FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Joe Prado, Director
Public Health Department

David Cardona, M.D.
At-large

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

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Timothy Haydock,
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: May 15, 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, May 21, 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 **11** 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
May 21, 2026
1:30pm - 3:30pm

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

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	J. Neves, Co-Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A	**Kings County BOS Appointed Commissioner** • **Tim Haydock** *Action: Ratify appointment of Kings County At-Large Commissioner*	J. Neves, Co-Chair
4 Action	Attachment 4.A	**Kings County At-Large Commission Seat Application** • Kerry Hydash *Action: Commission to vote on reappointment of Commissioner*	J. Neves, Co-Chair
5 Action	No attachment	**Chair and Co-Chair Nominations for Fiscal Year 2027** *Action: Nominate and Approve Nominations*	J. Nkansah, CEO
6 Action	Attachment 6.A Attachment 6.B Attachment 6.C Attachment 6.D	**Consent Agenda:** • Commission Minutes dated 3/19/26 • Finance Committee Minutes dated 2/19/26 • QI/UM Committee Minutes dated 2/19/26 • Compliance Report *Action: Approve Consent Agenda*	J. Neves, Co-Chair
7		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item:**	
Information	No attachment	**A. Public Employee Appointment - pursuant to Government Code Section 54957.** ▪ Title: Chief Compliance Officer	
	No attachment	**B. Public Employee Appointment - pursuant to Government Code Section 54957.** ▪ Title: Chief Medical Officer	

	Attachment	**C. Conference Report Involving Trade Secret – Discussion of service, program, or facility:** Estimated Date of Public Disclosure: July 2026 Government Code section 54954.5	
	No attachment	D. **Conference with Legal Counsel - Anticipated Litigation. Significant exposure to potential litigation, one potential case**. Pursuant to Government Code section 54956.9(b)	
8 Action	No Attachment	**CEO Annual Review: Ad-Hoc Committee Selection** • Select ad-hoc Committee *Recommended Action: Selection of Ad-Hoc Committee*	J. Neves, Co-Chair
9 Information	Attachment 9.A	**Sub-Committee Members for Fiscal Year 2027:** • BL 26-010 Sub-Committee Members	J. Neves, Co-Chair
10 Action	Attachment 10.A Attachment 10.B	**Community Support & DHCS Reinvestment Program** • BL 26-011 Community Support & DHCS Reinvestment Program • Proposed Grant Recommendations 2026-2027 *Action: Approve Community Funding Grant Recommendations*	J. Nkansah, CEO
	Handouts available at meeting	*PowerPoint Presentation will be used for items 11 – 13* ***One vote will be taken for combined items 11 – 13***	
11 Action	Attachment 11.A Attachment 11.B Attachment 11.C	**Health Equity Program** • 2025 End of Year Evaluation and Executive Summary • 2026 Program Description and Change Summary • 2026 Work Plan and Executive Summary *Action: see Item #13*	P. Marabella, MD, CMO
12 Action	Attachment 12.A	**Population Health** • 2026 Population Health Management Program Strategy Description & Change Summary *Action: see Item #13*	P. Marabella, MD, CMO
13 Action	Attachment 13.A Attachment 13.B	**Long Term Care** • 2026 Long Term Care Quality Assurance Performance Improvement Plan • Skilled Nursing Facility Quality Assurance Performance Improvement Q4 2025 Report *Action: Approve Health Equity 2025 End of Year Evaluation, Health Equity 2026 Program Description, Health Equity 2026 Work Plan, the 2026 PHM Program Strategy Description, the 2026 Quality Assurance Performance Improvement Plan, and the Skilled Nursing Facility Quality Assurance Performance Improvement Q4 2025 Repot.*	P. Marabella, MD, CMO

Item	Attachment	Agenda Item	Presenter
14 Action		**Standing Reports**	
		Finance	D. Maychen, CFO
	Attachment 14.A	• Financials as of March 31, 2026	
	Attachment 14.B	• FY 2027 Proposed Budget	
		Medical Management	P. Marabella, MD, CMO
	Attachment 14.C	• Appeals and Grievances Report	
	Attachment 14.D	• Key Indicator Report	
	Attachment 14.E	• Quarterly Summary Report	
		Equity	
	Attachment 14.F	• Health Equity Report	S. Xiong-Lopez, EqO
		Executive Report	
	Attachment 14.G	• Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	
15		**Final Comments from Commission Members and Staff**	
16		**Announcements**	
17		**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.*	
18		**Adjourn**	J. Neves, Co-Chair

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

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

Next Meeting scheduled for July 16, 2026 2025 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item 3

Attachment 3.A

Kings County BOS
Appointed Commissioner

Intra-Office Memo

TO: **CALVIVA/TRI-COUNTY HEALTH AUTHORITY COMMISSION**
Cheryl Hurley, Committee Coordinator
c/o email at: CHurley@calvivahealth.org

FROM: Catherine Venturella - Clerk of the Board

DATE: April 30, 2026

SUBJECT: **Appointment to the CalViva/Tri-County Health Authority Commission**

On April 7, 2026, the Board of Supervisors appointed the following member to the above named committee: Timothy Haydock as the County Community primary representative. I have attached a copy of the appointment letter and a new roster for your files. Please call if you have any questions at 559-852-2362.

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

RICHARD VALLE – DISTRICT 2
AVENAL, CORCORAN, HOME GARDEN & KETTLEMAN CITY

DOUG VERBOON – DISTRICT 3
NORTH HANFORD, ISLAND DISTRICT & NORTH LEMOOORE

RUSTY ROBINSON – DISTRICT 4
ARMONA & HANFORD

ROBERT THAYER – DISTRICT 5
HANFORD & BURRIS PARK

COUNTY OF KINGS
BOARD OF SUPERVISORS

MAILING ADDRESS: KINGS COUNTY GOVERNMENT CENTER, HANFORD, CA 93230
OFFICES AT: 1400 W. LACEY BLVD., ADMINISTRATION BUILDING # 1, HANFORD
(559) 852-2362, FAX: (559) 585-8047
Web Site: http://www.countyofkingsca.gov

April 7, 2026

Timothy Haydock
2602 Sun Drive
Hanford, CA 93230

Subject: **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission**

Dear Timothy;

It is a pleasure to inform you that on April 7, 2026 the Kings County Board of Supervisors appointed you to serve on the **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission** as the County Community at large primary position.

