: 67.7%, Kings: 59.91% Madera: 78.64%* *Measures that met the MPL (CIS-10: 66.67%, 2/3; LSC: 100%, 3/3; CDV: 66.67%, 2/3; W30-6+: 33.33%, 1/3; W30-2+: 33.33%, 1/3)	MY 2025: • CIS-10: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • LSC: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • CDEV: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • W30-6+: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • W30-2+: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% *Measures that met the MPL (CIS-10: X%, X/3; LSC: X%, X/3; CDV: X%, X/3; W30-6+: X%, X/3; W30-2+: X%, X/3)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
5.C. Pediatric/Dental – Pediatric Measures for Children 3-21 of age: IMA-2-E, WCV **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) **Type of program:** • Quality of Care • Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measures: IMA-2-E and WCV. • IMA-2-E 50th percentile MPL = 34.14% • WCV 50th percentile MPL = 55.41%	MY 2024 • IMA-2: (100%, 3/3) Fresno: 39.60%* Kings: 35.77%* Madera: 52.29%* • WCV: (100%, 3/3) Fresno: 54.17%* Kings: 49.28% Madera: 63.17%* *Measures that met the MPL (IMA-2: 100%, 3/3; WCV: 66.67%, 2/3)	MY 2025: • IMA-2: (X%, X/3) Fresno: X% Kings: X% Madera: X% • WCV: (X%, X/3) Fresno: X% Kings: X% Madera: X% *Measures that met MPL: (X%, X/6)	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
6.A. Preventive Health – Cancer and STI Screenings **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – maintain or address under performing MCAS) **Type of program:** • Quality of Care • Quality of Service	Ravneet Gill, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measures: • Breast Cancer Screening (BCS-E): MPL is 55.87% • Cervical Cancer Screening (CCS-E): MPL is 52.32% • Colorectal Cancer Screening (COL-E): MPL is 41.39%	MY 2024: • BCS: (100%, 3/3) Fresno: 59.99%, Kings: 64.39%*, Madera: 58.5% • CCS: (100%, 3/3) Fresno: 66.3%*, Kings: 66%*, Madera: 70%* • CHL: (100%, 3/3) Fresno: 64.83%*, Kings: 65.81%*, Madera: 66.96%* *Measures that met the MPL (100%, 9/9).	MY 2025: • BCS: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • CCS: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% • CHL: (X%, X/3) Fresno: X%, Kings: X%, Madera: X% *Measures that met the MPL (X%, X/9).	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	

Program Initiative Details	Responsible Party	Objectives	2025 (MY 2024) Objectives Met (%, ratio):	2026 (MY 2025) Objectives Met (%, ratio): (Populate at Mid-Year)	2026 Activities Completed (%, ratio):	Program Continuation (Populate at year-end)
6.B. Preventive Health – Flu Campaign **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – improve performance for preventive care) **Type of program:** • Quality of Care • Quality of Service	Clinical Pharmacist - TBD Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement from prior year for the Flu Vaccine Adult Immunization Status (AISE Flu).	MY 2024 AISE Flu: 0% (0/3) Fresno: 20.24% Kings: 21.88% Madera: 19.68%	MY 2025 AISE Flu: X% (X/3) Fresno: X% Kings: X% Madera: X%	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
7.A Member Experience - Improving CAHPS – Provider Focus **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – improve performance for Member Experience) **Type of program:** • Quality of Care • Quality of Service • Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement from prior year on CAHPS Access measures including: Getting Needed Care, Getting Care Quickly, Care Coordination. MY 2025 QC benchmarks are not available until Q3 2025.	MY 2024: (100%, 3/3) • Getting Needed Care: 75.9%* • Getting Care Quickly: 78.6%* • Care Coordination: 87.2%* *Measures that met directional improvement.	MY 2025: (X%, X/3) • Getting Needed Care: X% • Getting Care Quickly: X% • Care Coordination: X% *Measures that met directional improvement.	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
7.B Member Experience - Improving CAHPS – Plan Focus **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – improve performance NCQA quality measure) **Type of program:** • Quality of Care • Quality of Service • Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the national 25th percentile benchmark or directional improvement on the following CAHPS measures: Rating of Health Plan, Customer Service, Ease of Filling Out Forms. *MY2024 QC benchmarks are not available until Q3 2025.	MY 2024: (33.37%, 1/3) • Rating of Health Plan: 79.5%, • Customer Service: 90.5%* • Ease of Filling Out Forms: 93.5% *Measures that met directional improvemnet.	MY 2025: (X%, X/3) • Rating of Health Plan: X%, • Customer Service: X% • Ease of Filling Out Forms: X% *Measures that met directional improvemnet.	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	
8. Provider Communication/ Engagement - Improving Provider Survey Results **Type of activity:** • Ongoing activity – (monitoring of previously identified issue – compliance priority) **Type of program:** • Access and Availability	Paul Fuentes, Provider Relations Specialist II, Access and Availability Steven Si, Sr. Manager, Compliance and Privacy	To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%.	MY 2024 PAAS: 60% (3/5) •PCP Urgent: 77% •PCP Non-Urgent: 86% •Specialists (All) Urgent: 53% •Specialists (All) Non- Urgent: 67% •Ancillary Non-Urgent: 91% MY 2024 PAHAS: 100% (2/2) •Appropriate Emergency Instructions: 93.1% •Ability to Contact On-Call Physicians: 90.02%	MY 2025 PAAS: X% (X/5) •PCP Urgent: X% •PCP Non-Urgent: X% •Specialists (All) Urgent: X% •Specialists (All) Non- Urgent: X% •Ancillary Non-Urgent: X% MY 2024 PAHAS: X% (X/2) •Appropriate Emergency Instructions: X% •Ability to Contact On-Call Physicians: X%	Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log

Section II lists Enterprise Quality Improvement & Performance Tracker activities that support meeting program objectives for the year (listed in Section I). It also includes ongoing monitoring of cross-functional activities across the organization.

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0246	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Adrianna Shoji, Program Manager III, Amy Schneider, CalViva Sr. Director, Medical Management, Geoffrey Gomez, Director, Quality Improvement, Guille Toland, Program Manager III, CAHPS Quality Improvement, Louba Aaronson, Director, Quality Improvement, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Complete Member Satisfaction Reports.	Write integrated member satisfaction reports, in partnership with the QIRA Team, to satisfy NCQA Accreditation ME.7 Standard. This report captures appeals, grievances, CAHPS/ECHO results, and identifies barriers, areas of opportunity, and ongoing initiatives.	ECHO Survey, CAHPS Survey, and Appeals and Grievances Review	01/01/26	12/31/26				
CA-0199	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Daniel Saldarriaga, Sr. Manager, Appeals and Grievances, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Appeals and Grievance Trending Reports	A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	No Associated Measure	01/01/26	12/31/26				
CA-0243	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Erica Valdivia, Director, Provider Relations, Shekinah Wright, Director, Quality Improvement	Ongoing Monitoring Activities: MCAS Provider Training	Engage with CalViva provider offices to complete MY 2026 MCAS training focused on best practices for closing care gaps.	Measure Not Listed	01/01/26	12/31/26				
CA-0234	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Guille Toland, Program Manager III, CAHPS Quality Improvement, Louba Aaronson, Director, Quality Improvement, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: CAHPS monitoring	Maintain and manage the CAHPS Action Plan: Collaborate with CAHPS measure owners to identify areas of opportunity and activities to improve CAHPS, identifying process improvement activities. This also includes working with the Provider Engagement and Medical Affairs teams to review provider CAHPS improvement plans, identifying best practices, and recommending changes when plans are insufficient to improve the member experience in a measurable and meaningful way.	Measure Not Listed	01/01/26	12/31/26				
CA-0240	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Manisha Makwana, Director, Provider Relations, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: PPG Delegation Oversight Scorecards	Monitor Delegation Oversight activities through the PPG scorecards that captures PPGs' audit scores. The quarterly scorecard provides an opportunity to track/ trend low-high PPGs performers.	Measure Not Listed	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0221	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Manjula Miyashiro, Director, PNM Operations, Rudolph Davila, Program Manager II, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Provider Satisfaction Survey	Coordinate data and reporting for annual Provider Satisfaction Survey.	Measure Not Listed	01/01/26	12/31/26				
CA-0218	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Manjula Miyashiro, Director, PNM Operations, Rudolph Davila, Program Manager II, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Provider Satisfaction Survey	Monitor appropriate after-hours messaging and timely access to urgent/emergent care. Refer to Access and Availability Work Plan for additional details.	Measure Not Listed	01/01/26	12/31/26				
CA-0235	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Miriam Rosales, Program Manager III, Quality Improvement, Shekinah Wright, Director, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Initial Health Appointments Compliance	Maintain compliance with DHCS Initial Health Appointment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	IHA - Initial Health Appointments	01/01/26	12/31/26				
CA-0227	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Dao Fang, Manager, Health Equity, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: GeoAccess Report	Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.	Measure Not Listed	01/01/26	12/31/26				
CA-0224	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Dao Fang, Manager, Health Equity, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Health Equity Report	Analyze and report on Cultural and Linguistics.	Measure Not Listed	01/01/26	12/31/26				
CA-0231	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Erica Valdivia, Director, Provider Relations, Michelle Najarro, Manager, Program Accreditation	Ongoing Monitoring Activities: Quality EDGE	In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to improve access and complete interventions addressing systemic barriers to HEDIS performance.	Measure Not Listed	01/01/26	12/31/26				
CA-0217	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Access Survey Results	Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers (Q1-Q2). Issue CAPs & educational packets to non-compliant providers (Q3-Q4).	Measure Not Listed	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0215	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Telephone Access Survey	Conduct quarterly surveys and issue CAPs to noncompliant providers.	Measure Not Listed	01/01/26	12/31/26				
CA-0212	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: DHCS Medi-Cal Managed Care Timely Access Survey Report	Conduct quarterly education outreach to noncompliant providers identified by this survey.	Measure Not Listed	01/01/26	12/31/26				
CA-0208	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: DMHC Timely Access Report (TAR)	Complete and submit DMHC Timely Access Reporting (TAR) by May 1, 2026 filing due date.	Measure Not Listed	01/01/26	12/31/26				
CA-0205	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Access Survey Monitoring	Monitor and report access to care standards using telephonic surveys vendor(s).	Measure Not Listed	01/01/26	12/31/26				
CA-0203	Access, Availability, Satisfaction and Service	Medicaid (All Counties)	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Access Provider Training	Conduct quarterly provider webinars.	Measure Not Listed	01/01/26	12/31/26				
CA-0249	Behavioral Health	Medicaid (All Counties)	Adrianna Shoji, Program Manager III, Amy Schneider, CalViva Sr. Director, Medical Management, Geoffrey Gomez, Director, Quality Improvement	Ongoing Monitoring Activities: Behavioral Health Oversight	Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, etc.)	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults FUA - Follow-Up After Emergency Department Visit for Substance Use FUM - Follow-Up After Emergency Department Visit for Mental Illness	01/01/26	12/31/26				
CA-0559	Behavioral Health	Medicaid (Madera)	Rhonda Dick, Sr. Quality Improvement Specialist	Quality Monitoring & Improvement Project (QMIP) Madera County (2026)	Quality Improvement activities to be determined by DHCS.	FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up FUM - Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow up	01/01/26	09/30/26				
CA-0251	Care Coordination/Member Engagement	Medicaid (All Counties)	Adrianna Shoji, Program Manager III, Miriam Rosales, Program Manager III, Quality Improvement	Ongoing Monitoring Activities: NCQA Continuity of Care Reports	Monitor opportunities and interventions for NCQA QI 3 & QI 4 according to NCQA accreditation timelines.	APP - First-Line Psychosocial Care FUA - Follow-Up After Emergency Department Visit for Substance Use FUH - Follow-Up After Hospitalization for Mental Illness FUI - Follow-Up After High-Intensity Care for Substance Use Disorder FUM - Follow-Up After Emergency Department Visit for Mental Illness IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment PPC-P - Prenatal and Postpartum Care—Postpartum Care PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0320	Compliance	Medicaid (Fresno)	Denise Miller, Program Manager III, Vendor Performance Management	Ongoing Monitoring Activities: Disease/Chronic Conditions Management	Monitor Chronic Conditions (Disease) Management Program for appropriate member outreach quarterly.	No Associated Measure	01/01/26	12/31/26				
CA-0316	Compliance	Medicaid (Fresno)	Karen Bowling, Sr. Manager, Delegation Oversight	Ongoing Monitoring Activities: PPG Delegates Credentialing/ Recredentialing Oversight	PPG Delegates Credentialing/ Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	No Associated Measure	01/01/26	12/31/26				
CA-0339	Compliance Health Education/ Wellness Preventative Care Quality	Medicaid (All Counties)	Kimberly Greaney-Macsicza, Director, Clinical Programs	Ongoing Monitoring Activities: Clinical Practice Guidelines	Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	No Associated Measure	01/01/26	06/30/25				
CA-0356	Credentialing/ Recredentialing	Medicaid (All Counties)	Pamela Carpenter, Director, Clinical Support Services	Ongoing Monitoring Activities: Credentialing	Monitor credentialing findings and report to CalViva Credentialing Sub Committee quarterly.	No Associated Measure	01/01/26	12/31/26				
CA-0197	QUALITY AND SAFETY OF CARE AND SERVICE	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Leticia Carrera, Senior Director, Appeals and Grievances	Ongoing Monitoring Activities: Handling of Member Appeals and Grievances	Ongoing monitoring and assessment of compliance with the handling of member grievances and appeals; ensure compliance with regulatory requirements for TAT and process.	No Associated Measure	01/01/26	12/31/26				
CA-0326	Quality and Safety of Care and Service	Medicaid (Fresno)	Amy Schneider, CalViva Sr. Director, Medical Management, Leticia Carrera, Senior Director, Appeals and Grievances	Ongoing Monitoring Activities: Handling of Member Grievances and Appeals:	Ongoing monitoring and assessment of compliance with the handling of member grievances and appeals; ensure compliance with regulatory requirements for TAT and process.	No Associated Measure	01/01/26	12/31/26				
CA-0362	QUALITY AND SAFETY OF CARE AND SERVICE	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Pamela Carpenter, Director, Clinical Support Services	Ongoing Monitoring Activities: A&G Quality of Care Concerns	Update Clinical A&G Quality of Care Concerns Policy & Procedure and Peer Review Committee Policy & Procedure.	No Associated Measure	01/01/26	12/31/26				
CA-0324	Quality and Safety of Care and Service	Medicaid (Fresno)	Anastassia Tonkogolosuk, Sr. Manager, Ethics and Compliance, Karen Bowling, Sr. Manager, Delegation Oversight	Ongoing Monitoring Activities: PPG Delegates Compliance Oversight	Monitor PPG-level delegated activities and issues, including CAPs, and report findings to CalViva Credentialling Sub Committee and QIUM Committee at least annually. Activities include Utilization Management, including CCM; credentialing; and claims payments.	No Associated Measure	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0331	Quality and Safety of Care and Service	Medicaid (Fresno)	Carrie-Lee Patnaude, Director, Care Management	Ongoing Monitoring Activities: Integrated Care Management	Integrated Care Management • Implement PHM pyramid as the predictive modeling tool to identify high-risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	No Associated Measure	01/01/26	12/31/26				
CA-0365	QUALITY AND SAFETY OF CARE AND SERVICE	Medicaid (All Counties)	Pamela Carpenter, Director, Clinical Support Services	Ongoing Monitoring Activities: Potential Quality Issues (PQI)	Monitor potential quality incidents (PQI) and quality of care (QOC) findings and report to CalViva quarterly. Complete all PQIs/QOCs received thin 90 day TAT to maintain internal compliance.	No Associated Measure	01/01/26	12/31/26				
CA-0357	QUALITY AND SAFETY OF CARE AND SERVICE	Medicaid (All Counties)	Pamela Carpenter, Director, Clinical Support Services	Ongoing Monitoring Activities: Peer Review	Monitor peer review determinations and report to CalViva Credentialing Sub Committee quarterly.	No Associated Measure	01/01/26	12/31/26				
CA-0399	Quality Improvement and Compliance	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Jamie Spears, Manager, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Lynn Pak, Senior Manager, Quality Improvement, Maya Marmo, Director, Data Analytics, Sharon Rushing, Shekinah Wright, Taline Jaghasspanian, Sr. Director, Quality Improvement	Ongoing Monitoring Activities: QIHEd and Wellness Program Work Plan and Evaluations	Evaluation of the QIHEd and Wellness program of the previous year (Q1). Complete QI Work Plan evaluation semi-annually.	No Associated Measure	01/01/26	09/30/26				
CA-0400	Quality Improvement and Compliance	Medicaid (All Counties)	Amy Schneider, CalViva Sr. Director, Medical Management, Juli Coulthurst, Program Manager III, Justina Felix, Sr. Health Education Specialist, Quality Improvement, Linda Armbruster, Quality Improvement Specialist, Pamela Carpenter, Director, Clinical Support Services, Shekinah Wright, Director, Quality Improvement	Ongoing Monitoring Activities: Lead Screening Compliance	Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016, including anticipatory guidance. Quarterly monitoring of HEDIS Lead Screening for Children (LSC.) Member education materials include preventive service guidelines (PSGs); Provider training and education include the Medi-Cal provider operations manual and HEDIS provider tools on Lead Screening for Children (LSC). Medical Record Reviews for lead screening conducted during Facility Site Reviews submitted to DHCS twice a year.	LSC - Lead Screening in Children	01/01/26	09/30/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0389	Quality Improvement and Compliance	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement, Sharon Rushing, Sr. Manager, Quality Improvement	Ongoing Monitoring Activities: Safety and Quality Plan	Evaluate written plan for safety and quality data collection: To improve patient safety by collecting and providing information on provider and practitioner safety and quality (at least annually).	No Associated Measure	01/01/26	12/31/26				
CA-0368	Quality Improvement and Compliance	Medicaid (All Counties)	Pamela Carpenter, Director, Clinical Support Services	Ongoing Monitoring Activities: Facility Site Reviews and Medical Record Reviews	Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure provider offices and medical records comply with DHCS contracted requirements per APL 22-107 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023. Report FSR/MRR data to DHCS twice per year (1/31 and 7/31), including all sites with failed scores.	No Associated Measure	01/01/26	12/31/26				
CA-0383	Quality Improvement and Infastructure	Medicaid (All Counties)	Donald Melhouse, Healthcare Informatics Program Manager	Ongoing Monitoring Activities: HEDIS Care Gap Reports	Produce weekly HEDIS care gap reports, by contract level and participating provider group (PPG) level to identify non-compliant members.	No Associated Measure	01/01/26	12/31/26				
CA-0380	Quality Improvement and Infastructure	Medicaid (All Counties)	Shekinah Wright, Director, Quality Improvement	Ongoing Monitoring Activities: HEDIS Best Practices Tools	Support development of HEDIS best practice tools.	No Associated Measure	01/01/26	12/31/26				
CA-0377	Quality Improvement and Infastructure	Medicaid (All Counties)	Steven Myers, Sr Manager, Provider Engagement Strategy	Ongoing Monitoring Activities: Cozeva Adoption	Encourage further Cozeva adoption/usage among PCPs and provider groups in program's 5th year; Expand Cozeva-EHR integrations and bidirectional data-sharing with priority PCP/clinics; Enhance Cozeva platform to support regulatory requirements and key opportunities / initiatives.	No Associated Measure	01/01/26	12/31/26				
CA-0423	Wellness/Preventive Health	Medicaid (All Counties)	Anabel Jayme, Program Manager II, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Shekinah Wright, Director, Quality Improvement	Ongoing Monitoring Activities: Health Education Materials Managerment	Manage Health Education materials.	No Associated Measure	01/01/26	12/31/26				
CA-0426	Wellness/Preventive Health	Medicaid (All Counties)	Anabel Jayme, Program Manager II, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Shekinah Wright, Director, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Health Education Program	Health Education System P&Ps, monitoring of initiatives, maintenance of printed materials, digital programs and requirements, health promotion to providers.	No Associated Measure	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0410	Wellness/Preventive Health	Medicaid (All Counties)	Arzoo Mojadedi, Sr. Health Education Specialist, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Vendor Onboarding	New vendor onboarding and ongoing management to provide Diabetes Prevention Program (DPP) services to our eligible Medi-Cal population.	No Associated Measure	01/01/26	12/31/26				
CA-0435	Wellness/Preventive Health	Medicaid (All Counties)	Carrie-Lee Patnaude, Director, Care Management, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Pregnancy Program	Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	No Associated Measure	01/01/26	12/31/26				
CA-0414	Wellness/Preventive Health	Medicaid (All Counties)	Justina Felix, Sr. Health Education Specialist, Quality Improvement	Ongoing Monitoring Activities: Preventive Screening Guidelines	Distribute and/or make available Preventive Screening Guidelines (PSG) to Members and Providers.	No Associated Measure	01/01/26	12/31/26				
CA-0407	Wellness/Preventive Health	Medicaid (All Counties)	Kristen Kaila, Senior Health Education Specialist, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Member Newsletter	Member newsletter- Supports NCQA guidelines that requires specific member communication to be mailed to members' homes.	No Associated Measure	01/01/26	12/31/26				
CA-0420	Wellness/Preventive Health	Medicaid (All Counties)	Maria Lin, Program Manager II, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	Ongoing Monitoring Activities: Health Education Program and Services Flyer	Distribute the Health Education Programs and Services Flyer to members via the Medi-Cal member welcome packet.	No Associated Measure	01/01/26	12/31/26				
CA-0545	Behavioral Health	Medicaid (Fresno Kings Madera)	Adrianna Shoji, Program Manager III, Quality Improvement	CalViva outreach following discharge from emergency department (FUA/FUM)	Conduct telephone contacts to members by outreach team following a member being discharged from a hospital for mental illness utilizing the Admit, Transfer, and Discharge (ADT) report.	FUA - Follow-Up After Emergency Department Visit for Substance Use FUM - Follow-Up After Emergency Department Visit for Mental Illness	01/01/26	12/31/26				
CA-0305	Behavioral Health	Medicaid (All Counties)	Maria Lin, Program Manager II	CalViva Health Teladoc PSV (Primary Source Verification) - DSF	Complete and assure the CalViva Health PHQ9 data from Teladoc be approved by PSV auditors so it can be used as a supplemental data source to improve HEDIS DSF-E.	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0297	Behavioral Health	Medicaid (All Counties)	Maria Lin, Program Manager II	CalViva Health Teladoc Mental Health Digital Program Implementation	Implement the Teladoc Mental Health Digital Program and provide oversight and overall management of the program.	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults	01/01/26	12/31/26				
CA-0561	Behavioral Health	Medicaid (Fresno Madera)	Rhonda Dick, Sr. Quality Improvement Specialist	DHCS Non-Clinical PIP: Behavioral Health	CalViva Performance Improvement Project: Improve the percentage of provider notifications for members with SUD/MH diagnosis following or within 7 days of an emergency department (ED) visit in Fresno and Madera Counties. (2026). 1st Intervention Coding Education updated to include Smart Phrases; 2nd Intervention: Cultural Competency training; 3rd Intervention: Resiliency Center for referrals for first responders-goal of Resiliency Center to become a CalAIM provider for enhanced care management (ECM).	FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up FUM - Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow up	01/01/26	08/07/26				
CA-0583	Care Coordination/Member Engagement	Medicaid (Fresno Kings Madera)	Linda Armbruster, Quality Improvement Specialist	CVH: Initial Health Appointments (IHA) Low Performing Providers	Identify quarterly low-performing IHA providers with QIRA and collaborate with Provider Engagement on targeted training and support.	IHA - Initial Health Appointments	01/01/26	12/31/26				
CA-0539	Care Coordination/Member Engagement	Medicaid (Fresno Kings Madera)	Linda Armbruster, Quality Improvement Specialist	CalViva Initial Health Appointments (IHA) Quarterly Reporting	Provide quarterly updates to report on IHA rates and status to stakeholder committee members.	IHA - Initial Health Appointments	01/01/26	12/31/26				
CA-0266	Care Coordination/Member Engagement	Medicaid (All Counties)	Juli Coulthurst, Program Manager III, Quality Improvement	Ongoing Monitoring Activities: Well-Child Visits Provider Education	Educate providers on importance of well-child visits. Well-child visits include developmental screenings.	IHA - Initial Health Appointments	01/01/26	12/31/26				
CA-0682	Chronic Conditions	Medicaid (Fresno Kings Madera)	Arzoo Mojadedi, Sr. Health Education Specialist, Quality Improvement, Gigi Mathew, Program Manager III, Quality Improvement, Martha Zuniga, Sr. Quality Improvement Specialist	Sprinter Health Engagement - CBP	Member outreach campaign to provide in-home blood pressure readings to help close the CBP gap to be conducted by Sprinter Health.	CBP - Controlling High Blood Pressure	01/01/26	12/31/26				
CA-0618	Chronic Conditions	Medicaid (Fresno Kings Madera)	Gigi Mathew, Program Manager III, Quality Improvement	Abbott Diabetes Care Pilot	Pilot initially Medi-Cal targeting providers whose members have uncontrolled A1c. The pilot includes educational outreach to providers, onboarding to LibreView platform, and integrate continuous glucose monitoring (CGM) data into the electronic health record (EHR).	GSD - Glycemic Status Assessment for Patients with Diabetes GSD - Glycemic Status Assessment for Patients with Diabetes (Glycemic Status < 8%) GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0457	Chronic Conditions	Medicaid (All Counties)	Martha Zuniga, Sr. Quality Improvement Specialist	Direct Mail Kits for Blood Glucose (HbAc/A1c) - CVH-All	Outreach campaign to support members that may be due for an A1c (A1c kit). Quality Improvement (QI) is partnering with the vendor, Simple HealthKits, to directly mail A1c Kits (to support an A1c home test).	GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)	01/01/26	12/31/26				
CA-0313	Credentialing/ Recredentialing	Medicaid (Fresno)	Michael Catello, Sr. Manager, Quality Improvement	Ongoing Monitoring Activities: Credentialing/ Recredentialing Practitioners/Providers	Achieve and maintain a 100% timely compliance and 100% accuracy score.	No Associated Measure	01/01/26	12/31/26				
CA-0352	Health Education/Wellness	Medicaid (All Counties)	Brittany Head, Program Manager II, Quality Improvement, Lora Maloof-Miller, Program Manager II, Quality Improvement, Maria Lin, Program Manager II	Digital Health Education Resources to Support Patients	Promote Krames and nationally credible health education resources that providers can effectively share with their patients. This PowerPoint will encompass a broad spectrum of health-related topics, which also includes addressing topics that support various measures.	AMR - Asthma Medication Ratio, CAHPS / AFV - Annual Flu Vaccine, CBP - Controlling High Blood Pressure, CCS-E - Cervical Cancer Screening, CIS - Childhood Immunization Status, CIS-E (10) - Childhood Immunization Status Combination 10, CIS-E (3) - Childhood Immunization Status Combination 3, COA - Care for Older Adults, COU - Risk of Continued Opioid Use, DEV-CH - Developmental Screening in the First Three Years of Life, DIAB / PDC - Adherence to Diabetes Medications, EED - Eye Exam for Patients with Diabetes, FRM - Fall Risk Management, HBD - Hemoglobin A1c Control for Patients with Diabetes - HbA1c Control (>9%), IBC - Improving Bladder Control, IMA-E - Immunizations for Adolescents, IMPH - Improving or Maintaining Physical Health, LSC - Lead Screening in Children, MPA - Monitoring Physical Activity, OSW - Osteoporosis Screening in Older Women, PAO - Physical Activity in Older Adults, PBH - Persistence of Beta-Blocker Treatment After a Heart Attack, PPC - Prenatal and Postpartum Care, RRF - Reducing the Risk of Falling, SPD - Statin Therapy for Patients With Diabetes, STAT / PDC - Adherence to Cholesterol Medication (Statins), TFC - Topical Fluoride for Children, W30 - Well Child Visits in the First 30 Months of Life, WCV - Child and Adolescent Well-Care Visits	02/02/26	12/31/26				
CA-0396	Health Education/Wellness	Medicaid (All Counties)	Justina Felix, Sr. Health Education Specialist, Quality Improvement	Kick It California (KIC) - Smoking Cessation Services	Explore expanding partnership with KIC to outreach to members to facilitate program utilization and offer Nicotine Replacement Therapy (NRT) kits. Health plan will initiate outreach using notification letter to member prior to KIC outreaching to members. Contracts will need to be updated (SOW, BAA, MSA, IRQ Form etc.).	CAHPS / MSC - Medical Assistance With Smoking and Tobacco Use Cessation	01/01/26	12/31/26			N/A	
CA-0487	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Hospital outreach about patient safety	Outreach to hospitals about patient safety metrics, standards/expectations, and opportunities to improve. Focus on metrics and reports including hospital acquired infections, sepsis management, the Patient Safety Honor Roll, and the Opioid Care Honor Roll.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0473	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Participation on Leapfrog Partners Advisory Committee	Participate in Leapfrog's Partners Advisory Committee (serving as co-chair) and related activities.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0472	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Engagement with external collaboratives to promote hospital quality: California Maternal Quality Care Collaborative (CMQCC)	Collaborate with the CMQCC to coordinate and consult on improving hospital maternal health metrics.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0469	Hospital Quality/Patient Safety	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Participation on Leapfrog Committees and Events: Data Users Group	Member of Data Users Group. Coordinate with Leapfrog to promote their surveys and findings to encourage improvement on key metrics by network hospitals.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0467	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Engagement with external collaboratives to promote hospital quality: Health Services Advisory Group (HSAG)	Collaborate with Health Services Advisory Group to support our hospitals with QI resources and provide them with technical guidance on how to improve their performance on priority measures.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0466	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Hospital outreach about C-section overuse and maternal health issues	Conduct outreach to hospitals about C-section overuse, standards/expectations, and opportunities to improve. Includes focus on maternal health equity.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0461	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Collaboration with Hospital Quality Institute (HQI) on custom hospital quality performance tools	Collaborate with HQI on performance tools for use by internal quality and contracting staff. Features individual hospital performance and trends on priority metrics in areas including patient safety, maternal health, patient experience, and readmissions.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0449	HOSPITAL QUALITY/PATIENT SAFETY	Medicaid (All Counties)	Barbara Wentworth, Program Manager III, Quality Improvement	Participation on Leapfrog Partners Advisory Committee	Participate in Leapfrog's Partners Advisory Committee (serving as co-chair) and related activities.	HPQI - Health Plan Quality Improvement	01/01/26	12/31/26				
CA-0521	Maternal Health/Hospital/Patient Safety	Medicaid (All Counties)	Barbara Wentworth	CVH Confirmation of Pregnancy in Cozeva	Work with the Cozeva team to set up a feature/function for PCP users to indicate member's early pregnancy.	PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care	01/01/26	12/31/26				
CA-0629	Maternal Health/Hospital/Patient Safety	Medicaid (All Counties)	Meena Dhonchak, Senior Quality Improvement Specialist	PPC Workgroup (CVH)	Explore data solutions for the PPC measures converting to admin only in MY 2028.	PPC - Prenatal and Postpartum Care PPC-P - Prenatal and Postpartum Care—Postpartum Care PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care	01/01/26	12/31/26				
CA-0664	Maternal Health/Hospital/Patient Safety	Medicaid (Fresno Kings Madera)	Meena Dhonchak, Senior Quality Improvement Specialist	Covered CA PPC Compliance Maternal Health Equity Resources and Trainings: Implicit Bias Training (CVH)	Provide implicit bias training to OB providers. Provide maternal health equity resources and training links for providers. Contract extended until 3/31/2026 with Dr. Sayida Peprah-Wilson. Includes provider updates.	PPC - Prenatal and Postpartum Care PPC-P - Prenatal and Postpartum Care—Postpartum Care PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care PDS-E - Postpartum Depression Screening PND-e - Prenatal Depression Screening	01/01/26	03/31/26				
CA-0668	Maternal Health/Hospital/Patient Safety Pediatric/Dental	Medicaid (Fresno Kings Madera)	Meena Dhonchak, Senior Quality Improvement Specialist	Distribution of the Newborn Checklist (CVH)	Distribute the updated Newborn Checklist to CalViva Health counties	PPC - Prenatal and Postpartum Care PPC-P - Prenatal and Postpartum Care—Postpartum Care PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care W30 - Well Child Visits in the First 30 Months of Life W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months	01/01/26	12/31/26				
CA-0530	Member Experience	Medicaid (All Counties)	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	Flu Tip Sheet	Update flu tip sheet best practices as needed for providers to implement them in their practice for a more successful approach.	AIS-E - Adult Immunization Status - Influenza	06/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0524	Member Experience	Medicaid (All Counties)	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	CAHPS Provider Playbook	Revise CAHPS provider playbook best practices captured in one resource for providers to utilize and improve CAHPS measures.	CAHPS - All CAHPS Measures	01/01/26	12/31/26				
CA-0278	Member Experience	Medicaid (All Counties)	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	Fluvention Campaign	Review and monitor multi-channel campaign deployed by Corporate for flu prevention. Campaign includes emails, IVR on-hold messages, web page/messaging, and POM calls.	CAHPS / AFV - Annual Flu Vaccine	04/30/26	03/30/27				
CA-0335	Member Experience	Medicaid (All Counties)	Matthew Anderson, Program Manager III, Quality Improvement	Ongoing Monitoring Activities: CAHPS Stakeholder Meetings	QI improves communication with stakeholder departments and identifies interventions to improve CAHPS through monthly Quality Focus Touchbase meetings and Quality Governance Committee meetings.	CAHPS - All CAHPS Measures	01/01/26	12/31/26				
CA-0269	Member Experience	Medicaid (All Counties)	Matthew Anderson, Program Manager III, Quality Improvement	CAHPS Provider Training Series via Sullivan Group	Offer physician-led webinar trainings; topics will focus on improving provider communication and access.	CAHPS / GCQ / ZGCQ - Getting Care Quickly (Adult) CAHPS / GCQ / ZGCQ - Getting Care Quickly (Child) CAHPS / RHP / ZHPL - Rating of Health Plan (Adult) CAHPS / RHP / ZHPL - Rating of Health Plan (Child)	01/01/26	04/30/26				
CA-0555	Multi-Gap/Operations	Medicaid (All Counties)	Ana Sem, Program Manager II	Care Gap Cozeva Contact Tracking	Load care gap campaign calls into Cozeva monthly.	BCS-E - Breast Cancer Screening CBP - Controlling High Blood Pressure CCS-E - Cervical Cancer Screening CIS-E (10) - Childhood Immunization Status Combination 10 COL-E - Colorectal Cancer Screening GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9) IMA-E - Immunizations for Adolescents W30 - Well Child Visits in the First 30 Months of Life WCV - Child and Adolescent Well-Care Visits	02/02/26	12/31/26				
CA-0355	Multi-Gap/Operations Pediatric/Dental	Medicaid (Fresno Kings)	Brittany Head, Program Manager II, Quality Improvement	Q1 MCL Gap Calls - CVH	Member with WCV not completed in the prior year will get a call in Q1 encouraging gap closure by seeing provider.	BCS-E - Breast Cancer Screening CIS - Childhood Immunization Status CIS-E (10) - Childhood Immunization Status Combination 10 IMA-E - Immunizations for Adolescents IMA - Immunizations for Adolescents Combo 2 WCV - Child and Adolescent Well-Care Visits	01/12/26	04/30/26				
CA-0350	Pediatric/Dental	Medicaid (All Counties)	Linda Armbruster, Quality Improvement Specialist	Lead Blood Screening Provider Member Gap List	Quarterly lead blood screening provider member gap list for members who have not completed lead blood screening by age 1, age 2 or by age 6.	LSC - Lead Screening in Children	06/01/26	12/31/26				
CA-0347	Pediatric/Dental	Medicaid (All Counties)	Linda Armbruster, Quality Improvement Specialist	Lead Blood Screening Anticipatory Guidance Member Flyer and Cover letter	Mail Protect your Child from Lead: anticipatory guidance flyer to members under age 6 annually.	LSC - Lead Screening in Children	06/01/26	12/31/26				
CA-0507	Pediatric/Dental	Medicaid (All Counties)	Arpitha Banaji, brittany.head@healthnet.com	(CVH) Corporate Monthly Birthday Proactive Outreach Message (POM) for Members 3-17 Years	Monitor and report outcomes of the corporate monthly birthday POM messaging to parents of 3 to 17 year old members to schedule and complete their annual well child visit (WCV).	CIS-E (10) - Childhood Immunization Status Combination 10 WCV - Child and Adolescent Well-Care Visits	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0441	Pediatric/Dental	Medicaid (All Counties)	Arpitha Banaji, brittany.head@healthnet.com	(CVH) Corporate Quarterly Proactive Outreach Message (POM) for Members 2-28 Months	Configure the quarterly corporate POMs campaign data for members 2-28 months of age for QI reporting.	CIS-E (10) - Childhood Immunization Status Combination 10 W30 - Well Child Visits in the First 30 Months of Life W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	01/01/26	12/31/26				
CA-0513	Pediatric/Dental	Medicaid (All Counties)	Arpitha Banaji, Quality Improvement Specialist Senior, Brittany Head, Program Manager II, Quality Improvement	(CVH) Pfizer 1st Birthday IVR Only (Well-Visit)	Sends IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1-year checkup.	WCV - Child and Adolescent Well-Care Visits	01/01/26	12/31/26				
CA-0501	Pediatric/Dental	Medicaid (All Counties)	Arpitha Banaji, Quality Improvement Specialist Senior, Brittany Head, Program Manager II, Quality Improvement	(CVH) Pfizer Missed Dose IVR Only	Sends IVR phone messages to parents of children at ages 6 months, 8 months, and 16 months to remind them they may have missed a vaccine shot.	CIS-E (10) - Childhood Immunization Status Combination 10	01/01/26	12/31/26				
CA-0653	Pediatric/Dental	Medicaid (Fresno)	Arpitha Banaji, Quality Improvement Specialist Senior, Meena Dhonchak, Senior Quality Improvement Specialist	CVH W30-6+ Health Disparity PIP	CalViva Health W30-6+ Disparity PIP: DHCS has assigned to CalViva for 2023 thru 2026, a performance improvement project. The topic is infant well care visits targeting improvements in the Black/African American population.	W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	01/01/26	08/31/26				
CA-0624	Pediatric/Dental	Medicaid (All Counties)	Brittany Head, Program Manager II, Quality Improvement, Juli Coulthurst, Program Manager III	First Year of Life (Integration)	Focus on well-care visits and immunizations. Comprehensive and robust program that supports children through their first year of life, includes education, care coordination. This will likely replace concierge calls, and those not enrolled in this program will get a concierge call.	CIS-E (10) - Childhood Immunization Status Combination 10 W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	02/02/26	12/31/26				
CA-0606	Pediatric/Dental	Medicaid (Fresno Kings Madera)	Brittany Head, Program Manager II, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	Power Automate Outreach Email	Email (PAD) outreach to providers for patients that are missing one and/ or both flu shot for children 6 months - 2years.	CIS-E (10) - Childhood Immunization Status Combination 10	01/06/26	04/30/26				
CA-0567	Pediatric/Dental	Medicaid (All Counties)	Juli Coulthurst, Program Manager III, Quality Improvement	PE training and QFT (Quality Focus Touchbase) for all pediatric and dental HEDIS Measures for MY 2026	QI Program Manager to train Provider Engagement on MY 2026 pediatric, perinatal and dental HEDIS measures. Review action items the Provider Engagement will need to take to improve rates.	CIS-E (10) - Childhood Immunization Status Combination 10 DEV-CH - Developmental Screening in the First Three Years of Life IMA - Immunizations for Adolescents Combo 2 LSC - Lead Screening in Children W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months WCV - Child and Adolescent Well-Care Visits	01/01/26	12/31/26				
CA-0573	Pediatric/Dental	Medicaid (Fresno Kings Madera)	Juli Coulthurst, Program Manager III, Quality Improvement	Pediatric/Dental MY 2026 HEDIS Tip Sheets	Update and rebrand any pediatric or dental HEDIS provider tip sheets as needed per MY 2026 technical specifications.	CIS-E (10) - Childhood Immunization Status Combination 10 DEV-CH - Developmental Screening in the First Three Years of Life IMA - Immunizations for Adolescents Combo 2 LSC - Lead Screening in Children TFC - Topical Fluoride for Children W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months WCV - Child and Adolescent Well-Care Visits	01/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0661	Pediatric/Dental	Medicaid (Fresno Kings Madera)	Meena Dhonchak, Senior Quality Improvement Specialist	Promote CDC'S Milestone Tracker App (CVH)	Promote the CDC's Milestone Tracker App by promoting in future newsletters, website locations, adding QR codes to our Provider QR resource, promote it to CalViva's Health Pregnancy and First Year of Life programs, etc. CDC's Milestone Tracker App is currently being promoted to the high volume W30-6+ providers and BIH Fresno Members.	CIS - Childhood Immunization Status CIS-E (10) - Childhood Immunization Status Combination 10 CIS-E (3) - Childhood Immunization Status Combination 3 W30 - Well Child Visits in the First 30 Months of Life W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months WCV - Child and Adolescent Well-Care Visits	01/01/26	12/31/26				
CA-0658	Pediatric/Dental	Medicaid (Fresno)	Meena Dhonchak, Senior Quality Improvement Specialist	CVH W30-6+ PIP: Referrals to BIH Fresno	CalViva Health Referrals to Black Infant Health (BIH) Fresno for the PIP	W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	01/01/26	08/30/26				
CA-0657	Pediatric/Dental	Medicaid (Fresno)	Meena Dhonchak, Senior Quality Improvement Specialist	CVH W30-6+ PIP: Member Incentives	Provide member incentives to BIH Fresno for member participation in the Prenatal and Postpartum group sessions for the PIP.	W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	01/01/26	08/30/26				
CA-0655	Pediatric/Dental	Medicaid (Fresno)	Meena Dhonchak, Senior Quality Improvement Specialist	CVH W30-6+ PIP: Provider Webinar	CalViva Health x BIH Fresno Provider Webinar for the PIP	W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months	02/12/26	02/12/26				
CA-0376	Pediatric/Dental	Medicaid (Fresno Kings Madera)	Wendy Hernandez, Senior Quality Improvement Specialist	Calviva Health Quarterly Dental Proactive Outreach Manager (POM)	Implement Dental POM calls to CalViva Health members to promote dental checkup and topical fluoride applications.	TFC - Topical Fluoride for Children	01/01/26	12/31/26				
CA-0353	Pediatric/Dental	Medicaid (Fresno Kings Madera)	Wendy Hernandez, Senior Quality Improvement Specialist	COZEVA Provider Outreach	COZEVA push notifications will be sent to provider offices, asking about member's gaps for measures. Gap will be utilized from COZEVA.	CIS - Childhood Immunization Status	01/12/26	12/31/26				
CA-0296	Pediatrics/Adolescents	Medicaid (Fresno)	Amy Schneider, CalViva Sr. Director, Medical Management, Arpitha Banaji, Quality Improvement Specialist Senior, Naomi Lam, Program Manager II, Quality Improvement	2026 CalViva Health Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative (CHEC) Sprint Phase 2	Participate in a 12 month collaborative project to implement IHI interventions with a pilot site to improve WCV completion and related activities.	CIS-E (10) - Childhood Immunization Status Combination 10 DEV-CH - Developmental Screening in the First Three Years of Life LSC - Lead Screening in Children W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months	01/01/26	09/30/26				
CA-0639	Preventative Care	Medicaid (All Counties)	Elisa Stomski, Quality Improvement Specialist Senior, Michelle Cai, Quality Improvement Specialist, Sr., Ravneet Gill, Program Manager III, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	Me+U Text Campaign - BCS, CCS, COL	Launch a targeted text campaign designed to remind and encourage members to complete recommended breast, cervical, and/or colorectal cancer screenings.	BCS-E - Breast Cancer Screening CCS-E - Cervical Cancer Screening COL-E - Colorectal Cancer Screening	03/01/26	12/31/26				