Congratulations on your appointment and thank you for your interest in serving Kings County in this capacity. A copy of this letter is being sent to the Committee to inform them of your appointment. I have enclosed a copy of the oath of office which will need to be completed in the presence of a notary public and sent to me or you may come by our office and have the oath completed for free. Please call if you have any questions concerning the above.

Sincerely,

Catherine Venturella
Clerk to the Board of Supervisors

H:\BOS\Brdcomm\CalViva appt
cc: Committee Coordinator

Item #4

Attachment 4.A

Kings County At-Large Commission
Appointed Application

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
COMMISSION AT-LARGE APPOINTEE
APPLICATION FORM

Three Commission appointed positions have been designed as follows: one resident from Fresno County, one resident from Kings County and one resident from Madera County. Qualified applicants shall represent the general public, beneficiaries, physicians; hospitals, clinics and other non-physician health care provider. Individuals considering Commission at-large positions should have a commitment to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances, delivers high quality care and is financially viable.

Name of Applicant: Kerry L. Hydash
Home Address: . City: Zip: 93230
Current Employer: Family HealthCare Network
Business Address: 305 E. Center Ave City: Visalia Zip: 93291
Home Phone: Work Phone: 559-737-4731 E-mail Address: khydash@fhcn.org

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List past or present County appointments, as well as any other public service appointments, or elected positions held (please list dates served):

I was appointed to the Workforce Investment Board of Tulare County in 2009. Over the years, I served in many capacities, including Board Chair. I concluded my service on the board in 2023.

List past or present affiliations with private and/or public health plans.

NA

What experience or special knowledge can you bring to the Regional Health Authority?

I serve as Family HealthCare Network's President & CEO. Family HealthCare Network has 50 sites throughout four counties where we serve over 250,000 unique users a year, of which 169,000 are Medi-Cal managed care lives.

List community organizations to which you belong:

I serve on the boards of Advocates for Community Health, California Primary Care Association, Clinic Mutual Insurance Board, Central Valley Health Network, and Best Practices, LLC. I am a past board member of the Visalia Symphony, the Visalia Chamber of Commerce, the Workforce Investment Board of Tulare County, and the National Center for Farmworker Health.

Convictions and penalties- Have you ever been convicted of a felony? If yes, give date(s), Location(s) and penalties. (Convictions are evaluated for each position and are not necessarily disqualifying.)

NA

List any affiliation you or your spouse has with public service agencies:

NA

Provide a minimum of three references and their contact information that the commission Nominating Committee may contact:

1. Name: Jason Vega
   Affiliation: Principal, Vega Public Affairs, LLC
   Contact Phone Number: 916-995-9450

2. Name: Paulo Soares
   Affiliation: Chief Executive Officer, Camarena Health
   Contact Phone Number: 559-250-5636

3. Name: Amanda Pears Kelly
   Affiliation: Chief Executive Officer, Advocates for Community Health
   Contact Phone Number: 202-834-2592

Please Note: Commission appointees are required to submit California Form 700 for filing with the Fair Political Practices Commission.

I HAVE READ THE "FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION POLICY" REGARDING CONFLICT OF INTEREST FOR COMMISSION APPOINTEES AND AGREE TO ABIDE BY THE POLICIES AND PRODEDURES AT ALL TIMES WHILE AN APPOINTED MEMBER. AT PRESENT, TO THE BEST OF MY KNOWLEDGE, NO CONFLICT OF INTEREST EXISTS IN MY SERVING ON THIS COMMITTEE.

(Signature) 4/27/21 (Date)

COMPLETE FORM AND RETURN TO:

Clerk to the Commission
Fresno-Kings-Madera Regional Health Authority
7625 N. Palm Avenue, Suite 109
Fresno, CA 93711

Applications will be kept on file for a year.

Item #6

Attachment 6.A-D

Consent Agenda

A. Commission Minutes dated 3/19/26
B. Finance Committee Minutes dated 2/19/26
C. QI/UM Committee Minutes dated 2/19/26
D. Compliance Report