Unique ID	Pod	LOB	Initiative Point of Contact	Intervention Name	Intervention Description	Measure(s) Impacted	Start Date	End Date	Mid-Year Outcome	Year-End Outcomes	Opportunities / Barriers	Activity Change for Following Year
CA-0645	Preventative Care	Medicaid (All Counties)	Justina Felix, Sr. Health Education Specialist, Quality Improvement, Michelle Cai, Quality Improvement Specialist, Sr., Ravneet Gill, Program Manager III, Quality Improvement	Modality Equity Analysis	Analyze colorectal cancer screening modality use across populations to identify inequities and implement strategies that ensure equitable access, informed choice, and timely follow-up for all screening options.	COL-E - Colorectal Cancer Screening	01/01/26	12/31/26				
CA-0612	Preventative Care	Medicaid (All Counties)	Justina Felix, Sr. Health Education Specialist, Quality Improvement, Ravneet Gill, Program Manager III, Quality Improvement	Exact Sciences Cologuard Letter	This is a partnership with Exact Sciences who will outreach to Medi-Cal members and inform them of the importance of colorectal cancer screening via a letter. There are five versions to the letter: Asian American, Black American, Hispanic, general, and Native American. At or around the time Cologuard order is placed, Exact Sciences will also mail the Cologuard kits to members.	COL-E - Colorectal Cancer Screening	01/01/26	06/30/26				
CA-0649	Preventative Care	Medicaid (All Counties)	Michelle Cai, Quality Improvement Specialist, Sr.	High Risk COL-E	Identify members high-risk for COL-E and share actionable lists with providers to support targeted follow-up and care coodination	COL-E - Colorectal Cancer Screening	01/26/26	04/30/26				
CA-0637	Preventative Care	Medicaid (All Counties)	Rahma Abdillah, Project Manager III, Quality Improvement, Ravneet Gill, Program Manager III, Quality Improvement	Preventative Care - Provider Tip Sheets	Develop or update tip sheets to reflect updated measure guidelines, coding, and best practices	BCS-E - Breast Cancer Screening CCS-E - Cervical Cancer Screening COL-E - Colorectal Cancer Screening	01/01/26	12/31/26				
CA-0643	Preventative Care	Medicaid (Fresno Madera)	Rahma Abdillah, Project Manager III, Quality Improvement, Ravneet Gill, Program Manager III, Quality Improvement	Mobile Mammography Program	Increase access to breast cancer screening services, especially for individuals who have limited access to traditional healthcare facilities, including those in rural and underserved communities. By partnering with clinics to host on-site screening events, the program expands access and help close gaps in preventative care.	BCS-E - Breast Cancer Screening	01/01/26	12/31/26				
CA-0599	Preventative Care	Commercial Marketplace Medicaid (Fresno Kings Madera)	Ravneet Gill, Program Manager III, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	High Risk BSC-E	Identify members high-risk for BCS-E and share actionable lists with providers to support targeted follow-up and care coodination	BCS-E - Breast Cancer Screening	01/26/26	04/30/26				
CA-0633	Preventative Care	Medicaid (Fresno Kings Madera)	Ravneet Gill, Program Manager III, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	Mammogram Facility Incentive Program (MFIP) Projects	Implement multiple e-projects to promote and launch MFIP, including: - Email announcement sent to provider groups about MFIP (via Power Automate) - Develop opt-in survey for interested radiology facilities - MFIP launch webinar, required attendance for interested provider groups.	BCS-E - Breast Cancer Screening	02/02/26	12/31/26				

Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

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

Date

Item #9
Attachment 9.A-B

2026 Utilization Management

- 2026 Program Description & Change Summary
- 2026 Work Plan

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Abey Mathew, Utilization Management

COMMITTEE DATE: March 19, 2026

SUBJECT: Utilization Management Program Description Change Summary

Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Updated year from 2025 to 2026
Throughout	Multiple	Grammatical and formatting edits for readability
ii-iii	Table of Contents	Page numbering and section headers updated to align with content
10	Scope of Utilization Management	Removed Managed Risk Medical Insurance Board
11-12	Preauthorization / Prior Authorization	Updated decisions about following required medical necessity review. Also, added services related to the California prenatal screening program.
18	Behavioral Health Care Services	Behavioral health utilization management decisions follow Centene Clinical Policy and evidence-based guidelines from recognized professional organizations. To ensure consistent application of these criteria, all Behavioral Health Utilization Review Clinicians complete annual Inter-Rater Reliability (IRR) testing.
26	Utilization Decision Criteria	**Updated the most recent locations for mental health and substance abuse**
38	Health Net UM Clinical Staff	Added referral of Members to CalAIM Community Supports
48	Signature page	Updated the Vice President of Population Health and Clinical Operations

2026

Deleted: 2025

Health Net Community Solutions, Inc.
CalViva Health
Utilization Management (UM) Program Description

Deleted: February 5, 2025

health net

CalViva HEALTH

TABLE OF CONTENTS

Deleted: 1

Deleted: 1

Deleted: 1

Deleted: 2

Deleted: 2

Deleted: 2

Deleted: 2

Deleted: 3

Deleted: 3

Deleted: 4

Deleted: 4

Deleted: 5

Deleted: 5

Deleted: 5

Deleted: 5

Deleted: 6

Deleted: 7

Deleted: 7

Deleted: 8

Deleted: 8

Deleted: 8

Deleted: 9

Deleted: 9

Deleted: 1110

Deleted: 1312

Deleted: 13

Deleted: 1413

Deleted: 14

Deleted: 14

Deleted: 1514

Deleted: 15

Deleted: 15

Deleted: 1615

Deleted: 1817

Deleted: 18

Deleted: 19

Deleted: 22

Deleted: 2423

Deleted: 2524

Deleted: 2625

Deleted: February 5, 2025

Deleted: 2726
Deleted: 27
Deleted: 2827
Deleted: 2928
Deleted: 29
Deleted: 3029
Deleted: 3029
Deleted: 30
Deleted: 31
Deleted: 31
Deleted: 31
Deleted: 32
Deleted: 32
Deleted: 32
Deleted: 32
Deleted: 32
Deleted: 33
Deleted: 33
Deleted: 33
Deleted: 34
Deleted: 34
Deleted: 35
Deleted: 35
Deleted: 35
Deleted: 35
Deleted: 36
Deleted: 36
Deleted: 3736
Deleted: 38
Deleted: 38
Deleted: 39
Deleted: 39
Deleted: 39
Deleted: 41
Deleted: 41
Deleted: 41
Deleted: 42
Deleted: 42
Deleted: February 5, 2025

Deleted: 43

Deleted: 43

Deleted: *February 5, 2025*

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Section 1

Introduction and Background

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Introduction and Background

Introduction

The CalViva Health Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

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 or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net or CalViva Health.

Deleted: November 24, 2025

Deleted: 6

Deleted:

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, custodial care/long term care, intermediate care facility, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information are regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN staff via the corporate intranet website, “Centene University”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include member and provider feedback.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Section 2

Purpose

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

Mission

Transforming the health of the communities we serve, one person at a time.

Values

Accountability • Courage • Curiosity • Trust • Service

Health Net Community Solutions UM Purpose

The purpose of Health Net's Utilization Management Program is to design and implement programs that facilitate the highest level of the member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the CalViva Health Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary medical and behavioral health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address issues related to access and timeliness of care
- Initiate documentation to support investigation of potential quality of care concerns
- Identify and resolve issues leading to excessive resource utilization and inefficient delivery of health care services
- Identify and resolve issues that result in either underutilization or overutilization of services
- Assess the impact cost containment activities on the quality of care provided
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of members through integration and coordination within PHCO and external Public Health Programs
- Optimize the members' health benefits by linking and coordinating services with appropriate county and state sponsored programs

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Goals and Objectives

The Program has the following specific objectives:

- Ensure consistent application of all UM functions for members
- Review and assess health care services for quality, medical necessity and appropriate levels of care
- Identify and evaluate actual and potential quality issues during the review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and primary care providers(PCPs)
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program regularly to adapt to changes in the health care environment
- Collaborate with county Public Health-Linked Programs to ensure effective care delivery
- Provide equitable access to care by addressing health disparities, such as structural racism, social risks, social determinants of health (SDoH), and specific community needs
- Recommend and implement strategies to eliminate health disparities and improve individual and community health outcomes
- Ensure full compliance with mental health parity requirements, applicable laws, regulations, and accreditation standards, fostering equitable access to mental health services.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Section 3

Description of Program

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed to ensure all members receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program operates under the clinical supervision of the Chief Medical Officer of Health Net, LLC who plays a key role in the development and implementation of the program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities encompasses timely, direct referrals, prior authorization, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code §1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continually enhances its UM Program to ensure effective processes are in place to review and approve the provision of medically necessary covered services. The plan is staffed with qualified professionals who are dedicated to its implementation and oversight.

The plan ensures the separation of medical decision making from fiscal and administrative management, safeguarding against undue influence on medical decisions. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 28 section 1300.67.3 (a) (1) and California Health and Safety code section 1367 (g), except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) All Plan Letters.

Additionally, Health Net's Utilization Management Programs adhere to all applicable requirements set forth by NCQA, CMS, DHCS, and DMHC for Utilization Management and Care Coordination activities.

The Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq.

Deleted: and Managed Risk Medical Insurance Board (MRMIB) …

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Health Net ensures that Utilization Management (UM) policies and procedures are accessible to members and providers upon request.

Health Net Utilization Management nurses play a vital role by providing:

- Decision support and member advocacy,
- Identification and recommendation of alternative plans of care,
- Identification and use of alternative funding and
- Coordination with community resources to support members' plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director.

These services are outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals are designed to enhance the member's ability to access specialists quickly and efficiently.

Preauthorization / Prior Authorization

Health Net requires delegated PPGs to develop and maintain programs, policies and procedures that meet Health Net's established standards. Health Net Utilization Management staff is responsible for making pre-service decisions for request types that are not delegated.

Decisions about the following require medical necessity review:

- Any covered medical benefits defined by the Evidence of Coverage or Summary of Benefits
- Care, items or services whose coverage depends on specific circumstances.
- Out-of-network services, that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- "Experimental" or "investigational" requests covered by the Plan.

Decisions about the following do not require medical necessity review:

- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care, items or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL).

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

- "Experimental" or "investigational" requests that are always excluded and are never covered under any circumstances. In these instances, the Plan identifies the specific service or procedure excluded from the benefits plan.

Pre-service decisions include both the initial determination of requests for both urgent and non-urgent services, as well as requests for continuity of care services. Pre-service decisions are required for:

- Elective inpatient admissions
- Services out of the CalViva Health service area, if not an emergency or urgent care
- Selected ambulatory surgery
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Select durable medical equipment
- Select specialized treatments such as home IV infusion
- Selected diagnostic and radiology procedures
- Medical transportation services when it is not an emergency

The purpose of obtaining a pre-service decision is to evaluate proposed services to ensure they are:

- Medically necessary
- Covered by the member's benefit plan
- The most current and appropriate medical and behavioral health interventions, based on clinical evidence
- Provided by a contracted practitioner or provider, when appropriate
- Delivered in the most appropriate setting.

Health Net, along with its delegated PPGs, does not require prior authorization for the following services or others as required:

- emergency services,
- minor consent services
- adult sensitive care services
    - family planning and birth control including sterilization for adults 21 and older,
    - pregnancy testing and counseling and other pregnancy related services
    - HIV/AIDS prevention and testing
    - sexually transmitted infections prevention testing
    - sexual assault care
    - outpatient abortion services
- preventive services from a participating provider
- basic prenatal care with a participating network obstetrician
- specialist referral (initial referral to participating specialist)
- urgently needed services when the member is outside their county
- certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider

Deleted: November 24, 2025

Deleted: 6

Deleted:

- MOA 638 Indian Health Service facilities
- biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (FDA approved)
- COVID-19 diagnostic and screening testing
- services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule
- initial mental health and substance use disorder assessments
- adult preventive immunizations from a participating physician or other provider
- second opinion from a participating physician or other provider
- Comprehensive Perinatal Services Program (CPSP) services
- Services related to the California Prenatal Screening (PNS) Program

Health Net has established a tracking system to monitor referrals requiring prior authorization. Health Net's authorization tracking system includes authorized, denied, deferred and/or modified authorizations. Additionally, the authorization tracking process ensures the monitoring of timeliness on these decisions.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an ongoing assessment process that determines medical necessity or appropriateness of services as they are provided. It focuses on evaluating the need for continued inpatient care and the continued provision of an approved course of treatment over a period of time or a specific number of treatments. Concurrent review is a member-centric process that involves medical necessity review, discharge and transitional care planning, and coordination of care.

A goal of CCR is to support the member and their healthcare team in optimizing health outcomes, particularly when there is a change in the member's health status. This process is carried out in collaboration with the PPG, the member and the Interdisciplinary Care Team to:

1) Ensure timely access to services
2) Educate the member's healthcare team about the member's benefit structure and resources
3) Facilitate the expedited authorization of services when appropriate
4) Provide referrals to relevant member resources, such as the behavioral health team, care management, and community resources

The CCR nurse plays a key role in ensuring a smooth transition from the acute care setting or Skilled Nursing Facility (SNF) to the next level of care or community services. This is achieved by bridging the inpatient to outpatient process, facilitating healthcare services and supporting member care management programs.
Health Net nurses and Medical Directors along with delegated partners, conduct telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, or skilled nursing facilities. Health Net may also monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

The inpatient review process occurs within one business day from the day of hospital admission or notification of admission and continues throughout the patient's hospital stay. This review process includes:

- The application of standardized nationally recognized criteria for medical appropriateness
- Evaluation of levels of care
- Discharge planning and transitional care management
- Assessment of medically appropriate alternatives to inpatient care

The concurrent review nurses utilize nationally recognized criteria, including InterQual® criteria, Hayes, and Health Net's Medical Hierarchy Policy, to assess the appropriateness of the admission, level of care, and length of stay.

The determination of medical appropriateness takes into account both the individual patient's specific needs and the capacity of the local delivery system, which is particularly important in remote or underserved areas of the state. When necessary, board-certified physician specialists are involved in making medical determinations to ensure accuracy and clinical appropriateness.

Health Net's non-clinical staff plays a supportive role in pre-service and concurrent reviews by handling data entry, receipt and documentation of notifications, and attaching clinical content as needed.

When requests do not meet guidelines or criteria for approval, they are referred to a Health Net Medical Director for a second level case review. During the concurrent review process, nurses assess the member's specific care management needs, disease or chronic condition management. Cases requiring further evaluation are referred to Care Management for a comprehensive review and evaluation. Concurrent Review Nurses also collaborate with Care Managers on all members identified as part of active care management.

The primary goals of CCR include:

1. Supporting the member and their healthcare team to optimize health outcomes, especially when there is a change in member's health status.
2. Advocating on behalf of the member through collaboration with the PPG, member and the interdisciplinary care team to
    a. Ensure timely access to services
    b. Educate the member's healthcare team about the member's benefit structure and available resources,
    c. Facilitate expedited authorization of services when appropriate

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

d. Facilitate referrals to relevant member resources, such as the behavioral health team, care management, and community resources.

The CCRN further supports a smooth transition from the acute care setting or SNF to the next level of care or community. This is achieved by bridging the inpatient to outpatient process through facilitation of healthcare services and member care management support programs.

Discharge Planning

Health Net and/or its delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care, in collaboration with the practitioner, the member, and the member's family, ensuring a safe and timely discharge. Discharge planning begins pre-service or on the first day of the member's admission. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to:

- Home health care
- Durable medical equipment
- Transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation).

HN Concurrent Review nurses also identify potential care management cases and refer them to Care Management and other outpatient programs for post discharge evaluation and/or services.

The criteria used for guiding timely discharge planning include nationally recognized criteria, such as InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) and Health Net's Medical Hierarchy policy. Discharge planning is an integral part of the Utilization/Care Management Program and includes the following elements:

- Assessment of continuity of care, including the identification of Community Supports and Complex Care Management needs
- Assessment of member's support system to determine necessary services and support needs
- Development of a discharge plan of care based on short-term medical and psychosocial needs
- Coordination and implementation of services requested in the plan of care

Post Service/Retrospective Review

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Delegated PPGs conduct post service or retrospective review activities in alignment with Health Net standards. For non-delegated providers, Health Net carries out these activities directly.

Health Net and its delegated partners perform post-service or retrospective review of medical records when services rendered have not been pre-authorized. If services do not meet established criteria, they are forwarded to Health Net and delegated partners' Medical Directors for final determination and recommendations regarding payment adjudication. The purpose of the post-service review is to assess whether the requested services, as for documented in the member's medical records, meet the criteria for medical necessity. Review determinations are made once all required information has been obtained.

Second Opinion

A member, the member's authorized representative, or a provider may request a second opinion for medical, surgical or behavioral health conditions. Typically, PCPs will refer their assigned members to a participating physician within the same medical group for a second opinion. If a member requests a second opinion about specialty care from a participating specialist outside the member's PCP's medical group, the request will be forwarded to Health Net Utilization Management team for review.

Health Net does not routinely require prior authorization for second opinion services, whether the opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, if the member's plan requires prior authorization for these services, the determination will be made promptly, in line with state specific mandates.

The organization ensures the member can obtain a second opinion from an in-network provider or, if necessary, arranges for the member to receive a second opinion from an out of network provider at no cost to the member.

Members may obtain a second opinion from a qualified healthcare professional. If a qualified healthcare professional is not available within the Health Net Network, Health Net will coordinate arrangements for the member to access the second opinion from an out-of-network provider at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to efficiently enter, view, and audit medical management information, ensuring accurate and streamlined data management.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals, and ancillary service providers to deliver high-quality, cost-effective medical services to members and their dependents. The foundation for accessing

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

appropriate healthcare services is the selection of a Primary Care Provider (PCP) and establishment of a strong relationship with that provider. is the

PCPs include:

- Internists
- Family Practitioners
- General Practitioners
- Pediatricians
- Nurse Practitioners
- Women's Health Care Providers (WHCP)

Access / Availability to Health Care Services

Health Net conducts ongoing review of its network to ensure the availability of and access to all required levels of care. The review includes an analysis of the network's scope, including Primary Care Physicians, specialists, facilities and ancillary services in relation to members' healthcare needs.

Key components of the review process include:

- Analyzing the alignment of network resources with members' requirements
- Conducting site reviews and medical record audits to verify compliance with standards for access to care and services, and the confidentiality of member records.

When gaps or unmet needs are identified, targeted recruitment efforts are initiated to enhance the network and ensure comprehensive coverage for all members.

Coordination with Quality Improvement Programs

The Health Net Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve member care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

review. This review occurs throughout the scope of utilization management and care management activities.

- Identifies and refers appropriate members for Public Health, Long Term Services and Supports (LTSS), waiver programs and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers.
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits.
- Offers disease/chronic condition management Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health team administers the Medi-Cal Non-specialty Mental Health Services (NSMHS) carved into the Managed Care Plans.

The behavioral health team provides early and periodic screening, diagnosis and treatment services for members ages 0 to 20. These services include medically necessary Behavioral Health Treatment (BHT) such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

The behavioral health team will manage specified mental health benefits to adults, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as members seeking other services not provided by the behavioral health team, will be referred to the County Specialty MHP.

Behavioral health utilization management decisions are informed by Centene Clinical Policy and evidence-based guidelines issued by recognized professional associations, such as the American Psychiatric Association, the American Psychological Association, and the Council of Autism Service Providers.

Consistency in applying these criteria is maintained through the completion of annual Inter-Rater Reliability (IRR) testing by all Behavioral Health Utilization Review Clinicians.

The behavioral health team's utilization management decisions are based on the behavioral health team's evidence-based nonprofit professional association criteria and guidelines such as Council of Autism Service Provider (CASP) and American Psychological Association. The behavioral health team's evidence-based internal criteria guidelines are based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines.

Deleted: ¶ ... [1]

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). The behavioral health team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered an NQTL under the definitions of the federal rules. The behavioral health team may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by the behavioral health team and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process are supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at the behavioral health team is to manage available behavioral health care benefits to achieve the best possible clinical outcomes for members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, the behavioral health team has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

- The behavioral health team utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by the behavioral health team do not require authorization. All behavioral health team staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors. The behavioral health team staff providing services to CalViva members are located at the behavioral health team offices in California.
- The behavioral health team coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about Health Net's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are being managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes CalViva Health Chief Medical Officer, Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations.

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.
- Implementation of specific population-based, chronic condition management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal care management, asthma or diabetes.
- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan members with pre-

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a Continuity of Care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require Continuity of Care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.
- The Continuity of Care process is facilitated by licensed nurses based on member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.
- Care Managers are patient advocates and assist members to ensure that they receive timely and uninterrupted medical care during the transition process.

Primary Care Physician responsibility:

The Primary Care Physician is responsible for the management and coordination of a member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, member and provider education and triage services.

Health Promotion Programs

CalViva Health provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The goal is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to

Deleted: c
Deleted: c
Deleted: c
Deleted: c
Deleted: c
Deleted: c
Deleted: November 24, 2025
Deleted: 6
Deleted:

have member engagement and to have preventive wellness, and chronic condition management in accordance with national peer-reviewed published guidelines. Preventive medicine services, achieved through proactive education and active engagement of the members, promote optimal health.

Deleted: s

Programs include:

- Disease/ Chronic Condition Management
- Weight Management Programs
- Health education resources are offered to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health and hypertension.

Nurse Advice Line

The nurse advice line provides immediate symptom assessment and member support 24 hours a day, seven days a week. In addition to educating members how to better manage their health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is available in English and Spanish with interpreter services for other languages. Only California-licensed nurses assess, evaluate, triage or advise regarding the condition of an enrollee.

Chronic Condition Management

The Chronic Condition Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets members with high-risk chronic conditions including, but not limited to: chronic asthma, diabetes and heart failure conditions. It encourages them to participate in the program. This program includes a population-based identification process, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to chronic condition management are multichannel and come through provider, Care Management and member self-referrals.

Weight Management Programs

Members have access to weight management resources through our Krames and Staywell Libraries.

Health Education Programs, Services and Resources

Health Net provides health education programs, materials, and services to Medi-Cal members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. Health education services may include individual,

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors. Health Education programs, services and materials vary by membership type but generally include:

- CalViva Pregnancy Program - The pregnancy program incorporates the concepts of care management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy through 60 days postpartum. In addition, the program supports the following:

  - Information about pregnancy and newborn care.
  - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
  - Breastfeeding support and resources.
  - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
  - Resources for members who feel down during or after their pregnancy.
  - Methods to help pregnant members quit smoking, alcohol, or drug use.

  The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- Smoking cessation
  - Kick It California – Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7am-9pm, and Saturday from 9am-5pm (excluding holidays) by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.
  - CalViva offers members a 90-day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts.
  - CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.
- Diabetes Prevention Program – The Diabetes Prevention Program (DPP) is a 12-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include any member 18 years of age and older at risk for developing type 2 diabetes.
- Digital Health Education - Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website,

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and encourage members in accessing timely preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, substance use, pain management, and insomnia.

- Health Promotion Incentive Programs - The Health Education Department (HED) partners with Quality Improvement Department to develop, implement and evaluate incentive programs to encourage members to access HEDIS related preventive health care services. CalViva Health follows MMCD Policy Letter 16-005 to develop, implement and evaluate appropriate incentive programs to promote positive health behaviors among members.
- Community and Telephonic Health Education Classes – No-cost health education classes and webinars are available to members and the community. Classes are available in various languages. Topics vary and are determined by the community's needs and topic availability.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

The following educational resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental health, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form – Members complete an order form to request free health education materials available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on an annual basis and covers various health topics and the most up-to-date information on health education programs and services.

Over and Under Utilization

Health Net requires all providers to submit claims and encounter data for all services rendered. A variety of methodologies are utilized to monitor key aspects of utilization management, including under, over utilization, referral timeliness, provider appeals, denials and member appeals and grievances.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

The types of methods include:

- Annual On-Site Evaluation: Comprehensive reviews of network-wide PPGs Medi-Cal Utilization Management Programs to ensure compliance and effectiveness. Member Complaint Tracking: Identification of over or Under utilization patterns based on trends in member complaints.
- Focused Audits: Targeted reviews of specific providers or services to address potential concerns.
- Data Analysis: Examination of medical group-specific metrics, including inpatient utilization, ER usage, and pharmacology data, to identify trends and outliers.
- Evaluation of Practice Patterns: Assessment of individual direct contract physicians to ensure alignment with best practices and quality standards.

These methodologies enable Health Net to maintain high standards of care, address potential issues proactively, and ensure optimal resource utilization.

Health Net's Utilization Management Department and the behavioral health team facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.
- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance
- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Population Health Management key performance indicator metrics
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by members.
- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.
- Provider prescribing patterns including medication utilization metrics

Deleted: November 24, 2025
Deleted: 6
Deleted:

Health Net completes the Quality Management education process with its contracted providers through local interaction with the Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's Utilization Management Program uses the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided regarding the member's health status:

1. State law/guidelines:
    a. Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters
    b. California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals
    c. State definition of medical necessity: (Title 22 CCR Section 51303(a))
    d. Expanded guidelines for members under the age of 21 (W & I Code Section 14132 (v))
    e. Per Regulation SB855 for mental health and substance abuse (MH/SA) the most recent versions of treatment criteria developed by nonprofit professional agencies. The Knox-Keene Act statutory and regulatory citations for SB 855 are: Sections 1374.72 and 1374.721 and Rules 1300.74.72, 1300.74.72.01 and 1300.74.721.. In addition, the services covered and defined by SB 855 are services for "mental health and substance use disorders" or "MH/SUD" services.
2. Plan-specific clinical policy
    a. Includes custom content within InterQual® and other vendor specific criteria
3. Centene clinical policy
    a. Includes Centene customized clinical policies within InterQual®
4. Nationally Recognized Decision Support Tools:
    a. When no specific Plan, or Centene clinical policy exists, tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are applied
5. Medical necessity decisions for transgender health services are based on the criteria and guidelines set forth by the World Professional Association for Transgender Health (WPATH).
6. Additional considerations (if no guidance from 1-4), when available:
    a. Peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations
    b. Recognized US professional standards of safety and effectiveness for diagnosis, care, or treatment
    c. Nationally recognized drug compendia (e.g., Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines)
    d. Medical association publications (e.g., American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.);
    e. Government-funded or independent entities that assess and report on clinical care decisions and technology (e.g., Agency for Healthcare Research and

Deleted: November 24, 2025
Deleted: 6
Deleted:

Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.);
f. Published expert opinions (e.g., Up-To-Date);
g. Opinion from health professionals in the area of specialty involved;
h. Opinion of attending provider in case at hand.

Benefit Determinations Criteria:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

Conflict Resolution:
- When Medi-Cal (state Medicaid) coverage provisions conflict with the Plan or Centene specific clinical policies, Medi-Cal provisions take precedence.
- Refer to the Medi-Cal manual for applicable coverage provisions.

Transparency and Accessibility:
- Clinical policies, benefit provision, guideline, protocol or criteria are available upon request, in compliance with Federal and State regulations

Separation of Medical Decisions from Fiscal and Administrative Management

Health Net's UM Program is structured to ensure that medical decisions made by the Plan or PPG medical directors are not unduly influenced by fiscal or administrative considerations. To achieve this, Health Net affirms that it adheres to the following principles:

Medical Necessity and Appropriateness:
- All utilization management decisions are based solely on medical necessity and medical appropriateness

No Compensation or Incentives for Denial:
- Health Net does not provide compensation to physicians or nurse reviewers for denials of service requests
- No incentives are offered to encourage denials of coverage or service
- Special attention is given to mitigate the risk of under-utilization

Policy Transparency:
- Health Net and its delegates distributes a statement outlining its policies and restrictions on financial incentives to all practitioners, providers, and employees

Decision Making integrity:
- Utilization management decisions are based solely on the appropriateness of care, service and existence of coverage
- Delegated entities are also prohibited from rewarding practitioners or others involved in utilization review for denying coverage or service

Independent Oversight:
- Health Net Medi-Cal Medical Directors and the Health Net Community Solutions CMO/VP Medical Director do not report to:
  - Health Net's Chief Financial Officer

Deleted: November 24, 2025
Deleted: 6
Deleted:

- Health Net's Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net ensures the consistent application of utilization decision criteria through structured processes and evaluations involving both Health Net staff and delegated PPG's such as:

- **Weekly Regional Utilization Management (UM) Rounds** – Use of Rounds facilitates interdisciplinary collaboration to enhance consistent decision-making, optimize patient outcomes, and improve resource management.
- **PPG Collaboration –** PPG management issues are referred to the Provider Oversight Department for resolution.
- **Real-Time Feedback from Leadership** – Continuous guidance and support from medical leadership are provided to reinforce standardized decision-making practices.
- **Ongoing UM Training** – Mandatory training sessions led by the Learning and Development team for all clinical review staff, both new and existing including training that focuses on:
  - Clinical Criteria Hierarchy and its application
  - Identification and utilization of available criteria sources
- **Inter-Rater Reliability (IRR) Testing**

Inter-Rater Reliability (IRR) Review Process:

New hire and annually, IRR testing are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any new hire and annual IRR test. If a staff scores < 90% for any subset the staff must complete remediation and successfully retest within 30 days of completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff, or auditing five (5) cases in production, providing two additional testing opportunities to demonstrate remediation success, for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader.

IRR results are reported annually at the CalViva Health Quality Improvement/Utilization Management (QI/UM) Committee Meeting.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

- Annual PPG oversight, includes a file review of denial files using Health Net Delegation Oversight Interactive Tool (DOIT). Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed.

Standards of Timeliness of UM Decision Making

Health Net maintains strict adherence to established time frames for UM decision making to ensure that members receive timely care. These time frames are designed to minimize disruptions in the provision of healthcare services and are based on the urgency of the clinical situation.

Key Points on Timeliness of Decision Making:

- Turnaround Time (TAT) Standards
  - The TAT standards for decisions making regarding medical necessity and authorization requests are guided by current DHCS, DMHC, and State regulatory guidelines.
  - The most stringent of these guidelines are applied to ensure compliance and consistency.
- Timeliness Communication
  - All decisions regarding authorization or medical necessity are communicated to both the member and the provider within the required regulatory timeframes.
  - The communication method and timeframe are determined by DHCS, DMHC, and State regulations, whichever set of guidelines has the most stringent requirement
- Delegated Provider's Compliance
  - Health Net's delegated providers are informed of the decision timeliness standards as outlined in the Provider Operations Manual.

By maintaining these standards and monitoring compliance, Health Net ensures that healthcare decisions are made promptly and in accordance with regulatory requirements, ensuring members receive timely care and services.

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. The clinical reviewer may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines.

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into "threshold languages" in collaboration with Health Industry Collaboration Effort (HICE).

The rationale contained in denial letters includes a summary denial reason/rationale that is easily understandable for the member. In addition, a detailed denial reason/rationale is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the contact telephone number to schedule a conversation with the Medical Director or Pharmacist who issued the denial and Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all member medical necessity appeals.

CalViva Health has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CalViva Health, CalViva Health is responsible for appeals for their members. However, Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net Medical Director. The case is forwarded to the CalViva Health CMO for review and final determination.

CalViva Health maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CalViva Health, the behavioral health team or its delegates.

Each denial letter that is sent to the member includes the member's right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member's right of appeal is communicated to the practitioners in the Provider Operations Manual and to the members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member Services representative then forwards requests for member appeals to the Appeals and Grievances Department.

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the Hayes, Inc. Medical Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

Satisfaction with the Utilization Management Process

At least annually, Health Net surveys members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the CalViva Health QI/UM Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the CalViva Health QI/UM Committee.

Communication Services

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

The Plan, the behavioral health team and the delegated partners provide access to Utilization Management staff for members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, the behavioral health team and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal members have 24/7 access to the nurse advice line. Inbound and outbound communication regarding utilization management issues is accomplished through the following:

- Toll-free member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CalViva Health members upon request

The Plan will notify contracting health care providers, as well as members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Evaluation of the Health Net UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CalViva Health UM Program Description is forwarded to CalViva Health for review and approval. This ensures that all relevant policies, procedures, and protocols are aligned and in accordance with CalViva Health's standards before they are finalized and implemented. The review and approval process is a key step in ensuring the consistency, compliance, and quality of the UM program.