Fresno-Kings-Madera Regional Health Authority

CalViva Health
Commission
Meeting Minutes
March 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		**Vacant**, 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 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** David Hodge, MD, Chairman	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *15 – 0 – 0 – 1* *(Naz / De La Torre)*
#4 Closed Session	Jason Epperson reported out of closed session. The Commission went in closed session to discuss the item agendized as item #4.A, Conference with Legal Counsel – Anticipated Litigation. Significant exposure to potential litigation, one potential case pursuant to government code section 54956.9(b). The commission discussed that in closed session; direction was given to staff. It took no further reportable action. Closed session was recessed at 2:18 pm.		***No Motion*** **Kerry Hydash left meeting during closed session due to technical difficulties.*
#5 FKM RHA Commission Meeting Location **Action** J. Nkansah, CEO	Jeff Nkansah provided a summary of the March commission meeting discussion and provided historical challenges of the FKM RHA Commission Meeting locations. The Commission discussed and Madera County and Kings County commissioners indicated they do not see an issue with keeping the meetings in Fresno County. The commission voted to keep the meetings in Fresno County.	*Sara Bosse asked the Equity Officer if having the Commission meetings always in Fresno County was equitable for the Plan's members that may want to attend.* *Sia Xiong-Lopez reiterated that keeping the meetings in Fresno County would be*	***Motion**: Commission approved to keep meeting location in Fresno County.* *14 – 0 – 0 – 2* *(Naz / Fields-Keene)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		challenging for locating a meeting location, technology, attendance, etc.	
6. CYBHI MOU CBH-MCP ASO Payment Model **Action** J. Nkansah, CEO	Jeff presented the CYBHI MOU 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.		***Motion:*** *Commission approved Jeffrey Nkansah to execute the CYBHI ASO Payment Model MOU* *14 – 0 – 0 – 2* *(Rahn / Frye)* **Dr. Cardona left at 2:28 pm; no vote after agenda item #5*
7. Community Support & DHCS Reinvestment Program Ad-hoc Committee Selection **Action** J. Nkansah, CEO	An ad-hoc committee is needed for the Community Support & DHCS Community Reinvestment Program. Jeff Nkansah recommended that since the current ad-hoc committee members have been educated on the new requirements and also to avoid a conflict of interest with public health department commissioners, that the previous ad-hoc members Dr. Hodge, Paulo Soares, and Dr. Naz remain in place moving forward.		***Motion:*** *Ad-Hoc Committee members remained the same and Commission approved.* *14 – 0 – 0 – 2* *(Rogers / Neves)*
8. 2026 Quality Improvement & Health Education **Action** P. Marabella, CMO	Dr. Marabella presented the 2026 Quality Improvement and Health Education Program Description and 2026 Work Plan. The highlights of changes for 2026 Program Description are: • Information Systems and Analysis: Removed section since it is redundant to the additional resources - Information Systems section. • Quality Improvement Goals: Added bullet item: Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities. • Scope: Services Covered by CalViva: Removed Health Homes Program (HHP), added Community Supports to meet social needs of all members. • Health Education Programs: Added description on Complex Health Needs/Care Management		***Motion:*** *See #9 for motion*

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

	• Care Management (CM) Program: Removed section and added Complex Health Needs/Care Management to Health Management Programs section
	• Operations and Service: Provider Performance & Analytics team name updated to Data Strategy & Insights. Removed Sales from collaboration efforts.
	• 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).
	  ○ MCAS and DMHC Health Equity and Quality measure performance were added to CalViva's monitoring activities. Specified that member outreach activities are conducted to close care gaps to improve outcomes and performance metrics.
	• 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."
	• Health Equity and Cultural and Linguistic Needs: Replaced Diversity, Equity, and Inclusion training with Cultural Competency Training.
	• 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.
	• Satisfaction: Revised and rephrased Satisfaction description. Added ECHO/OPMH surveys and description of Program Manager responsibilities.
	• Health Education Programs: Removed the Health Education phone number. Rephrased the Kick It California description.
	• Telehealth Services: Added ConferMed of CA as vendor. Removed and replaced the goals for the Telehealth Program.
	• Staff Resources and Accountability:
	  ○ Added Case/Care Management department description; Updated Management Information Systems (MIS) summary description and updated the titles of several departments or functional areas.
	  ○ Revised Enterprise Data Warehouse (EDW) and Statistical Analysis Software (SAS) descriptions and added other new software descriptions.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• QI Program Activities: Projects, Surveys and Audits, Incentive Programs: Added ECHO and OPMH; Revised Member and Provider Incentive Programs. • QI Process: Added DMHC Health Equity and Quality measure performance as areas for focused performance improvement. • Other minor edits. 2026 QI, Health Ed and Wellness Work Plan is divided into Two Sections: • Work Plan Initiatives • Quality Improvement Tracking System Activities Log The eight (8) key areas for Quality Improvement and Health Education Work Plan include: 1. Behavioral Health: a. MPL met for both measures in Kings County for MY2024. b. Statistically significant directional improvement noted in Fresno and Madera Counties, but MPL not met for either measure in MY2024. c. Continue efforts on both FUM/FUA measures in 2026. d. Ensure broad and consistent implementation of depression screening by all providers in all 3 counties (DSF-E). e. Work with providers to capture depression screening data. 2. Chronic Conditions: a. Maintain achievement of MPL for two measures in 2026. b. Asthma Medication Ratio measure retired. c. "Follow-up After Acute and Urgent Care Visits for Asthma" is new measure this year. MCPs are not held to MPL for this measure in MY26. 3. Hospital Quality/Patient Safety: a. Goals not met in MY2024 b. MY2026 focus is to increase number of reporting hospitals. c. Reduce infection rates & c-section rates. d. In 2026 maintain achievement of MPL with new priority activity that will focus on coordination of care. e. Implement two new depression screening measures consistently in all three counties ensuring appropriate follow-up and data capture. 4. Member Engagement and Experience (IHA) for 2026:		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	a. Meet or exceed goal for timely IHA of 59.40%. b. Ensure providers are clear on minimum requirements for comprehensive initial health appointment. c. Connect new members with medical home and support timely completion of IHA within 120 days. 5. Pediatric: a. Improvement noted in Children’s Domain measures in MY2024, but continued focus needed in MY2026 for: i. Well Child Visits (W30) in Fresno County and (WCV & W30) in Kings County. ii. Topical Fluoride (TFL-CH), Developmental Screening (DEV) and Immunizations (CIS-10) in Kings County. iii. Maintain achievement in other Children’s Domain measures in all counties. 6. Preventive Health: a. Maintain achievement of MPL for BCS, CCS & COL through special events, mobile events, and member outreach. b. Strive to understand barriers and improve flu vaccine rates. 7. Member Engagement and Experience (CAHPS): a. Continue to obtain directional improvement on Access related measures. b. Implement strategies to meet or exceed the CAHPS 25th percentile for Rating of Health Plan, Customer Service and Ease of Filling Out Forms. 8. Provider Communications/Engagement: a. After Hours Access met performance goal > 90% on both metrics. b. Improvement needed for Appointment Access related to: c. Specialist Urgent d. Specialist Non-urgent e. Interventions will focus on improving member access to appointments with Specialists in 2026. Quality Improvement Tracking System Activities examples: 1. Behavioral Health: • Monitor results of BH member satisfaction surveys at least annually and Appeal and Grievance Quarterly results and analysis to identify trends and opportunities for improvement.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Conduct Member outreach (Outreach Team or CHW) following ED Visit for substance use or mental health issue post-discharge utilizing the Admit, Transfer, and Discharge (ADT) report (Lanes Report). • Ensure PHQ-9 data from Teledoc appointments can be used to improve HEDIS Depression Screening rates for Adults and Adolescents (DSF-E). 2. Chronic Conditions: • Member outreach campaign (by Sprinter Health) to provide in-home blood pressure device to self-monitor blood pressure (CBP). • Outreach campaign to support Diabetic Members that may be due for an A1c test to provide "Simple HealthKits", A1c home test kits sent directly to the Member via mail. 3. Hospital Quality/Patient Safety: • Outreach to hospital leadership regarding patient safety metrics, standards/expectations, and opportunities to improve. Metrics will focus on hospital acquired infections, sepsis management, the Patient Safety Honor Roll, and the Opioid Care Honor Roll. o Produce and distribute Hospital Quality Scorecards. 4. Member Experience (IHA): • Identify high volume, low-performing Initial Health Appointment (IHA) providers on a quarterly basis and collaborate with Provider Engagement to provide targeted training and support to the identified providers. • Report quarterly IHA results of monitoring and training status to stakeholder committee members. 5. Pediatric: • Share Quarterly Blood Lead Screening gap lists with providers for members who have not completed blood lead screening by age 1, age 2 or by age 6. • 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. • Promote the CDC's Milestone Tracker App in future newsletters, website locations, add to Health Education Provider Resource (QR Codes), promote it to CalViva's Pregnancy and First Year of Life programs, etc. 6. Preventative Health:		