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Section 4

Organizational Structure and Resources

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Organizational Structure and Resources

CalViva Health Staff Resources and Accountability

CalViva Chief Medical Officer

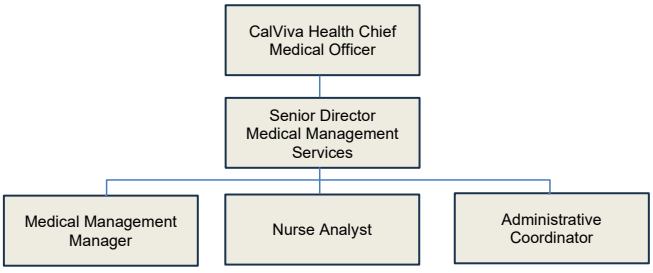
The CalViva Chief Medical Officer's responsibilities include chairing the QI/UM Committee and work group, providing oversight of QI/UM Programs, and assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations. This position makes recommendations to the RHA Commission to initiate major program revisions and communicates the RHA Commission's directives to both internal and external stakeholders.

Department Resources

CalViva staff, with assistance from HNCS interdisciplinary staff, contributes to the success of the CalViva UM Program. These administrative and clinical staff work with CalViva's Chief Medical Officer and Senior Director of Medical Management to oversee UM activities for CalViva's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the UM process are described below.

Medical Management Team

The Medical Management team will include a Chief Medical Officer, Senior Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Senior Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.



CalViva Health Quality Improvement/Utilization Management Committee

The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to

Deleted: November 24, 2025
Deleted: 6
Deleted:

provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity. Members of the committee are appointed by the RHA Commission Chairperson. The Committee is chaired by the CalViva Chief Medical Officer ("CMO"). Committee size is determined by the RHA Commission with the advice of the CMO.

The QI/UM Committee is composed of Participating health care providers, including physicians, behavioral health practitioners, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

Health Net LLC's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations.

The CMO has overall decision-making responsibilities for Health Net medical matters. The CMO oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other PHCO leadership team members. PHCO departments for which they have clinical oversight responsibility to include: Quality Improvement, Utilization Management, Care Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/ Chronic Condition Management.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

The CMO's responsibilities include, but are not limited to: leading the health plan in California PHCO initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Health Net Community Solutions (HNCS) CMO / Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the HNCS CMO/VP Medical Director is responsible for QI activities for these programs. The HNCS CMO/VP Medical Director is the chair of the Health Net Community Solutions Committee and is actively involved in implementing the UM Program. The HNCS CMO/VP Medical Director reports to HN LLC's CMO.

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and care management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost-effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement and Health Equity Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Vice President of Population Health and Clinical Operations (VP PHCO)

The VP PHCO is a registered nurse with experience in utilization management and care management activities. The VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The VP PHCO reports to the Plan Chief Operating Officer. The VP PHCO, in collaboration with the HNCS CMO/VP Medical Director, assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

The VP PHCO is responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and care/chronic condition management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Utilization Management (UM) Resources

Director/Senior Director, PHCO

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the member's benefit structure.
- Emphasizes continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e., Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Referral of members to LTSS and Waiver Programs
- Referral of Members to CalAIM Community Supports
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health
- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Team Medical Director and Medical Staff

The behavioral health Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of behavioral health program and clinical policies, the behavioral health team Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The behavioral health team Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN members. The behavioral health team Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the CalViva Health QI/UM Committee, and to the Health Net Quality Improvement Health Equity Committees (QIHEC). The behavioral health team Medical Staff sits on the following committees: HN QIHEC, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the HN Medical Advisory Council.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Health Net Community Solutions (HNCS) Quality Improvement/Health Equity Committee (QIHEC)

The HNCS QIHEC reports directly to the HNCS Board of Directors. The committee is charged with the monitoring of the PHCO and quality of care and services rendered to members within HNCS including identification and selection of opportunities for improvements, monitoring interventions and addressing UM,QI, PMH and Health Equity activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the HNCS QIHEC quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI. The Committee membership also includes practicing network physician representatives. The HNCS QIHEC is chaired by the HNCS CMO/VP Medical Director for HNCS and meets quarterly.

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Section 5

Delegation

Deleted: November 24, 2025
Deleted: 6
Deleted:

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs), contracted vendors and strategic partners (delegated partners).
Health Net has established processes in place to assess and determine the appropriateness delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment.

Health Net has an experienced team of Compliance Auditors to oversight of delegated entities. At least annually, Delegation Oversight audits delegated partners which include file and policy and procedure reviews. Delegates are required to provide monthly turn around time reporting This reporting is reviewed for completeness and required performance standards. The Delegation Oversight team also routinely conducts system validation checks to evaluate the delegates' data quality. If an auditor discovers a below standard performance during an auditing or monitoring activity, a Corrective Action Plan (CAP) is requested from the delegate. All CAP remediations are evaluated, tracked and validated prior to closure. These oversight processes are established to ensure compliance with Federal, State, contractual and Health Net's criteria for delegated activities.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CalViva Health's monthly Management Oversight Meeting.

Delegation Oversight Committee

The purpose of the Delegation Oversight Committee (DOC) is to provide a forum for discussion of the delegates' performance and to address significant risks with health plan leadership. During this meeting d oversight activities, recommendations of the subcommittee Delegation Oversight Workgroup (DOW), audit results, and corrective actions are discussed. As needed, the DOC will discuss remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing oversight
- Financial sanctions through a capitation deduction
- Membership Freeze; and/or
- Required change in Management Services Organization
- Denial of business expansion or changes
- De-delegation, and/or contract termination
- Terminating the organization's contract with Health Net

Sub-delegation

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate's program.

A review of the contracted delegates shall be conducted annually, or more frequently as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

Deleted: November 24, 2025
Deleted: 6
Deleted:

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

Section 6

Utilization and Care Management (UM/CM) Program Evaluation

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

UM/CM Program Evaluation

Health Net's Vice President of PHCO annually prepares the CalViva Health Utilization/Care Management Program Evaluation and presents the evaluation to CalViva Health for review.

The annual evaluation of the CalViva Health Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and members on CalViva Health Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net Community Solutions CMO/VP Medical Director and Vice President Population Health and Clinical Operations annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Deleted: *November 24, 2025*

Deleted: *6*

Deleted:

Section 7

Approvals

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

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, Fresno County Date
Regional Health Authority Commission Chairperson

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

Health Net Medi-Cal Utilization Management Program Approval

Deleted: *November 24, 2025*
Deleted: *6*
Deleted:

The Chief Medical Officer and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Matthew Bensley
Vice President of Population Health and Clinical Operations

Deleted: Brenda Belmudez

Deleted: November 24, 2025

Deleted: 6

Deleted:

Page 18: [1] Deleted Abey Mathew 2/6/2026 4:24:00 PM

CalViva Health
2026
Utilization Management (UM)/ Care Management (CM)
Work Plan

Last updated: March 11, 2026

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and are reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2026, April 2026, July 2026, October 2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors CMO/CHEO Meetings ▪ MMCD workgroups ▪ DHCS-MCP Quality and Health Equity Think Tank There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer/ Health Equity Officer participate in DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2026. The Health Equity Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2026. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures as needed and at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements. Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Core group comprised of State Health Programs Chief Medical Officer (CMO), Regional Medical Directors, VP and Directors of PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2026 UM and CM Program Descriptions. Write and receive CalViva approval of 2025 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2026 UMCM Work Plan. Write and receive CalViva approval of 2026 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q1 2026 Q1 2026 Q1 2026 Q3 2026 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.7 Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making	☒ Medi-Cal	All new and current UM clinical criteria and practice guidelines related to UM decision making are reviewed and approved annually by the Medical Advisory Council (MAC), which includes input from local Medical Directors. The Plan makes UM criteria and clinical practice guidelines available to practitioners via the provider portal.	Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) reviews and approves policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. Medical policies and clinical practice guidelines are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria are available to providers upon request. CalViva QIUM Committee reviews and adopts policies for physical and behavioral health clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Confirm annually: • Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviews, updates as necessary, and approves policies for clinical criteria and behavioral health criteria for UM decision making. • Ensure UM/BH clinical criteria and UM/BH clinical practice guidelines are made available to practitioners via provider portal (or website) and practitioners are notified of new policies and changes via the monthly Provider Update.	Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.8 Evaluate inclusion of new technologies and new application of existing technologies in applicable benefit packages including: medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies	☒ Medi-Cal	Standardized process is used for review of new technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages	New technologies are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Decisions are based on nationally recognized primary sources including: Hayes® Medical Technology Directory and Hayes® Alert technology-based evaluations, InterQual® and information from evidence-based medical journals, colleges and academies. CalViva QIUM Committee reviews and adopts policies for clinical criteria for UM/BH decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Evaluate new technologies and ensure inclusion in member benefits as applicable throughout 2026	Ongoing monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend physical and behavioral health authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Number of denials appealed and overturned	Utilize the Key Indicator Report and BH Performance Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Continue support for long-term care benefit carve in and ensure continuity of care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend physical and behavioral health authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report and behavioral health performance indicator report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining. Initiate end to end assessment of UM TAT monitoring processes.	Ongoing UM TAT summaries due monthly 12/31/2026

	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development administers new hire and annual IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews All new hire and annually staff must achieve a minimum passing score of 90% on each IRR test	Administer the Change HealthCare/Optum InterQual and relevant non profit criteria IRR tests in Q3-Q42026 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews for medical, behavioral, and pharmacy benefits. Documented coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented coaching may include but is not limited to the following: precepting of staff, retraining of the staff or auditing five (5) cases in production, providing two additional testing opportunities to demonstrate remediation success, for any IRR Product(s) not passed. In the event the new hire and annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and documented coaching is initiated by the People Leader.	Q3-4 2026 Q4-2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of physical and behavioral health clinical appeals for physical and behavioral health received for authorization decisions and the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. Utilize the CalViva Health A&G Dashboard on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Appeals & Grievances timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements in addition to reviewing overturn rates and patterns of high overturn rates. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ ACTIVITY ON TARGET ☐ TOO SOON TO TELL				
Annual Evaluation ☐ MET OBJECTIVES ☐ CONTINUE ACTIVITY IN 2027				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.5 Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction	☒ Medi-Cal	Continually assess customers' satisfaction with the UM process to identify areas that can be improved. Interventions are implemented to improve satisfaction levels where dissatisfaction is identified	The Plan strives to improve Satisfaction with UM Process. Annually satisfaction surveys are conducted and followed by: • Review of satisfaction survey data and trends. • Comparison of survey results with other source data. • Prioritization and implementation of interventions to improve member and practitioner satisfaction with UM processes. • Re-measurement of satisfaction periodically to ensure interventions is effective. Improved member and practitioner satisfaction results based on surveys and other satisfaction data, including but not limited to: <u>Member</u> Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Member Grievances <u>Practitioner Survey</u> Provider Satisfaction Survey	Complete annual Member and Practitioner Satisfaction surveys to assess satisfaction with UM Process. Assess annual satisfaction survey outcomes. Utilize the CalViva Health Dashboard on a monthly basis as a tool for systematic oversight of Grievance trends.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2026 Goals: • • TBD	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data and predictive modeling to identify high cost/high utilizing members to target for care management. The UM team will continue transitional care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care post-acute care settings, including recuperative care, short-term post hospitalization housing, Residential Care Facilities for the Elderly (RCFE), Adult Residential Facilities (ARF) and other settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Support on-site and telephonic enrollment of members into programs such as CalAim, Complex Care Management and Community Supports. Explore areas for additional on-site support (non - clinical). Establish 2026 Utilization goals in Q1-2026	Ongoing 03/31/2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics are reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and Plan include SPD, MCE and TANF populations: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. Health Net tracks PHM KPI quarterly including: • Percentage of members who had more ED visits than primary care visits within a 12-month period; • Percentage of members who had a primary care	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net (Central Valley) and Health Net Medi-Cal State wide. PPGs with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPGs identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. Direct network and PPG membership over/under utilization report includes ambulatory care measures (OP visits PTMPY, ED visits PTMPY) and selected surgical procedures PTMPY as markers of over-under utilization and is reported to CalViva MOM semi-annually in the MOM 18 PPG Dashboard. Adjust PHM KPI reporting per DHCS guidance as needed.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
			visit within a 12-month period; • Percentage of members with no ambulatory or preventive visit within a 12-month period.		

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.3 PPG Profile and Vendor List	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM. The MOM 20 vendor list provides audit dates and findings for each vendor. For completed audits an audit summary is shared with the monthly report, detailing audit results. Issues identified during audits or via ongoing performance monitoring are included in the monthly MOM 20 update.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The PPG Profile Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN. The Health Net vendor audit and monitoring process includes annual auditing of delegates' policies and files and ongoing review of delegates' adherence to service level performance.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

4. Monitoring Coordination with Other Programs

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report including PHM Key Indicators to track and trend Care Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in care management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction o Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and o Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.	Dedicated staff of RNs, LCSWs, Care Navigators, Care Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group. Transitional Care Services staff to do onsite bedside enrollment of members into TCS program at Hospital/Facilities. TCS to transition members to Physical Health (PH) or Behavioral Health (BH) CM teams after immediate discharge needs have been met. Collaboration with PPGs, Providers, Facilities on members who would benefit from Care Management to support appropriate interventions and improve member outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Care Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPGs of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high-risk moms. Dedicated staff of RNs, Care Navigators, and Care Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Provide members with education about and referrals to Doulas throughout their pregnancy. Help members schedule prenatal and postpartum appts. Help members schedule their newborn child first well child exam visit, and refer into our First Year of Life Program. Outcome measures are included in the CCM Quarterly reports and reviewed in Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group and QI/UM Committee.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, and Care Navigators to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Partner with Health Net Behavioral Health Teams to increase referrals to BH CM team to support outreach to follow up with Members who were provided resources. Help members schedule appointments with BH CM providers and connect with resources in the community to meet Member's SDOH needs. Collaborate with ECM and CS providers to ensure warm hand off of members care plan needs. Provide guidance to ECM CM taking over members care related to benefits as appropriate. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI/UM Workgroup and QI/UM Committee.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy, medical claims, and referrals. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing monitoring of the chronic condition management program Annual presentation of disease management outcomes in the Annual Disease Management/chronic Condition Report.	Ongoing Q1 2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2026 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	State Health Program (SHP) MDs, the Health Net Pharmacy Advisory Committee (PAC) and the CalViva Health Chief Medical Officer work with Pharmacy Department to refine the injectable guidelines for medical benefit drugs to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to improve CCS ID using pharmacy data.	Monthly report of PA requests.	Continued active engagement with pharmacy. CVH UM/QI reporting based on Medical Benefit drug review. DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that the behavioral health team staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health team provides. BH referrals to/from each county are monitored and reported quarterly to QI UM Work Group	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: ABA Authorization volume Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios --- Authorization Decision Timeliness: goal 100% with corrective action initiated at <95%	Participate in cross functional team to improve quality of behavioral health care. Consistent monitoring of performance measures to ensure continued compliance.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.8 Enhanced Care Management	☒ Medi-Cal	Demonstrate 12-month growth in percentage of members receiving ECM Members not meeting ECM criteria will be referred to alternative programs or care management Notice of Action Letters (NOA) are distributed to members being disenrolled from ECM	Quarterly monitoring of ECM enrollment including break out of ECM enrollment for adults and children Achieve 1% enrollment	ECM program enrollment rates by county are reported quarterly CalViva Health (CVH) UM/QI Committee and CVH Medical Operations Management Meeting (MOM). The Plan will implement NOA letters for members being disenrolled from ECM Q1-2026 and implement quarterly audits Q2-2026.	Ongoing Q2-2026 and Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, care management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2026 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Care Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Fresno-Kings-Madera Regional Health Authority Approval

The Fresno-Kings-Madera Regional Health Authority Commission has reviewed and approved this Work Plan.

David Hodge, MD, Fresno County
Regional Health Authority Commission Chairperson

Date

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

Date

Item #10
Attachment 10.A

Finance Report

- Financials as of January 31, 2026

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of January 31, 2026

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	211,479,909.22
5	Total Bank Accounts	$ 211,479,909.22
6	Accounts Receivable	
7	Accounts Receivable	198,449,936.06
8	Total Accounts Receivable	$ 198,449,936.06
9	Other Current Assets	
10	Interest Receivable	966,378.93
11	Investments - CDs	0.00
12	Prepaid Expenses	975,655.83
13	Security Deposit	0.00
14	Total Other Current Assets	$ 1,942,034.76
15	Total Current Assets	$ 411,871,880.04
16	Fixed Assets	
17	Buildings	5,665,105.19
18	Computers & Software	6,222.19
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	123,100.63
22	Total Fixed Assets	$ 8,955,847.11
23	Other Assets	
24	Investment -Restricted	304,139.71
25	Lease Receivable	2,717,745.15
26	Total Other Assets	$ 3,021,884.86
27	TOTAL ASSETS	$ 423,849,612.01
28	LIABILITIES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	167,448.23
33	Accrued Admin Service Fee	4,654,012.00
34	Capitation Payable	128,096,297.86
35	Claims Payable	85,191.24
36	Directed Payment Payable	786,630.46
37	Total Accounts Payable	$ 133,789,579.79
38	Other Current Liabilities	
39	Accrued Expenses	1,062,396.07
40	Accrued Payroll	151,854.52
41	Accrued Vacation Pay	436,110.17
42	Amt Due to DHCS	25,694,451.05
43	IBNR	318,753.72
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	$ 90,780,636.48
49	Total Current Liabilities	$ 224,570,216.27
50	Long-Term Liabilities	
51	Renters' Security Deposit	43,928.29
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	$ 43,928.29
54	Total Liabilities	224,614,144.56
55	Deferred Inflow of Resources	2,305,526.33
56	Equity	
57	Retained Earnings	184,108,458.37
58	Net Income	12,821,482.75
59	Total Equity	$ 196,929,941.12
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 423,849,612.01

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2025 - January 2026 Income Statement

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	Interest Income	5,517,680.27	3,250,000.00	2,267,680.27
3	Premium/Capitation Income	1,356,098,009.84	1,193,510,208.00	162,587,801.84
4	**Total Income**	**$ 1,361,615,690.11**	**$ 1,196,760,208.00**	**$ 164,855,482.11**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	864,973,030.57	707,238,592.00	157,734,438.57
7	Medical Claim Costs	3,153,397.22	3,850,000.00	(696,602.78)
8	**Total Costs of Medical Care**	**$ 868,126,427.79**	**$ 711,088,592.00**	**$ 157,037,835.79**
9	**Gross Margin**	**$ 493,489,262.32**	**$ 485,671,616.00**	**$ 7,817,646.32**
10	**Expenses**			
11	Admin Service Agreement Fees	33,034,551.00	31,168,214.00	1,866,337.00
12	Bank Charges	0.00	4,200.00	(4,200.00)
13	Computer & IT Services	125,260.10	158,156.00	(32,895.90)
14	Consulting & Accreditation Fees	64,762.94	317,915.00	(253,152.06)
15	Depreciation Expense	201,005.90	217,000.00	(15,994.10)
16	Dues & Subscriptions	152,835.64	189,000.00	(36,164.36)
17	Grants (Community Reinvestment)	2,952,667.70	2,993,910.00	(41,242.30)
18	Insurance	230,012.46	283,418.00	(53,405.54)
19	Labor	2,660,426.47	3,130,838.00	(470,411.53)
20	Legal & Professional Fees	95,780.51	218,460.00	(122,679.49)
21	License Expense	750,823.99	1,038,828.00	(288,004.01)
22	Marketing	859,092.17	875,000.00	(15,907.83)
23	Meals and Entertainment	15,900.16	21,250.00	(5,349.84)
24	Office Expenses	61,605.88	72,915.00	(11,309.12)
25	Parking	245.07	910.00	(664.93)
26	Postage & Delivery	1,156.90	2,870.00	(1,713.10)
27	Printing & Reproduction	695.61	3,210.00	(2,514.39)
28	Recruitment Expense	46,222.06	100,625.00	(54,402.94)
29	Rent	0.00	7,000.00	(7,000.00)
30	Seminars & Training	4,192.66	19,600.00	(15,407.34)
31	Supplies	7,515.79	8,750.00	(1,234.21)
32	Taxes	439,541,666.67	439,541,666.67	0.00
33	Telephone & Internet	12,403.62	28,000.00	(15,596.38)
34	Travel	12,402.90	18,600.00	(6,197.10)
35	**Total Expenses**	**$ 480,831,226.20**	**$ 480,420,335.67**	**410,890.53**
36	**Net Operating Income**	**$ 12,658,036.12**	**$ 5,251,280.33**	**7,406,755.79**
37	**Other Income**			
38	Other Income	163,446.63	207,369.00	(43,922.37)
39	**Total Other Income**	**$ 163,446.63**	**$ 207,369.00**	**(43,922.37)**
40	**Net Other Income**	**$ 163,446.63**	**$ 207,369.00**	**(43,922.37)**
41	**Net Income**	**$ 12,821,482.75**	**$ 5,458,649.33**	**7,362,833.42**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

July 2025 - Jan 2026 vs July 2024 - Jan 2025 Income Statement

		Total	
		July 2025 - January 2026 (Current Year)	July 2024 - January 2025 (Prior Year)
1	Income		
2	Interest Income	5,517,680.27	6,792,100.86
3	Premium/Capitation Income	1,356,098,009.84	1,177,908,954.47
4	**Total Income**	**$ 1,361,615,690.11**	**$ 1,184,701,055.33**
5	Cost of Medical Care		
6	Capitation - Medical Costs	864,973,030.57	783,640,567.49
7	Medical Claim Costs	3,153,397.22	3,466,436.42
8	**Total Costs of Medical Care**	**$ 868,126,427.79**	**$ 787,107,003.91**
9	**Gross Margin**	**$ 493,489,262.32**	**$ 397,594,051.42**
10	Expenses		
11	Admin Service Agreement Fees	33,034,551.00	33,526,823.00
12	Computer & IT Services	125,260.10	90,234.33
13	Consulting & Accreditation Fees	64,762.94	40,413.00
14	Depreciation Expense	201,005.90	197,872.36
15	Dues & Subscriptions	152,835.64	141,089.16
16	Grants (Community Reinvestment)	2,952,667.70	2,910,536.29
17	Insurance	230,012.46	203,967.17
18	Labor	2,660,426.47	2,490,088.36
19	Legal & Professional Fees	95,780.51	70,282.75
20	License Expense	750,823.99	867,867.92
21	Marketing	859,092.17	753,084.89
22	Meals and Entertainment	15,900.16	13,848.76
23	Office Expenses	61,605.88	52,539.79
24	Parking	245.07	214.98
25	Postage & Delivery	1,156.90	1,056.70
26	Printing & Reproduction	695.61	2,239.28
27	Recruitment Expense	46,222.06	(549.00)
28	Rent	0.00	0.00
29	Seminars & Training	4,192.66	10,478.71
30	Supplies	7,515.79	7,358.09
31	Taxes	439,541,666.67	344,666,666.67
32	Telephone & Internet	12,403.62	31,772.25
33	Travel	12,402.90	13,452.05
34	**Total Expenses**	**$ 480,831,226.20**	**$ 386,091,337.51**
35	**Net Operating Income**	**$ 12,658,036.12**	**$ 11,502,713.91**
36	Other Income		
37	Other Income	163,446.63	206,097.80
38	**Total Other Income**	**$ 163,446.63**	**$ 206,097.80**
39	**Net Other Income**	**$ 163,446.63**	**$ 206,097.80**
40	**Net Income**	**$ 12,821,482.75**	**$ 11,708,811.71**

Item #10
Attachment 10.B

Compliance Report

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 YTD Total
# of DHCS Filings													
Administrative/ Operational	27	19	5										51
Member Materials Filed for Approval;	6	3	1										10
Provider Materials Reviewed & Distributed	16	4	4										24
# of DMHC Filings	9	2	1										12

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	1	3	2										6
High-Risk	0	0	1										1

Summary of High-Risk Privacy & Security Breach Cases: Since the 2/19/2026 Compliance Regulatory Report to the Commission, one high risk privacy and security breach case was reported on March 5, 2026. The case involved a threat actor gaining access to PHI within a Plan vendors database.

.

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 YTD Total
# of New MC609 Cases Submitted to DHCS	0	5	1										6
# of Cases Open for Investigation (Active Number)	29	31	31										

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 2/19/2026 Compliance Regulatory Report to the Commission, there were 5 new MC609 filings. The filings were related to the following:

- Inappropriate Billing: 1 case
- Phantom Provider: 1 case
- Ineligible Provider: 1 case
- False Representation: 1 case
- Inappropriate use of transportation: 1 case

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: UMCM, Call Center, Claims/PDR, and Provider Network. No audits have been completed since the 2/19/26 report to the Commission.
Regulatory Reviews/Audits and CAPS:	**Status**

Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	No change in status: DHCS will issue forward-looking guidance at future CAP closure and allow 90 days to implement any required changes.
Department of Health Care Services ("DHCS") 2025 Medical Audit	DHCS issued its final audit report and Corrective Action Plan (CAP) citing deficiencies related to delegated oversight of Health Net, including: 1) application of EPSDT criteria for members under age 21; 2) provision of all required ECM core service components; 3) timely notification of ECM benefit discontinuation; and 4) inclusion of required elements in member-facing ECM materials. The Plan submitted its monthly CAP update on 2/27/2026 and will continue to send updates until the CAP is closed.
2026 DMHC/DHCS Joint Medical Survey Audit	The Plan submitted all required DMHC pre-audit documentation on February 20, 2026, and is currently awaiting additional guidance from DHCS regarding their pre-audit requirements.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has not executed any MOUs.
Annual Community Advisory Committee (CAC) Demographic Report	In compliance with the DHCS Contract, the Plan has completed the annual demographic report for CalViva's CAC (also know as the Public Policy Committee (PPC)). The annual analysis is conducted to ensure that the PPC's membership reflects the general Medi-Cal Member population in CalViva's service area. Demographics analyzed are race, ethnicity, age, gender and spoken language. The analysis shows that the PPC membership does reflect the Plan's general Medi-Cal population. The Plan must file this report with DHCS by 4/1/26.
Revised ASA and CPSA with Health Net	On 2/12/26, the Plan filed the revised ASA and CPSA with DHCS and is awaiting their response/approval. Depending on whether DHCS has any additional requirements, we must also update DMHC in order to assure both agencies are reviewing approving the same final document.

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 2026.
Committee Report:	**Status**
Public Policy Committee (PPC)	The last PPC meeting was held on March 4, 2026. The following reports were presented:

	• Appeal and Grievance Report • A&G Review and Discussion from Dr Marabella • Annual Public Policy Committee Charter • Annual Report • Semi-Annual Member Incentive Programs • 2025 Annual Compliance Report The next PPC meeting will be held on June 3, 2026, 11:30am-1:30pm.

APPENDIX A

2026 DHCS All Plan Letters:

- APL 26-001 IHA
- APL 26-002 NSMHS Rsponsibilities

2026 DMHC All Plan Letters:

- APL 26-002 - Delegation of Risk for COVID-19 Testing or Immunizations.

Item #10
Attachment 10.C

Equity Report

Current Health Equity Project(s) and Initiative(s):	Objective	Status
Madera Live Well	Continue to collaborate with the **Madera County's Public Health team** on **Community Health Improvement Plan (CHIP) initiatives**.	3/2026- Current efforts are focused on **merging the Resilience Workgroup with the Diabetes and Heart Health Workgroup** to strengthen alignment of priorities and activities. The **merger kickoff meeting was held on March 9, 2026**, where partners reviewed shared **goals and objectives** and began **strategizing key activities** to guide the combined workgroup moving forward.
Kings County CHIP	Collaborate with the **Kings County Public Health team** on **Community Health Improvement Plan (CHIP) initiatives**.	02/2026- The **Kings County Community Health Improvement Plan (CHIP) kickoff** took place in **February 2026**. As previously shared during the last Commission meeting, the **perimenopause and menopause initiative** will continue as part of the CHIP priorities. This effort aligns with focus areas related to **access to health care, maternal and child health, and Community Health Workers (CHWs)**. **CVH's Equity Officer** will participate in the **initial workgroup kickoff scheduled for March 23, 2026**.
FCHIP HOPE HUB	Continue to collaborate with Perinatal Taskforce work group and adding in the Central Valley Disabilities Service Provider (CVDSP) network to CVH's HE initiative in 2026	1/2026- The **first CVDSP network meeting** took place in **January 2026**, with the **next meeting scheduled for April 2026**. **CVH**, in partnership with **FCHIP**, will be leading a **Health Equity (HE) initiative** with the network.

Health Equity Annual Activities	Status
Diversity, Equity and Inclusion Survey and training	1/2026 Health Outcome Survey Distributed
NCQA Health Equity Accreditation-	1/2026- Look back period started for CVH. Next NCQA Health Outcome Accreditation will be in 2028 using the 2027 NCQA standard.
Health Equity Annual Oversight Audit- HN	Oversight Audit Schedule to start- April 2026,

Health Equity Community Activities/ Updates	Who	Activity
	NCQA Standard Changes – High-Level Overview The new **Health Outcomes and Community-Focused Care accreditation** updated previous standards in five ways: 1. **Retired** – The standard was removed and is no longer required. 2. **Revised** – The requirement still exists but the language or expectations were updated. 3. **New Requirement** – A completely new standard that organizations must implement if not already in place. 4. **Renamed** – The title changed, but the evidence and requirement remain the same. 5. **Moved** – The standard was reorganized or consolidated into a different section of the framework. These updates help align the accreditation with **current health outcomes, community partnerships, and population health priorities**.	The **web-based standards were available for purchase but have not yet been released.** **Health Outcomes (formerly Health Equity)** • **2 standards removed**, primarily related to **DEI terminology**. • **23 standards revised** to align with updated language after the removal of DEI wording. • **10 new standards added**, focusing on **data collection and activities related to individuals with developmental disabilities and other population-specific groups**. **Community-Focused Care (formerly HE+)** • **19 standards revised** to align with updated language. • **3 new standards added**, also focusing on **individuals with disabilities**. • **4 standards renamed** to align with the removal of DEI terminology. • **2 standards moved** due to restructuring or consolidation. •

Item #10
Attachment 10.D

Medical Management

- Appeals and Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2026

Current as of End of the Month: January
Revised Date: 02/25/2026

CalViva - 2026																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2026 YTD**	**2025**
Expedited Grievances Received	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	111
Standard Grievances Received	202	0	0	202	0	0	0	0	0	0	0	0	0	0	0	0	202	2295
Total Grievances Received	**209**	**0**	**0**	**209**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**209**	**2406**
Grievance Ack Letters Sent Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	8
Grievance Ack Letter Compliance Rate	**99.5%**	**0.0%**	**0.0%**	**99.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.50%**	**99.65%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Grievances Resolved Compliant	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	110
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.10%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	163	0	0	163	0	0	0	0	0	0	0	0	0	0	0	0	163	2292
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**170**	**0**	**0**	**170**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**170**	**2403**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**158**	**0**	**0**	**158**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**158**	**2259**
Access - Other - DMHC	29	0	0	29	0	0	0	0	0	0	0	0	0	0	0	0	29	431
Access - PCP - DHCS	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	153
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	73
Administrative	31	0	0	31	0	0	0	0	0	0	0	0	0	0	0	0	31	438
Balance Billing	19	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	19	313
Community Supports	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	58
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	19	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	19	213
Behavioral Health	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	1
Other	14	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14	178
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
SNF-Long Term Care	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	15
Transportation - Access	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	126
Transportation - Behavior	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	49
Transportation - Other	20	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	20	209
Quality Of Care Grievances	**12**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**144**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	26
PCP Care	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	58
PCP Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	23
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Exempt Grievances Received	**171**	**0**	**0**	**171**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**171**	**1798**
Access - Avail of Appt w/ PCP	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	**27**
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**2**
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**4**
Access - Wait Time - wait too long on telephone	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**10**
Access - Wait Time - in office for appt	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**2**
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**38**
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**1**
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**2**
Access - Geographic/Distance Access PCP	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**4**
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**	**1**
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**2**
Benefit Issue - Specific Benefit not covered	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**0**
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**15**
Attitude/Service - Provider	9	0	0	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**9**	**93**
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**3**
Attitude/Service - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**36**
Attitude/Service - Health Plan	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	**8**
Authorization - Authorization Related	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**17**
Eligibility Issue - Member not eligible per Health Plan	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**40**
Eligibility Issue - Member not eligible per Provider	10	0	0	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	**100**
Health Plan Materials - ID Cards-Not Received	36	0	0	**36**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**36**	**238**
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**10**
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**7**
Behavioral Health Related	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**16**
PCP Assignment/Transfer - Health Plan Assignment - Change Request	42	0	0	**42**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**42**	**533**
PCP Assignment/Transfer - HCO Assignment - Change Request	13	0	0	**13**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**13**	**131**
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	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**24**
PCP Assignment/Transfer - Rollout of PPG	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	**3**
PCP Assignment/Transfer - Mileage Inconvenience	5	0	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	**23**
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**0**
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**0**
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**0**
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**0**
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**0**

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**	**4**
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**3**
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	**5**
Transportation - Other	14	0	0	**14**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**14**	**85**
OTHER - Other	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	**27**
Claims Complaint - Balance Billing from Provider	18	0	0	**18**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**18**	**284**

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2026 YTD	2025 YTD
Expedited Appeals Received	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	49
Standard Appeals Received	51	0	0	51	0	0	0	0	0	0	0	0	0	0	0	0	51	564
Total Appeals Received	**55**	**0**	**0**	**55**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**55**	**613**
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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	100%
Expedited Appeals Resolved Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Expedited Appeals Resolved Compliant	3	0	0	3	0	0	0	**0**	0	0	0	**0**	0	0	0	0	3	49
Expedited Appeals Compliance Rate	**66.7%**	**0.0%**	**0.0%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**75.0%**	**100%**
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	50	0	0	50	0	0	0	0	0	0	0	0	0	0	0	0	50	562
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100%**
Total Appeals Resolved	**54**	**0**	**0**	**54**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**611**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**54**	**0**	**0**	**54**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	**54**	602
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Consultation	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	16
Community Supports	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	**13**	95
DME	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	**12**	111
Experimental/Investigational	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	34
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	5
Advanced Imaging	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	**9**	127
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	75
Pharmacy/RX Medical Benefit	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	**7**	61
Surgery	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	**8**	58
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	19
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**
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
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	2
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	5
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**	2
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	24	0	0	**24**	0	0	0	0	0	0	0	0	0	0	0	0	24	272
Uphold Rate	**44.4%**	**0.0%**	**0.0%**	**44.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**44.4%**	**44.5%**
Overturns - Full	18	0	0	**18**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	18	272
Overturn Rate - Full	**33.3%**	**0.0%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**	**44.5%**
Overturns - Partials	12	0	0	**12**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	12	42
Overturn Rate - Partial	**22.2%**	**0.0%**	**0.0%**	**22.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**22.2%**	**6.9%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	25
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%**	**4.1%**
Membership	**420,475**	-	-		-	-	-		0	0	0		0	0	0			
Appeals - PTMPM	0.13	-	-	**0.39**	-	-	-	-	-	-	-	-	-	-	-	-	**0.39**	0.24
Grievances - PTMPM	0.40	-	-	**1.21**	-	-	-	-	-	-	-	-	-	-	-	-	**1.21**	0.94

CalViva Health Appeals and Grievances Dashboard (Fresno County)

Fresno County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2026 YTD**	**2025**
Expedited Grievances Received	6	0	0	**6**	0	0	0	0	0	0	0	0	0	0	0	0	**6**	87
Standard Grievances Received	172	0	0	**172**	0	0	0	0	0	0	0	0	0	0	0	0	**172**	1870
Total Grievances Received	**178**	**0**	**0**	**178**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**178**	**1957**
Grievance Ack Letters Sent Noncompliant	1	0	0	**1**	0	0	0	0	0	0	0	0	0	0	0	0	**1**	7
Grievance Ack Letter Compliance Rate	**99.4%**	**0.0%**	**0.0%**	**99.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.4%**	**99.63%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Expedited Grievances Resolved Compliant	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	**6**	87
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Standard Grievances Resolved Compliant	134	0	0	134	0	0	0	0	0	0	0	0	0	0	0	0	**134**	1864
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**140**	**0**	**0**	**140**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**140**	**1951**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**129**	**0**	**0**	**129**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**129**	**1832**
Access - Other - DMHC	25	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	**25**	358
Access - PCP - DHCS	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	124
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	54
Administrative	25	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	**25**	353
Balance Billing	14	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	**14**	251
Community Supports	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	50
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Interpersonal	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	**16**	173
Behavioral Health	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	**5**	1
Other	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	**12**	152
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
SNF-Long Term Care	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	15
Transportation - Access	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	104
Transportation - Behaviour	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	37
Transportation - Other	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	**16**	159
Quality Of Care Grievances	**11**	**0**	**0**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11**	**119**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	2
Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	**3**	20
PCP Care	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	**7**	46
PCP Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	21
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	17
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	7
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**3**

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	2026 YTD	2025 YTD
Expedited Appeals Received	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	**3**	36
Standard Appeals Received	40	0	0	40	0	0	0	0	0	0	0	0	0	0	0	0	**40**	444
Total Appeals Received	**43**	**0**	**0**	**43**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**	**480**
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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Expedited Appeals Resolved Compliant	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	36
Expedited Appeals Compliance Rate	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**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	39	0	0	39	0	0	0	0	0	0	0	0	0	0	0	**0**	**39**	444
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**42**	**0**	**0**	**42**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**	**480**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**0**	**0**	**42**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**	**472**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Consultation	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	14
Community Supports	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	**11**	73
DME	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	**11**	91
Experimental/Investigational	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	27
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	5
Advanced Imaging	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	**5**	105
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	50
Pharmacy/RX Medical Benefit	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	**7**	52
Surgery	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	**3**	40
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	14
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Post Service Appeals	**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	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**	**2**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	4
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**	2
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	16	0	0	**16**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**16**	204
Uphold Rate	**38.1%**	**0.0%**	**0.0%**	**38.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**38.1%**	**42.5%**
Overturns - Full	16	0	0	**16**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**16**	223
Overturn Rate - Full	**38.1%**	**0.0%**	**0.0%**	**38.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**38.1%**	**46.5%**
Overturns - Partials	10	0	0	**10**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**10**	33
Overturn Rate - Partial	**23.8%**	**0.0%**	**0.0%**	**23.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**23.8%**	**6.9%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**0**	20
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%**	**4.2%**
Membership	332,462																	
Appeals - PTMPM	0.13	-	-	**0.38**	-	-	-	**0.00**	-	-	-	**0.00**	-	-	-	0.00	**0.09**	0.29
Grievances - PTMPM	0.42	-	-	**1.26**	-	-	-	**0.00**	-	-	-	**0.00**	-	-	-	0.00	**0.32**	1.20