<table>
<tr><th>AGENDA ITEM / PRESENTER</th><th>MAJOR DISCUSSIONS</th><th>RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)</th><th>MOTION / ACTION TAKEN</th></tr>
<tr><td></td><td>• Launch a targeted text campaign designed to remind and encourage Members to complete recommended breast, cervical, and/or colorectal cancer screenings.
• Partner with Exact Sciences who will outreach to members and inform them of the importance of colorectal cancer screening via a letter.
• Increase access to breast cancer screening services using mobile mammography, especially for individuals who have limited access to traditional healthcare facilities, including those in rural and underserved communities.
7. Member Experience (CAHPS):
• Revise CAHPS Provider Playbook Best Practices into one resource for providers to utilize and improve CAHPS measures.
8. Member Experience (CAHPS):
• Offer physician-led webinar trainings; topics will focus on improving provider communication and access.
• Develop a Behavioral Health (BH) Resource Sheet for PCPs to support member referral to the appropriate BH services.</td><td></td><td></td></tr>
<tr><td>9. 2026 Utilization Management

Action
P. Marabella, CMO</td><td>Dr. Marabella presented the 2026 Utilization Management Care Management Program Description and Work Plan.

The UMCM Work Plan changes include:
• Five Sections remain consistent with the 2025 Work Plan with updates and minor edits throughout.
• Expanding the integration of Behavioral Health into utilization activities was a key enhancement this year.
• The addition of a separate section for Enhanced Care Management was also a priority.

The 2026 Work Plan Updates include:
• Annual Review of UM Clinical Criteria: Added Behavioral Health (BH) to Physical Health (PH) to ensure annual review and approval of UM criteria by Medical Advisory Committee and QI/UM Committee.
• The number of authorizations for services requested: Clarified objectives to track both PH and BH authorizations monthly.</td><td></td><td>Motion: Approve the 2026 QI & HE Program Description & Change Summary; 2026 QI & HE Work Plan; 2026 UM Program Description & change Summary; and UM Work Plan