Kings County																		
	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2026 YTD	2025
Expedited Grievances Received	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
Standard Grievances Received	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	0	17	196
Total Grievances Received	**18**	**0**	**0**	**18**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**207**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**1**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	15	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15	196
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**16**	**0**	**0**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**16**	**207**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**197**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	32
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Administrative	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	35
Balance Billing	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	26
Community Supports	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	24
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	12
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Transportation - Other	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	26
Quality Of Care Grievances	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**10**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
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	3
PCP Care	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
PCP Delay	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
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Delay	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	1

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	2026 YTD	2025 YTD
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Standard Appeals Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	36
Total Appeals Received	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	2	**43**
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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Expedited Appeals Compliance 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%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37
Standard Appeals Compliance 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%**	**100.00%**
Total Appeals Resolved	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
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	0	0	0	0	0	0	0	0	0	0	0	4
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
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	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	0	23
Uphold 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%**	**52.3%**
Overturns - Full	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	0	13
Overturn Rate - Full	**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%**	**29.5%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	0	7
Overturn Rate - Partial	**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%**	**15.91%**
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%**	**2.3%**
Membership	**38,237**															**0**		
Appeals - PTMPM	-	-	-	**0.00**	-	-	-	**0.00**	-	-	-	**0.00**	-	0	-	0.00	**0.00**	**0.16**
Grievances - PTMPM	0.42	-	-	**0.42**	-	-	-	**0.00**	-	-	-	**0.00**	-	0	-	0.00	**0.10**	**0.68**

Madera County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2026 YTD**	**2025**
Expedited Grievances Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Standard Grievances Received	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	229
Total Grievances Received	**13**	**0**	**0**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13**	**242**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.1%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Expedited Grievance Compliance 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%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	14	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14	232
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**14**	**0**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**245**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**0**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**230**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	41
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
Administrative	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	50
Balance Billing	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	36
Community Supports	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	16
Behavioral Health	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	14
Pharmacy/RX Medical Benefit	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 - Access	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	14
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24
Quality Of Care Grievances	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	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	3
PCP Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
PCP Delay	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
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Specialist Delay	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

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	2026 YTD	2025 YTD
Expedited Appeals Received	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Standard Appeals Received	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	59
Total Appeals Received	**10**	**0**	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	10	**63**
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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**96.61%**
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	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	**0**	11	63
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**12**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**87**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**12**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**86**
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	0
Community Supports	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3
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
Advanced Imaging	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	7
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**	**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	0	0	**8**	0	0	0	0	0	0	0	0	0	0	0	**0**	**8**	**45**
Uphold Rate	**66.7%**	**0.0%**	**0.0%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**66.7%**	**51.7%**
Overturns - Full	2	0	0	**2**	0	0	0	0	0	0	0	0	0	0	0	**0**	**2**	36
Overturn Rate - Full	**16.7%**	**0.0%**	**0.0%**	**16.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**16.7%**	**41.4%**
Overturns - Partials	2	0	0	**2**	0	0	0	0	0	0	0	0	0	0	0	**0**	**2**	2
Overturn Rate - Partial	**16.7%**	**0.0%**	**0.0%**	**16.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**16.7%**	**2.3%**
Withdrawal	0	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	4
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%**	**4.6%**
Membership	49,776															-		
Appeals - PTMPM	0.24	-	-	**0.72**	-	-	-	**0.00**	-	-	-	0.00	-	0	-	0.00	**0.18**	**0.38**
Grievances - PTMPM	0.28	-	-	**0.84**	-	-	-	**0.00**	-	-	-	0.00	-	0	-	0.00	**0.21**	**1.02**

CalViva SPD only

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2026 YTD	2025
Expedited Grievances Received	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	31
Standard Grievances Received	26	0	0	26	0	0	0	0	0	0	0	0	0	0	0	0	26	658
Total Grievances Received	**29**	**0**	**0**	29	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**689**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.39%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	34
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	50	0	0	50	0	0	0	0	0	0	0	0	0	0	0	0	50	718
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**53**	**0**	**0**	**53**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53**	**752**
Grievance Descriptions - Resolved Cases	**53**	**0**	**0**	**53**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53**	**752**
Access to primary care	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	43
Access to specialists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	1
Other	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	0	17	233
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	29
QOS Non Access	30	0	0	30	0	0	0	0	0	0	0	0	0	0	0	0	30	428
Exempt Grievances Received	**22**	**0**	**0**	**22**	0	0	0	**0**	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**22**	**271**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Access - Wait Time - wait too long on telephone	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	6
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Attitude/Service - Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	13
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Attitude/Service - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	19
Attitude/Service - Health Plan	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	0
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	6
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	11
Eligibility Issue - Member not eligible per Provider	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	15
Health Plan Materials - ID Cards-Not Received	10	0	0	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	10	31
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
Behavioral Health	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	44
PCP Assignment/Transfer - HCO Assignment - Change Request	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	13
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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	1
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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	1
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	9
Transportation - Other	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	34
OTHER - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	7
Claims Complaint - Balance Billing from Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	42

CalViva Health Appeals and Grievances Dashboard (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2026 YTD	2025 YTD
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Standard Appeals Received	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	159
Total Appeals Received	**9**	**0**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	9	**175**
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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17
Expedited Appeals Compliance 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%**	**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	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	**0**	17	164
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**17**	**0**	**0**	**17**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**181**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**17**	**0**	**0**	**17**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**160**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	6
Community Supports	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	34
DME	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	40
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	25
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
Pharmacy/RX Medical Benefit	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	13
Surgery	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	7
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
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	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	85
Uphold Rate	**47.1%**	**0.0%**	**0.0%**	**47.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**47.1%**	**47.0%**
Overturns - Full	6	0	0	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**6**	70
Overturn Rate - Full	**35.3%**	**0.0%**	**0.0%**	**35.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**35.3%**	**38.67%**
Overturns - Partials	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	15
Overturn Rate - Partial	**17.6%**	**0.0%**	**0.0%**	**17.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**17.6%**	**8.3%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	10	0	**10**	**10**	11
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%**	**58.8%**	**6.1%**
Membership	43,916																	
Appeals - PTMPM	0.39	-	-	**1.16**	-	-	-	**0.00**	-	-	-	**0.00**	0	-	-	0.00	**0.29**	**0.79**
Grievances - PTMPM	1.21	-	-	**3.62**	-	-	-	**0.00**	-	-	-	**0.00**	0	-	-	0.00	**0.91**	**3.22**

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, paln 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
Withdrawls	Number of withdrawn appeals
Withdrawl 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 eligibilty 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 behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir 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
The Outlier Tab	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.
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.E

Medical Management

- Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 1/01/2026 to 1/31/2026

Report created 2/23/2026

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:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Shima Lotfi
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.com
Authorization Metrics	John Gonzalez

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 1/01/2026 to 1/31/2026
Report created 2/23/2026

ER utilization based on Claims data	2025-01	2025-02	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2025-Trend	2026-01	2026-Trend	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Qtr Trend	CY- 2025	YTD-2026	YTD-Trend
MEMBERSHIP																Quarterly Averages					Annual Averages		
Expansion Mbr Months	121,277	121,332	122,118	122,345	123,026	123,322	123,901	122,392	121,296	121,003	120,883	120,655		119,264		121,576	122,898	122,530	120,847		121,963	119,264	
Adult/Family/O TLIC Mbr Mos	261,031	262,374	262,053	261,911	262,247	262,070	262,013	260,399	258,290	257,463	257,291	257,397		255,067		261,819	262,076	260,234	257,384		260,378	255,067	
Aged/Disabled Mbr Mos	47,624	47,618	47,808	47,837	48,038	48,242	48,532	48,562	48,579	48,705	48,603	48,463		47,702		47,683	48,039	48,558	48,590		48,218	47,702	
COUNTS																							
Admits - Count	2,288	2,023	2,067	2,035	2,054	2,078	2,114	2,141	2,014	2,140	2,066	2,141		2,091		2,126	2,056	2,090	2,116		2,097	3,059	
Expansion	860	729	726	727	755	773	785	803	736	828	738	733		761		772	752	775	766		766	1,107	
Adult/Family/O TLIC	923	884	891	846	873	844	892	884	861	894	898	960		899		899	854	879	917		888	1,336	
Aged/Disabled	505	410	450	462	426	461	437	454	417	418	430	448		431		455	450	436	432		443	616	
Admits Acute - Count	1,550	1,313	1,359	1,402	1,327	1,357	1,331	1,375	1,229	1,321	1,313	1,334		1,395		1,407	1,358	1,363	1,362		1,351	2,073	
Expansion	692	566	576	590	602	625	602	634	571	659	589	582		619		611	606	602	610		607	897	
Adult/Family/O TLIC	463	439	433	438	395	388	399	389	356	352	398	401		428		445	407	381	384		404	668	
Aged/Disabled	395	308	350	374	330	344	330	352	302	310	326	351		348		351	349	328	329		339	508	
Readmit 30 Day - Count	250	212	231	254	234	243	230	221	228	248	225	205		130		231	244	226	226		232	131	
Expansion	112	96	107	117	108	118	101	112	108	138	110	101		61		105	114	107	116		111	61	
Adult/Family/O TLIC	41	36	31	36	28	41	41	44	41	38	39	19		23		36	35	42	32		36	23	
Aged/Disabled	97	80	93	101	98	84	88	65	79	72	76	85		46		90	94	77	78		85	47	
**ER Visits - Count	17,259	16,345	17,227	16,590	17,625	16,116	15,810	16,349	16,579	16,270	15,461	15,702		4,139		16,944	16,777	16,246	15,811		16,444	4,139	
Expansion	4,978	4,558	4,959	4,898	5,342	5,165	5,325	5,347	5,232	4,955	4,577	4,712		1,429		4,832	5,135	5,301	4,748		5,004	1,429	
Adult/Family/O TLIC	10,199	9,920	10,199	9,649	10,147	8,845	8,335	8,843	9,378	9,220	8,928	9,172		2,320		10,106	9,547	8,852	9,107		9,403	2,320	
Aged/Disabled	2,082	1,867	2,069	2,043	2,136	2,106	2,150	2,159	1,969	2,095	1,956	1,818		390		2,006	2,095	2,093	1,956		2,038	390	
PER/K																							
Admits Acute - PTMPY	43.3	36.5	37.8	38.9	36.7	37.6	36.8	38.3	34.4	37.1	36.9	37.5		39.7		39.2	37.6	37.9	38.3		37.7	58.9	
Expansion	68.5	56.0	56.6	57.9	58.7	60.8	58.3	62.2	56.5	65.4	58.5	57.9		62.3		60.3	59.1	59.0	60.6		59.8	90.3	
Adult/Family/O TLIC	21.3	20.1	19.8	20.1	18.1	17.8	18.3	17.9	16.5	16.4	18.6	18.7		20.1		20.4	18.6	17.6	17.9		18.6	31.4	
Aged/Disabled	99.5	77.6	87.9	93.8	82.4	85.6	81.6	87.0	74.6	76.4	80.5	86.9		87.5		88.3	87.3	81.1	81.3		84.5	127.8	
Bed Days Acute - PTMPY	228.7	178.1	201.5	210.4	169.3	183.6	165.2	174.0	170.1	170.9	185.6	194.6		195.2		202.7	187.7	169.8	183.7		186.0	299.5	
Expansion	393.4	302.2	335.1	301.7	290.1	305.0	264.1	297.0	291.7	316.7	308.3	319.2		311.5		343.6	298.9	284.2	314.7		310.3	474.4	
Adult/Family/O TLIC	83.9	66.8	74.3	101.3	60.9	64.4	70.7	66.4	64.0	58.5	65.0	74.7		78.6		75.0	75.5	67.0	66.1		70.9	133.5	
Aged/Disabled	602.5	474.8	557.5	574.2	451.9	520.9	422.8	441.3	431.1	402.8	518.5	521.2		528.3		544.9	515.6	431.7	480.8		493.0	750.2	
ALOS Acute	5.3	4.9	5.3	5.4	4.6	4.9	4.5	4.5	4.9	4.6	5.0	5.2		4.9		5.2	5.0	4.5	4.8		4.9	5.1	
Expansion	5.7	5.4	5.9	5.2	4.9	5.0	4.5	4.8	5.2	4.8	5.3	5.5		5.0		5.7	5.1	4.8	5.2		5.2	5.3	
Adult/Family/O TLIC	3.9	3.3	3.7	5.1	3.4	3.6	3.9	3.7	3.9	3.6	3.5	4.0		3.9		3.7	4.1	3.8	3.7		3.8	4.2	
Aged/Disabled	6.1	6.1	6.3	6.1	5.5	6.1	5.2	5.1	5.8	5.3	6.4	6.0		6.0		6.2	5.9	5.3	5.9		5.8	5.9	
Readmit % 30 Day	10.9%	10.5%	11.2%	12.5%	11.4%	11.7%	10.9%	10.3%	11.3%	11.6%	10.9%	9.6%		6.2%		10.9%	11.9%	10.8%	10.7%		11.1%	4.3%	
Expansion	13.0%	13.2%	14.7%	16.1%	14.3%	15.3%	12.9%	13.9%	14.7%	16.7%	14.9%	13.8%		8.0%		13.6%	15.2%	13.8%	15.2%		14.4%	5.5%	
Adult/Family/O TLIC	4.4%	4.1%	3.5%	4.3%	3.2%	4.9%	4.6%	5.0%	4.8%	4.3%	4.3%	2.0%		2.6%		4.0%	4.1%	4.8%	3.5%		4.1%	1.7%	
Aged/Disabled	19.2%	19.5%	20.7%	21.9%	23.0%	18.2%	20.1%	14.3%	18.9%	17.2%	17.7%	19.0%		10.7%		19.8%	21.0%	17.7%	18.0%		19.1%	7.6%	
**ER Visits - PTMPY	481.7	454.7	478.6	460.7	488.1	446.0	436.7	454.8	464.7	457.1	434.7	441.8		117.7		471.7	464.9	452.0	444.5		458.3	117.7	
Expansion	492.6	450.8	487.3	480.4	521.1	502.6	515.7	524.2	517.6	491.4	454.4	468.6		143.8		476.9	501.4	519.2	471.5		492.3	143.8	
Adult/Family/O TLIC	468.9	453.7	467.0	442.1	464.3	405.0	381.7	407.5	435.7	429.7	416.4	427.6		109.1		463.2	437.1	408.2	424.6		433.4	109.1	
Aged/Disabled	524.6	470.5	519.3	512.5	533.6	523.9	531.6	533.5	486.4	516.2	482.9	450.2		98.1		504.8	523.3	517.2	483.1		507.1	98.1	

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	2026 - Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	Q1-2026	2026 - Quarters Trend	YTD-2025	YTD-2026	Year trends
Services	**TAT Compliance Goal: 100%**															**TAT Compliance Goal: 100%**							**TAT Compliance Goal: 100%**		
Routine Pre-Service Authorization TAT (non-BH)	100%	100%	100%	96%	100%	98%	100%	98%	100%	100%	100%	100%		100%		100%	98%	98%	97%						
Routine Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	94%	98%	98%	74%	66%	68%	86%	93%	100%	100%	100%	100%		100%		97%	69%	96%	100%						
Expedited Pre-Service Authorization TAT (non-BH)	100%	100%	100%	100%	100%	100%	80%	94%	94%	100%	100%	94%		96%		100%	100%	89%	98%						
Expedited Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	100%	100%	75%	80%	100%			100%		100%	100%	100%		NA		88%	83%	100%	100%						
Post-Service Authorization TAT (non-BH)	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%	98%	100%	98%	100%	100%	100%		100%		100%	100%	98%	100%						
	CCS ID rate															**CCS ID rate**							**CCS ID rate**		
CCS %	8.43	8.57	8.42	8.34	8.43	8.36	8.35	8.47	8.39	8.48	8.49	8.51		8.48		8.47	8.38	8.40	8.49				8.44		

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-trend	Jan-26	2026 - Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	Q1-2026	2026 - Quarters Trend	YTD-2025	YTD-2026	Year trends
	Perinatal Case Management															**Perinatal Case Management**							**Perinatal Case Management**		
Total Number Of Referrals	237	223	317	366	320	221	274	204	272	236	216	233		239		777	907	750	685				3,119		
Pending	-	-	-	-	-	-	-	-	-	1	-	13		28		-	-	-	14				14		
Ineligible	18	15	17	18	22	13	19	12	13	6	7	8		8		50	53	44	21				168		
Total Outreached	219	208	300	348	298	208	255	192	259	229	209	212		203		727	854	706	650				2,937		
Engaged	113	141	187	225	197	122	162	127	182	164	141	157		154		441	544	471	462				1,918		
Engagement Rate	52%	68%	62%	65%	66%	59%	64%	66%	70%	72%	67%	74%		76%		61%	64%	67%	71%				65%		
Total Screened and Declined	-	3	6	5	6	3	3	1	6	4	2	12		3		9	14	10	18				51		
Unable to Reach	106	64	107	118	95	83	90	64	71	61	66	43		46		277	296	225	170				968		
Total Cases Managed	307	311	342	374	389	361	363	359	385	372	364	359		320		477	494	530	448				1,089		
Total Cases Closed	75	60	50	62	74	85	81	61	61	63	58	69		71		185	221	203	190				799		
Cases Remained Open	199	231	277	297	310	270	266	289	311	303	289	284		225		277	270	311	284				284		
	Physical Health Case Management															**Physical Health Case Management**							**Physical Health Case**		
Total Number Of Referrals	185	185	401	544	516	385	334	403	397	337	267	351		499		771	1,445	1,134	955				4,305		
Pending	-	-	-	-	-	-	-	1	3	2	3	55		94		-	-	4	60				64		
Ineligible	4	2	4	28	16	10	18	15	18	6	16	10		6		10	54	51	32				147		
Total Outreached	181	183	397	516	500	375	316	387	376	329	248	286		399		761	1,391	1,079	863				4,094		
Engaged	113	120	180	292	273	215	175	227	226	206	136	182		255		413	780	628	524				2,345		
Engagement Rate	62%	66%	45%	57%	55%	57%	55%	59%	60%	63%	55%	64%		64%		54%	56%	58%	61%				57%		
Total Screened and Refused/Decline	9	6	72	33	57	32	28	30	18	17	18	19		24		87	122	76	54				339		
Unable to Reach	59	57	145	191	170	128	113	130	132	106	94	85		120		261	489	375	285				1,410		
Total Cases Closed	63	77	100	104	81	88	104	90	95	96	74	112		118		240	273	289	282				1,084		
Cases Remained Open	277	267	277	253	287	308	297	295	314	345	355	329		342		277	308	314	329				329		
Total Cases Managed	353	364	388	384	388	418	419	401	440	464	437	458		489		528	572	634	558				1,430		
Complex Case	34	38	35	29	28	37	38	49	59	76	73	78		90		48	42	70	81				148		
Non-Complex Case	319	326	353	355	360	381	381	352	381	388	364	380		399		480	530	564	477				1,282		
	Transitional Care Services															**Transitional Care Services**							**Transitional Care Services**		
Total Number Of Referrals	577	502	511	514	623	502	660	640	710	801	591	563		781		1,590	1,639	2,010	1,955				7,194		
Pending	-	-	-	-	-	-	-	-	-	2	-	15		105		-	-	-	17				17		
Ineligible	7	1	2	3	2	2	4	4	5	3	14	6		3		10	7	13	23				53		
Total Outreached	570	501	509	511	621	500	656	636	705	796	577	542		673		1,580	1,632	1,997	1,915				7,124		
Engaged	519	456	462	466	558	442	581	519	602	637	462	470		609		1,437	1,466	1,702	1,569				6,174		
Engagement Rate	91%	91%	91%	91%	90%	88%	89%	82%	85%	80%	80%	87%		90%		91%	90%	85%	82%				87%		
Total Screened and Refused/Decline	8	3	10	6	6	-	6	8	6	18	9	6		4		21	12	20	33				86		
Unable to Reach	43	42	37	39	57	58	69	109	97	141	106	66		60		122	154	275	313				864		
Total Cases Closed	322	232	283	285	253	303	321	323	348	399	340	387		327		837	841	992	1,126				3,796		
Cases Remained Open	298	332	324	301	367	364	395	418	445	478	450	386		392		324	364	445	386				386		
Total Cases Managed	683	617	653	639	679	721	778	793	850	938	840	789		778		1,207	1,227	1,493	1,164				4,198		

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	2026 - Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	Q1-2026	2026 - Quarters Trend	YTD-2025	YTD-2026	Year trends
	Behavioral Health Care Management															**Behavioral Health Care Management**							**Behavioral Health Care**		
Total Number Of Referrals	127	106	154	158	132	133	114	120	129	241	95	106		135		387	423	363	442				1,615		
Pending	-	-	-	-	-	-	-	-	1	-	-	15		21		-	-	1	15				16		
Ineligible	6	-	1	6	4	1	-	2	4	-	1	1		2		7	11	6	2				26		
Total Outreached	121	106	153	152	128	132	114	118	124	241	94	90		112		380	412	356	425				1,573		
Engaged	81	74	112	114	94	100	79	74	86	152	65	65		80		267	308	239	282				1,096		
Engagement Rate	67%	70%	73%	75%	73%	76%	69%	63%	69%	63%	69%	72%		71%		70%	75%	67%	66%				70%		
Total Screened and Refused/Decline	1	1	-	-	1	-	-	-	2	2	3	1		4		2	1	2	6				11		
Unable to Reach	39	31	41	38	33	32	35	44	36	87	26	24		28		111	103	115	137				466		
Total Cases Closed	49	53	57	90	65	54	29	29	27	42	28	25		37		159	209	85	95				548		
Cases Remained Open	153	142	169	124	101	70	86	97	110	88	93	104		114		169	70	110	104				104		
Total Cases Managed	216	219	236	232	174	140	125	132	149	139	127	135		160		338	282	209	168				658		
Complex Case	16	15	17	16	9	9	9	10	11	10	10	11		15		22	16	15	12				39		
Non-Complex Case	200	204	219	216	165	131	116	122	138	129	117	124		145		316	266	194	156				619		
	First Year of Life Care Management															**First Year of Life Care Management**							**First Year of Life Care**		
Total Number Of Referrals	36	38	50	55	47	47	62	40	45	55	40	47		57		124	149	147	142				562		
Pending	1	-	-	1	1	-	3	2	-	-	-	2		16		1	2	5	2				10		
Ineligible	-	-	1	-	-	1	1	-	1	2	1	4		1		1	1	2	7				11		
Total Outreached	35	38	49	54	46	46	58	38	44	53	39	41		40		122	146	140	133				541		
Engaged	35	38	44	54	46	46	51	37	41	51	39	40		39		117	146	129	130				522		
Engagement Rate	100%	100%	90%	100%	100%	100%	88%	97%	93%	96%	100%	98%		98%		96%	100%	92%	98%				96%		
Total Screened and Refused/Decline	-	-	-	-	-	-	-	-	1	-	-	1		-		-	-	1	1				2		
Unable to Reach	-	-	5	-	-	-	7	1	2	2	-	-		1		5	-	10	2				17		
Total Cases Closed	32	23	23	34	24	29	46	28	27	20	23	33		29		78	87	101	76				342		
Cases Remained Open	278	296	327	357	375	395	396	400	405	432	450	449		452		327	395	405	449				449		
Total Cases Managed	350	355	369	393	405	427	442	428	437	455	474	483		486		424	479	510	503				792		

Item #10
Attachment 10.F

Medical Management

- Credentialing Sub-Committee Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: March 19, 2026

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Q1 2026

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2026 CalViva Health (CVH) Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 19th, 2026. At the February meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering Q3 2025 were reviewed for delegated entities and Q4 2025 for HN, including Behavioral Health. Q3 2025 data for all organizations is summarized in Table 1 below. There were no significant issues identified in this reporting period.

III.

Table 1. Q3 2025 CalViva Health Credentialing/Recredentialing by Organization

	BH	HN	Adventist	ASH	CVMP	ChildNet	CSV	Envolve	Grow	IMG	LaSalle	Mindpath	Sante	Teladoc	UPN	Totals
Initial Credentialing	19	6	15	0	69	17	10	2	184	9	58	28	41	31	75	**564**
Recredentialing	17	3	28	0	82	45	21	12	164	14	50	16	26	33	17	**528**
Supsensions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**36**	**9**	**43**	**0**	**151**	**62**	**31**	**14**	**348**	**23**	**108**	**44**	**67**	**64**	**92**	**1092**

IV. **The 2025 Adverse Events Report** for Q4 2025 (October through December) was presented to the Credentialing Sub-Committee. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CVH CMO requests to be forwarded to the Peer Review Committee.

- Credentialing submitted one (1) new case to the Credentialing Committee in Q4 2025 involving an individual practitioner.
  - The case stemmed from a state licensing board action.
  - The case was placed on pending status, awaiting the board's ruling on the accusation.
  - Zero (0) cases involved behavioral health
  - There were no reconsiderations or fair hearings during Q4 2025.

- October, November, and December credentialing, recredentialing, denial, and termination rosters were submitted and approved via live or electronic Credentialing Committee meetings to meet business needs.
- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 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 Q4 2025.
- Reviews completed in September, October, November, and December did not identify any practitioners requiring removal from the Plan's network.
- October, November, and December delinquent license reports for termination and monitoring were submitted and approved via live or electronic Credentialing Committee meetings to meet business needs.
- Zero (0) cases required reporting for 805 in Q4 2025.

V. The **Access & Availability Substantial Harm Report Q4 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 appointment availability. The cases are severity outcome scored and ranked by severity level.
- After a thorough review of all Q4 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).

VI. The **Credentialing Adverse Actions** report for Q4 for CalViva Credentialing Sub-Committee from HN Credentialing Committee was presented. There was one (1) case presented for discussion for October, November, and December 2025:
The Medical Board of California issued a Cease Practice Order against a practitioner's medical license. The practitioner failed to complete the assigned program; therefore, the practitioner is prohibited from engaging in the practice of medicine. The practitioner shall not resume the practice of medicine until a final decision has been made.
Considering this, the Credentialing Department administratively terminated the practitioner from the provider network. This administrative termination requires no state or federal reporting by the Plan, and there are no appeal rights. The case was closed with no further action.

VII. The **Credentialing Sub-Committee 2026 Charter** was presented and approved. There were no changes to the Charter this year.

VIII. The **Credentialing Policies & Procedures Annual Review** was presented to the committee.
The majority of policies were presented with minor or no changes made. Two credentialing policies and their attachments were updated regarding primary source verification (PSV) timeframes with a change from 180 days to 120 days throughout to align with revised NCQA standards. All policies were approved.

IX. The county-specific **Credentialing Subcommittee Reports** of significant sub-committee activities for October through December 2025 were presented. There were no (0) new cases identified in Fresno, Kings, or Madera Counties for Q4 2025.

X. Follow-up activities will be scheduled, and ongoing monitoring and reporting will continue.

Item #10
Attachment 10.G

Medical Management

- Peer Review Sub-Committee Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD, Chief Medical Officer Amy R. Schneider, RN, Senior Director Medical Management
COMMITTEE DATE:	March 19, 2026
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Q1 2026

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the CalViva Health (CVH) Peer Review Sub-Committee activities. All Peer Review information is confidential and protected by law under the Knox Keene Health Care Services Plan Act of 1975, Section 1370, which prohibits disclosure to any parties outside the peer review process.

I. The Peer Review Sub-Committee met on February 19th, 2026. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2025 were reviewed for approval. There were no significant cases to report.

II. The **2025 Adverse Events Report for Q4** was reviewed. This report provides a summary of ongoing monitoring of Potential Quality Issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CVH CMO requests to be forwarded to the Peer Review Committee.
   - Seven (7) cases were identified in Q4 2025 that met the criteria for reporting.
   - Three (3) of these cases involved practitioners, and four (4) cases involved organizational providers (facilities).
   - Of the seven (7) cases, one (1) was tabled, one (1) was closed to track and trend with a letter of concern, and five (5) were closed to track and trend.
   - Six (6) cases were quality of care grievances, one (1) was a potential quality issue, zero (0) were lower-level cases, and zero (0) were identified through track and trend.

    - Three (3) 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 to a member or members in Q4 2025.
  - Grievance data reviews completed in August, September, October, and November did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. (NCQA CR 5.A.3-4)
  - Zero (0) cases were placed on corrective action in the fourth quarter of 2025.
  - Grievance data reviews for health equity, site review, chaperone, or medical records, completed in October, November, and December, 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) in Q4 2025.
  - The reviewing Medical Directors determined that further outreach was required for thirteen (13) 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.
  - One (1) case was referred to peer review for further review. Further review includes trended grievances and a license and sanction/exclusion review. This case did not require escalation for presentation at the Peer Review Committee.
  - Zero (0) cases required reporting for 805.01 in Q4 2025.

III. The **Access & Availability Substantial Harm Report for Q4 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 Issues (PQIs) related to identified appointment availability issues (Severity Levels III & IV). Each case is severity outcome scored and ranked by severity.

- Sixteen (16) cases were submitted to the Peer Review Committee in Q4 2025.
  - Of the sixteen (16) cases, two (2) cases were related to appointment availability issues without significant harm, and five (5) were related to significant harm without appointment availability issues.
- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2025.

IV. The **2026 Peer Review Sub-Committee Charter** was presented and approved by the committee. There were no changes to the Charter this year.

V. The **2026 Peer Review Policy & Procedure Annual Review** was presented.. All Peer Review policies were approved with minor or no changes.

VI. The **Q4 2025 Peer Count Report** was presented at the meeting with a total of 16 cases reviewed. Case outcomes included:

- Eleven (11) cases were closed and cleared.
- Zero (0) cases were closed and terminated.
- Zero (0) cases were deferred.
- Two (2) cases were tabled for further information.
- Two (2) cases were closed with CAP outstanding/continued monitoring, and
- One (1) case was pending closure for CAP compliance.

VII. The **Peer Review Sub-Committee reports** for October through December 2025 were reviewed. These reports summarize the outcomes of Peer Review cases for Fresno, Kings, and Madera counties. There were zero (0) cases reported in Q4 2025.

VIII. Follow-up will be initiated to obtain additional information for the tabled cases, and ongoing monitoring and reporting will continue.

Item #10
Attachment 10.H

Executive Report

- Executive Dashboard

	2025	2025	2025	2025	2025	2025	2025	2025	2025	2025	2025	2025	2026
Month	**January**	**Feburary**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**
CVH Members													
Fresno	343,331	343,661	344,009	343,946	344,786	345,260	345,340	342,450	340,709	339,554	339,029	338,291	334,955
Kings	38,319	38,416	38,595	38,593	38,656	38,654	38,730	38,789	38,783	38,729	38,689	38,719	38,543
Madera	49,686	49,936	50,015	50,185	50,466	50,725	50,974	50,958	50,850	50,648	50,627	50,523	50,017
Total	431,336	432,013	432,619	432,724	433,908	434,639	435,044	432,197	430,342	428,931	428,345	427,533	423,515
SPD	47,384	47,559	47,614	47,581	47,873	48,033	48,339	48,274	48,274	48,382	48,315	48,254	47,340
CVH Mrkt Share	66.70%	66.71%	66.75%	66.77%	66.79%	66.79%	66.78%	66.81%	66.79%	66.83%	66.84%	66.89%	66.83%
ABC Members													
Fresno	152,847	152,663	152,377	151,970	151,951	151,925	151,700	149,921	148,987	147,973	147,293	146,465	144,988
Kings	24,836	24,916	25,007	24,942	25,042	25,020	25,119	25,190	25,146	25,108	25,166	25,184	25,211
Madera	27,940	27,879	27,723	27,650	27,553	27,607	27,669	27,375	27,240	27,076	26,930	26,742	26,472
Total	205,623	205,458	205,107	204,562	204,546	204,552	204,488	202,486	201,373	200,157	199,389	198,391	196,671
Kasier													
Fresno	8,130	8,479	8,737	9,020	9,356	9,681	10,001	10,252	10,551	10,714	10,976	11,117	11,321
Kings	187	199	206	209	206	209	215	231	239	246	259	259	269
Madera	1,372	1,428	1,485	1,565	1,608	1,656	1,700	1,741	1,775	1,811	1,843	1,864	1,923
Total	9,689	10,106	10,428	10,794	11,170	11,546	11,916	12,224	12,565	12,771	13,078	13,240	13,513
Default													
Fresno		65.71%	61.18%	62.07%	60.31%	61.10%	61.03%	58.94%	61.52%	59.59%	60.44%	63.29%	
Kings			56.49%	42.30%	44.07%	57.76%	60.13%	56.57%	46.17%				
Madera			63.13%	47.18%	46.80%	61.63%	49.28%	45.13%	50.43%				
County Share of Choice as %													
Fresno		63.95%	64.88%	62.72%	61.33%	60.48%	61.50%	59.30%	61.73%	60.40%	60.85%	61.54%	
Kings		40.29%	61.16%	58.03%		52.59%	54.22%	55.81%	56.51%		55.43%	56.30%	
Madera		69.36%	64.47%	71.61%	63.59%	65.45%	64.90%	65.07%	61.08%	63.92%	65.14%	57.46%	

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	**23**	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	**3.4 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**	**2025**	**2025**	**2025**	**2025**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**38,251**	**33,900**	**41,923**	**40,133**	**42,619**	**37,637**
		# of Calls Answered	**37,970**	**33,610**	**41,609**	**39,766**	**42,295**	**37,365**
		Abandonment Level (Goal < 5%)	**0.70%**	**0.90%**	**0.70%**	**0.90%**	**0.80%**	**0.70%**
		Service Level (Goal 80%)	**96%**	**93%**	**92%**	**94%**	**96%**	**95%**
	Behavioral Health Member Call Center	**# of Calls Received**	**957**	**827**	**1,008**	**917**	**963**	**847**
		# of Calls Answered	**950**	**816**	**1,004**	**909**	**959**	**843**
		Abandonment Level (Goal < 5%)	**0.70%**	**1.30%**	**0.40%**	**0.90%**	**0.40%**	**0.50%**
		Service Level (Goal 80%)	**93%**	**88%**	**95%**	**96%**	**98%**	**98%**
	Transportation Call Center	**# of Calls Received**	**14,196**	**14,123**	**14,958**	**15,899**	**18,401**	**21,331**
		# of Calls Answered	**13,940**	**14,010**	**14,868**	**15,819**	**18,327**	**21,246**
		Abandonment Level (Goal < 5%)	**1.50%**	**0.60%**	**0.40%**	**0.20%**	**0.20%**	**0.30%**
		Service Level (Goal 80%)	**63%**	**82%**	**86%**	**85%**	**84%**	**91%**
	CalViva Health Website	**# of Users**	**64,000**	**69,000**	**79,000**	**34,000**	**54,000**	**52,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (67%)**	**Mobile (73%)**	**Mobile (70%)**	**Mobile (63%)**	**Mobile (62%)**	**Mobile (63%)**
		Session Duration	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website activities. Approximately 4,200 members have registered and created a member portal account.							

Provider Network & Engagement Activities	**Year**	**2025**	**2025**	**2025**	**2025**	**2025**	**2025**	**2026**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Hospitals	**10**	**11**	**11**	**11**	**11**	**11**	**11**
	Clinics	**162**	**165**	**166**	**166**	**167**	**168**	**169**
	PCP	**446**	**448**	**448**	**446**	**453**	**457**	**447**
	PCP Extender	**508**	**521**	**522**	**509**	**504**	**511**	**515**
	Specialist	**1664**	**1690**	**1693**	**1622**	**1629**	**1633**	**1553**
	Ancillary	**331**	**329**	**334**	**336**	**338**	**341**	**341**
	Year	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**	**2025**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Behavioral Health	**652**	**658**	**558**	**545**	**562**	**486**	
	Vision	**116**	**113**	**114**	**112**	**104**	**106**	
	Urgent Care	**16**	**16**	**17**	**17**	**16**	**16**	
	Acupuncture	**3**	**3**	**2**	**3**	**3**	**3**	
	Year	**2024**	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**94%**	**94%**	**94%**	**91%**	**89%**	**89%**	**92%**
	% Of Specialists Accepting New Patients - Goal (85%)	**97%**	**98%**	**97%**	**96%**	**96%**	**96%**	**97%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**96%**	**97%**	**98%**	**99%**	**99%**	**99%**	**95%**
	Year	**2025**	**2025**	**2025**	**2025**	**2025**	**2025**	**2026**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Providers Interactions by Provider Relations	**505**	**679**	**446**	**363**	**326**	**445**	**375**
	Reported Issues Handled by Provider Relations	**16**	**33**	**39**	**23**	**17**	**23**	**23**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**8**	**21**	**3**	**13**	**9**	**0**	**3**
	Interventions Deployed for PCP Quality Performance Improvement	**8**	**21**	**3**	**13**	**9**	**0**	**3**
Message From the CEO	Management is continuing to work with the Plan's Administrator on addressing irregularities with the network data which is being represented in the Plan's provider directories. As a result, Q4 2025 numbers for Behavioral Health, Vision, Urgent Care, and Acupuncture are not yet available at this time. Management anticipates reporting both Q4 2025 and Q1 2026 data in the near future when data is validated.							

	Year	**2024**	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
Claims Processing	**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	94% / 98% N/A	96% / 98% N/A	99% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	N/A	99% / 100% NO	100% / 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	1% / 93% NO						
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	94% / 97% YES	88% / 99% YES	80% / 100% YES	79% / 95% YES	91% / 100% YES	84% / 99% YES	83% / 99% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	79% / 93% YES	99% / 100% NO	94% / 97% NO	96% / 100% YES	93% / 100% YES	92% / 100% NO	92% / 100% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	95% / 100% NO	97% / 100% YES
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	95% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 100% NO	100% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	97% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 100% NO	79% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 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	Q3 2025 numbers were previously presented on February 19, 2026. Q4 2025 numbers are not yet available.							

Provider Disputes	**Year**	**2024**	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	98%	99%	99%	99%	100%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	99%	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%)	89%						
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	70%	93%	99%	96%	99%	95%	99%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	100%	100%	100%	100%	99%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	97%	97%	98%	100%	100%	99%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	99%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	99%	100%	100%	99%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	97%	100%	100%	100%	100%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	98%	100%	100%	100%
Message from the CEO	Q3 2025 numbers were previously presented on February 19, 2026. Q4 2025 numbers are not yet available.							