14 – 0 – 0 – 2

(Rogers / Naz)</td></tr>
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AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Timeliness of processing authorization requests: Monitor turnaround times for both PH and BH authorizations. • Annual Interrater Reliability (IRR) testing of healthcare professionals: Clarified IRR testing applies to both PH and BH; and Clarified 2 remediation opportunities offered for scores below 90%. • Number of Appeals of UM Decisions Received: Clarified tracking for PH and BH; and Expanded planned interventions when TATs aren't met • Improve Shared Risk & Fee for Service UM Acute Inpatient Performance: Updated Planned Interventions to emphasize support of discharge to various post-acute care destinations; and Goals for Key Metrics (admits, ALOS, Bed Days, etc) under review, to be established by end of Q1. • Care Management: Removed ECM enrollment and graduation rates. • Disease/Chronic Condition Management: New program implemented last year; and added new annual report to monitor Member outcomes • Behavioral Health Care Coordination: Added measures related to Screening for Referrals to County Programs; Other Referral Data; Referrals to Case Management; and Appointment Access Data • Enhanced Care Management (ECM) - New Section of Work Plan: Added Demonstrate 12-month growth in % of members receiving ECM; Members not meeting criteria are referred to alternative programs or CM; and Notice of Action Letters are distributed to Members who are disenrolled from ECM.		
10. Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of January 31, 2026</u> As of January 2026, total current assets were approximately $411.8M; total current liabilities were approximately $224.6M. Current ratio is approximately 1.83. TNE as of the end of January 2026 was approximately $196.9M which is approximately 661% above the minimum DMHC required TNE amount. For the DHCS standard, the minimum required TNE is approximately $193.7M, which the Plan is approximately $3.2M above the DHCS standard.		***Motion***: *Commission approved standing reports* *13 – 0 – 0 – 3* *(Frye / Naz)* **Paulo Soares left meeting at 2:59 pm, no vote for #10*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Compliance Report** Mary Lourdes Leone, CCO	Interest income actual recorded was approximately $5.5M which is approximately $2.3M more than budgeted due to rates being higher than projected. Premium capitation income actual recorded was approximately $1.36B which is approximately $162.6M more than budgeted primarily due to rates and enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $868.1M which is approximately $157M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $33M which is approximately $1.9M more than budgeted due to enrollment being higher than projected. Labor expense actual recorded was approximately $2.7M which is approximately $470K less than projected mainly due to open positions (e.g., an open position related to succession planning for a key management position). All other expense items are below or in line with what was budgeted. Total net income through January 2026 was approximately $12.8M, which is approximately $7.4M more than budgeted primarily due to interest income being approximately $2.3M more than projected and enrollment and rates being higher than projected. **Compliance** <u>Compliance Report</u> Year to date there have been 51 Administrative & Operational regulatory filings for 2026; 10 Member Materials filed for approval; 24 Provider Materials reviewed and distributed, and 12 DMHC filings. There have been 7 potential Privacy & Security breach cases reported year to date, with one being high risk. 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• False Representation: 1 case • Inappropriate use of transportation: 1 case The Annual Oversight Audits currently in progress since last reported include UMCM, Call Center, Claims/PDR, and Provider Network. No audits have been completed since the last Commission meeting. Regarding the 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. Regarding the 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. Regarding the 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. Since the last Commission Meeting, the Plan has not executed any MOUs. Regarding the 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding the 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 and approving the same final document. The last PPC meeting was held on March 4, 2026. The following reports were presented: • Q4 2025 Appeal and Grievance Report • A&G Review and Discussion from Dr Marabella • Annual Public Policy Committee Charter • 2025 CalViva Health 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.		
• **Health Equity** Sia Xiong-Lopez, EqO	**Equity** <u>Equity Report</u> Regarding Madera Live Well, as of March 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. Regarding Kings County CHIP, as of February 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Health Workers (CHWs). CVH's Equity Officer will participate in the initial workgroup kickoff scheduled for March 23, 2026. Regarding FCHIP HOPE HUB, 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. Regarding the Health Equity Annual Oversight Audit, the audit is scheduled to start April 2026. With regard to the changes for NCQA: 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.		
• **Medical Management** P. Marabella, MD, CMO	**Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievance Data Analysis Report through January 2026.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• The total number of grievances at the end of January remained consistent with previous months. The Quality-of-Service category represents the highest volume of total grievances. • For the Quality of Service (QOS) category, the types of cases noted to contribute the most to case volume are Access-Other, Administrative, Community Supports, Other, and Transportation-Other. • The volume of Exempt Grievances is consistent with previous months. • Total Appeals volume remained consistent with previous months. The majority being Community Supports, DME, Advanced Imaging, and Surgery. • <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through January 2026. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through January 2026. • Membership has had a slight decrease. Admits and Acute Admits remain consistent with previous months. Readmission rates for all categories have decreased with the exception of SPDs. ER visits remain consistent. • Turn-Around-Time Compliance (TAT) categories met compliance goals with the exception of Expedited Pre-Service. • Case Management (CM) engagement rates are up, and all areas continue to improve. <u>Credentialing Sub-Committee Quarterly Report</u> The Credentialing Sub-Committee met on February 19, 2026. 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 reports covering Q3 2025 were reviewed for delegated entities and Q4 2025 for HN, including Behavioral Health.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The Adverse Events report for Q4 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 Q4 2025 involving an individual practitioner. 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. 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). 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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. The Credentialing Sub-Committee 2026 Charter was presented and approved. There were no changes to the Charter this year. 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. 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. Follow-up activities will be scheduled, and ongoing monitoring and reporting will continue. <u>Peer Review Sub-Committee Quarterly Report</u> The Peer Review Sub-Committee met on February 19, 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. 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. 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		

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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The 2026 Peer Review Sub-Committee Charter was presented and approved by the committee. There were no changes to the Charter this year. The 2026 Peer Review Sub-Committee Meeting Calendar was presented and accepted. The 2026 Peer Review Policy & Procedure Annual Review was presented. All Peer Review policies were approved with minor or no changes. 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. 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. Follow-up will be initiated to obtain additional information for the tabled cases, and ongoing monitoring and reporting will continue		
• **Executive Report** J. Nkansah, CEO	**Executive Report** Executive Dashboard Enrollment as of January 2026 is 423,515. Enrollment for Anthem is approximately 196,671, and the enrollment for Kaiser is approximately 13,513. Market Share is currently approximately 66.83%. With regard to IT Communications & Systems, and the Member Call Center there are no significant issues or concerns. Website activity continues to grow organically. Member portal registration has reached approximately 4,200 members.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	With regard to Provider Network & Engagement, the running count for Hospitals from 10 (July 2025) to 11 (August 2025) is due to Madera Community Hospitals being added to the network. J. Nkansah informed the Commission there is currently a contractual dispute between the Plan's administrator, Health Net, and Madera Community Hospital on the terms of the Agreement the two parties executed in March of 2025. Regarding Claims Processing & Provider Disputes no significant updates. Activity remains consistent with prior reporting. Currently there is a high sensitivity around program integrity and there is a letter sent to the State of CA both from CMS and Committee of Energy & Commerce, and CVH as a managed care plan are also tasked by the State to meet with DHCS on the subject of program integrity.		
11. Final Comments from Commission Members & Staff	None.		
12. Announcements	None.		
13. Public Comment	None.		
14. Adjourn	The meeting adjourned at 3:20 pm. The next Commission meeting is scheduled for May 21, 2026, in Fresno County.		

Submitted this Day: _______________________________

Submitted by: ____________________________________

Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

February 19, 2026

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 October 16, 2025 Attachment 2.A Action, D. Maychen, Chair	The minutes from October 16, 2025, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Frye / Rahn)*
#3 Financials – as of December 31, 2025 Action D. Maychen, Chair	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		Motion: *Financials as December 31, 2025, were approved* *6 – 0 – 0 – 1* *(Soares / Rahn)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	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 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.		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	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.		
#4 Fiscal Year 2027 Proposed Budget Action D. Maychen, Chair	The basic assumptions being used to create the FY 2027 budget was presented to the Committee. An official proposed FY 2027 budget is planned for presentation at the March 2026 Finance meeting with intent to accept and forward to the Commission. If, for whatever reason, the UIS membership actually stays in Medi-Cal managed care or if the State is able to stand up the prepaid health plan and is still contracting with CalViva Health as the prepaid health plan and the State and CalViva can stand up a prepaid heath plan in 6.5 months, a revised budget may be needed to be presented to the Finance committee in May 2026 to be reviewed and approved; if approved the revised budget would then be presented to the Commission in July. Enrollment is projected to decline in FY 2027 primarily due to the freeze on undocumented individuals aged 19 and over, effective January 1, 2026, and anticipated federal compliance changes. On September 30, 2025, Centers for Medicare & Medicaid Services (CMS) issued guidance to State Medicaid Directors revising its interpretation of Section 1903(v) of the Social Security Act, clarifying that federal financial participation for undocumented members is limited to emergency services actually rendered. CMS indicated that capitated managed care arrangements, such as California's Medi-Cal managed care model, are not compliant as payment is not directly tied to services rendered noting that capitated, at-risk payments are paid to Plans on a prospective basis vs actual services rendered basis. CMS outlined two options: transition undocumented members to a fee-for-service (FFS) delivery system or establish a separate, non-risk prepaid limited service plan for emergency services only. CMS strongly encouraged the FFS model as they stated this was the simplest and clearest compliance pathway. Given the State's projected budget deficits—approximately $2.9 billion in FY 2027 and $22–$30 billion over the following three fiscal years as outlined in Governor Gavin Newsom's January budget release—and the operational complexity of implementing a prepaid health plan within 6.5		Motion*: Approve Budget Timetable and Budget Assumptions* *6 – 0 – 0 – 1* *(Frye / Rahn)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	months, the Plan conservatively assumed a transition of approximately 57,000 CVH members from Medi-Cal managed care to FFS effective January 1, 2027, the federal compliance deadline. This represents the most significant driver of enrollment decline. The Plan also evaluated the impact of new Medicaid work requirements under the "One Big Beautiful Bill" Act, which condition eligibility on at least 80 hours per month of work or qualifying activities beginning in 2027. State projections estimate approximately 233,000 Medi-Cal members statewide could lose coverage by June 20, 2027, including an estimated 7,000 CalViva members. However, the statute includes exemptions, including a hardship exemption for counties with unemployment rates exceeding the lesser of 8 percent or 150 percent of the national unemployment rate. Based on a December 2025 national unemployment rate of approximately 4.4 percent, the applicable threshold is 6.6 percent; all three counties within the CVH service area currently exceed this level. While CalViva members would likely qualify for exemption, the Plan conservatively budgeted for potential disenrollment in FY 2027. Additionally, the legislation increases redetermination frequency for the adult expansion population from annually to semiannually. State projections estimate 289,000 Medi-Cal members may lose coverage by June 30, 2027, equating to approximately 8,500 CalViva members. Revenue is projected to decline primarily due to anticipated changes to the Managed Care Organization (MCO) tax structure and enrollment reductions, partially offset by higher capitation rates driven by higher utilization and member acuity. New federal requirements mandate that future MCO taxes be broad-based and uniform, prohibiting disproportionate taxation of Medicaid lives relative to commercial lives. Currently, Medicaid members are taxed at approximately $274 per member month compared to $2.25 for commercial members. Recent voter approval of California Proposition 35 (2024) further limits commercial plan taxation to $36 million and directs most MCO tax revenues to Medi-Cal rather than the General Fund. The statewide tax benefit is approximately $7.5 billion, with CalViva's portion totaling roughly $753 million. The Plan's FY 2027 budget assumes the current MCO tax will sunset on 12/31/2026; any future compliant structure is projected to be financially immaterial at this time due to uncertainty regarding its design. Regarding Community Supports and Grants, the Plan will continue funding		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	community-based organizations, food banks, and scholarships, while increasing allocations to comply with Department of Health Care Services (DHCS) community reinvestment requirements. These require reinvestment of approximately 5 percent of net income annually—and 7.5 percent if certain quality metrics are not met. Based on DHCS policy guidance, Phase I reinvestment (related to CY 2024 net income) must begin by the end of calendar year 2026, with Phase II (related to CY 2025 net income) expected to be received by the Plan following DHCS reconciliation/calculation by Q2 2027. The FY 2027 budget reflects increased funding in anticipation of both phases potentially occurring within the next fiscal year. Per preliminary FY 2027 budget, medical revenue is projected to be $1.73B, which is $286M less than projected primarily due to the decrease in MCO taxes by approximately $376.7M, net of an increase in rates. Interest income projected to be approximately $6.9M which is an increase of approximately $1.9M primarily due to in the FY 2026 budget, the Plan projected more rate cuts than what actually occurred. Medical cost expense is projected to be approximately $1.28B, which is $92.5M more than projected due to an increase in capitation rates. Admin Service Agreement Fee expense is projected to be approximately $48.4M which is approximately $3.6M less than projected due to a projected decline in enrollment. Grants (Community Reinvestment) expense is projected to be $6M which is approximately $1.6M more than FY 2026 due to the Plan accounting for making investments in phase one and phase two during FY 2027 as required by DHCS Community Reinvestment APL. All other expense line items are relatively consistent with budgeted amounts for FY 2026. MCO taxes projected to be approximately $376.7M which is approximately $376.7M less due to MCO taxes projected to end midway through FY 2027. Net income is projected to be approximately $10.9M, which is approximately $1.9M more than budgeted for FY 2026 primarily due to an increase in interest income and an increase in capitation rates net of a decrease in enrollment.		
#5 Announcements/Comments	Daniel Maychen recommends changing the budget timetable to present key budget assumptions to the Finance Committee in March so that the proposed budget can be presented to the Finance Committee in May. Since COVID, the California State May revised budget has been dramatically different from their January release and pushing this out gives the Plan a better picture of what the actual budget will look like.		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	Due to the Secure 2.0 Act, which passed December 2022, it required the Plan's retirement plan to implement Roth contributions for the 457b retirement plan. Any catch up contributions have to be made on a Roth basis beginning 2026. To be compliant, the Plan changed the plan documents to reference this change. The option has been made available to all staff, not just those 50+.		
#6 Adjourn	Meeting was adjourned at 11:56 am		

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission
Dated: 3.19.26

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson
Dated: 3/19/26

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
February 19th, 2026

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

Attachment A

	Committee Members in Attendance		CalViva Health Staff in Attendance
✓	**Patrick Marabella, M.D.**, Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Senior Director of Medical Management Services
✓	**David Cardona, M.D.,** Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓*	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**Christian Faulkenberry-Miranda, M.D.,** Pediatrics, University of California, San Francisco	✓	**Sia Xiong-Lopez,** Equity Officer
	Ana-Liza Pascual, M.D., Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group		**Morgan Simpson,** Senior Director of Compliance
✓	**Carolina Quezada, M.D.,** Internal Medicine/Pediatrics, Family Health Care Network		**Maria McDivitt,** Senior Compliance Manager
	Joel Ramirez, M.D., Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Nicole 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, MD, Chair	The meeting was called to order at 10:03 AM. A quorum was present.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#2 Approve Consent Agenda Committee Minutes: November 20, 2025 - A&G Inter-Rater Reliability Report (Q4 2025) - A&G Classification Audit Report (Q4 2025) - A&G Member Letter Monitoring Report (Q4 2025) - Customer Contact Center DMHC Expedited Grievance Report (Q4 2025) - Concurrent Review IRR Report (Q4 2025) - Member Incentive Programs Semi-Annual Report (Q3 & Q4 2025) - Call Center Inquiry Audit Report (Q4 2025) - Enhanced Care Management and Community Supports Performance Report (Q3 2025) - Provider Office Wait Time Report (Q4 2025) - Provider Preventable Conditions (Q4 2025) - County Relations Quarterly Report (Q4 2025) - California Children's Services Report (Q4 2025) - SPD HRA Outreach (Q3 2025) - TurningPoint Musculoskeletal	The November 20th, 2025, QI/UM minutes were reviewed and highlights from today's consent agenda items were reviewed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	**Motion:** *Approve* Consent Agenda (Quezada/Cardona) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Utilization Review (Q3 2025) - Access Work Group Minutes from 9/30/2025, 12/02/2025 (Attachments A-P) **Action** Patrick Marabella, MD, Chair		
#3 **QI Business** - A&G Dashboard (December 2025) - A&G Executive Summary (Q4 2025) - A&G Quarterly Member Report (Q4 2025) (Attachments Q-S) **Action** Patrick Marabella, MD, Chair	The **Appeals & Grievances Dashboard through December 2025, Appeals & Grievances Executive Summary Q4 2025, and Appeals & Grievances Quarterly Member Report Q4 2025** were presented. Appeals and Grievances can be submitted via phone, fax, email, or online. Appeals and Grievances are categorized and reported on the dashboard, with supportive narratives in the separate quarterly reports. Monthly Excel files include the logs identifying each member who submitted a grievance during the monthly reporting period with a narrative description of the grievance and resolution (as applicable). Overall, 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. In Q4 2025, a total of 659 grievances were received, with 222 categorized as Access to Care. The top five Access to Care grievance categories, representing 26.1% of all grievances, were identified with their corresponding opportunities for improvement: 1. Prior Authorization Delay o The provider should keep the member informed of prior authorization and the timeline of approval. o Continue providing live and recorded provider training webinars to address prior authorizations on a regular basis. 2. Network Availability o Expand telehealth services, offering diverse payment options, and utilizing data analytics to optimize network design and ensure equitable access to care. 3. Transportation Missed Appointment o Request feedback from the vendor on how they will address complaints related to no-show transportation and make reliable transportation accessible to members.	**Motion**: *Approve* - A&G Dashboard (December 2025) - A&G Executive Summary (Q4 2025) - A&G Quarterly Member Report (Q4 2025) (Quezada/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	4. PCP Referral for Services o Establish or reassess the current referral process and turnaround approval times. 5. Availability of Appointments with a Specialist o Expand specialist network in rural areas through the Provider Network team. o Leverage contract language to incentivize provider groups to increase volume, as well as meet member experience expectations. In Q4 2025, CVH observed a decrease in appeal volume, with 150 total appeals. 81.3% (122 appeals) were classified as Not Medically Necessary. Overall, 42% of appeals were upheld, 43% overturned, 9% partially upheld, and 6% were withdrawn. The top 52% of appeals fell into the following categories: • Self-injectable Medications • Outpatient Procedures • Inpatient Admission • DME-Other • Diagnostic MRI • Housing Deposits (50% of appeals were upheld). • Medically Tailored Meals (All appeals were upheld 100%). Improvement opportunities include: • Not Medically Necessary: o Educate providers on the criteria for medical procedures coverage and what needs to be submitted to avoid unnecessary denials and procedure delays. o Ensure providers are submitting all needed information prior to medically necessary procedures. • Community Supports – Medically Tailored Meals: o Educate providers on the criteria to qualify for medically supportive meals. • Community Supports – Housing Deposits: o 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 submissions and avoidable denials.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Discussion: *Dr. Cardona asked whether the main problem with Access is the ability to get an appointment with the member's PCP?* *Dr. Marabella stated that Access Grievance issues are mainly due to prior authorization delay, medication denials, access to Specialists, DME, and missed transportation.*	
#3 **QI Business** - Behavioral Health Performance Indicator Report (Q3 2025) (Attachment T) **Action** Patrick Marabella, MD, Chair	The **Behavioral Health Performance Indicator Report Q3 2025** provides a summary to evaluate BH risk rating and authorization decision timeliness metrics, which reflect current performance and reveal emerging patterns over time. In Q3 2025, all metrics were met. The non-ABA review timeliness metric met the 100% target. Therefore, a barrier analysis and an improvement plan were not required. • The Q3 2025 BH utilization rate, as reflected in unique members/k, has remained steady over the first half of 2025 at 283.7. • Appointment accessibility by risk rating met the target at 100%, and there were zero (0) Life-Threatening Emergent cases, two (2) Non-Life-Threatening Emergent cases, and one (1) Urgent case. • Authorization decision timeliness is reported at 100% for Non-ABA (122 reviews), and 95.1% for ABA (2,706 reviews). • Overall Q3 2025 timeliness result for CVH BH utilization management was 95.3%, exceeding the threshold for action of 95% by a small margin.	**Motion**: *Approve* - Behavioral Health Performance Indicator Report (Q3 2025) (Quezada/Waugh) 5-0-0-3
#3 **QI Business** - Potential Quality Issues Report (Q4 2025) (Attachment U) **Action** Patrick Marabella, MD, Chair	The **Potential Quality Issues (PQI) Report Q4 2025** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or Peer Review activity. Peer Review activities include cases with a severity code level of III or IV, or any case that the CVH CMO requests to be forwarded to Peer Review. The PQI report also includes behavioral health under SB 850 (parity regulations). Data for Q4 2025 was reviewed for all case types including the follow-up actions taken when indicated. • There were three (3) non-member-generated PQIs in Q4 2025, all scoring a level II. • Member-generated PQIs for Q4 2025 included a total of 47 Physical Health cases and none (0) for Behavioral Health. PCP-related cases were reported at 28, Specialist-related cases were reported at nine (9), Hospital/ER cases were reported at seven (7), SNF reported two (2), and a	**Motion**: *Approve* - Potential Quality Issues Report (Q4 2025) (Cardona/Waugh) 5-0-0-3

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<tr><td></td><td>vendor reported one (1). Outcome scores were reported as 29 at level zero, three (3) at level I, and fifteen (15) cases scored at level II.
• There were sixteen (16) Peer Review-generated cases (none were Behavioral Health). Eleven (11) cases are closed, and five (5) cases are open.
• Eight (8) Peer Review-generated cases required further action (none were Behavioral Health).

Zaman Jennaty left the meeting at 10:55 AM.</td><td></td></tr>
<tr><td>#4 QI/UM/CM Business
- QI/HE Work Plan End of Year Evaluation & Executive Summary 2025

(Attachment V)

Action
Patrick Marabella, MD, Chair</td><td>The 2025 Quality Improvement Work Plan End-of-Year Evaluation and Executive Summary were presented and reviewed. The 2025 Quality Improvement and Health Education (QIHEd) End of Year Program Evaluation includes three sections:
1. QI & HEd Work Plan Initiatives
2. Ongoing Work Plan Activities
3. Enterprise Quality Improvement and Performance Tracker Activities Log
The QIHEd Oversight Structure was reviewed, noting the roles and frequency of each committee's meetings.
Goals and Quality Indicators: The QIHEd 2025 Work Plan includes the following eleven (11) categories:
1. Behavioral Health: 6/6 MY2025 Objectives Met: 100% Rate
o Focus on improving follow-up after E.D. visits for substance use or mental health disorders measured by the HEDIS® metrics FUA-7/30 and FUM-7/30.
o Overall, CVH did not meet the 50th Percentile Quality Compass performance goal. Kings County did meet the MPL for both measures.
▪ Non-clinical PIP 2023 to 2025 to focus on Fresno and Madera Counties with three (3) interventions on:
1. Smart Phrase education for CHWs/SUNs & social workers
2. Hispanic Cultural Competency (same staff)
3. Collaborate with the Resiliency Center to expand access
▪ The project ended 12/31/2025.
▪ Data gathering continues for final submission due 08/06/2026.
2. Chronic Conditions/Chronic Disease: 6/6 Objectives Met: 100% Rate
o Implement strategies to improve performance in Asthma Medication Ratio (AMR), Blood Pressure Control (CBP), and Diabetes (CDC >9):</td><td>Motion: Approve
- QI/HE Work Plan End of Year Evaluation & Executive Summary 2025

(Quezada/Cardona)
5-0-0-3</td></tr>
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AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Connected via phone calls with members to close care gaps in diabetes management and blood pressure control. ▪ Promoted Best Practice for Asthma Care via modified prescribing practice to include use of Formoterol/ICS combo. Successfully met all measures in all three counties. 3. Hospital Quality/Patient Safety: 8/11 Objectives Met: 73% Rate o CVH has five (5) participating Acute Care Facilities. The goal of this effort is to ensure hospitals provide appropriate, safe care to patients that avoids preventable harm, and to guide members regarding informed choices when selecting a hospital for care and services. ▪ All CVH hospitals submitted sufficient data to develop a scorecard. ▪ Some improvements were shown in hospital-acquired infections (CLABSI, CAUTI, and SSI Colon did not improve). ▪ MRSA did not achieve directional improvement, but Clostridioides difficile (C. difficile) rates declined. ▪ C-section performance declined, with 2/5 hospitals meeting the target rate of 23.5%. ▪ Targeted improvement is the goal for 2026. 4. Member Engagement & Experience: 2/2 Objectives Met: 100% Rate o CAHPS Survey: 3/8 measures met the Outcome Quality Compass (QC) 25th percentile goal. ▪ For MY2024, 90.50% of members felt that the plan provided good customer service. ▪ For MY2024, 87.20% of members felt that the plan provided good coordination of care. ▪ For MY2024, 79.50% of members rated the Health Plan favorably. 5. Pediatric/Children's Health: 28/30 Objectives Met (Pediatric/Perinatal/Dental): 93.33% Rate o Clinical PIP Project: Increase rates of Well-Child Visits for Black/African American members in the first 30 months of life (W30-6+) in Fresno County. o Two Interventions 1. Refer birthing parents and infants up to three (3) months to Black Infant Health for education and encouragement to attend well-child visits.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2. Promotes the use of the CDC Milestone Tracker app by parents/caregivers and providers to educate and engage in the identification of developmental milestones and attend well-child visits. o The project ended on 12/31/2025. o Data gathering continues for the final submission due on 8/6/2026. 6. Perinatal Health/ Reproductive Health o All CVH Counties are exceeding the 50th percentile for timely prenatal care, postpartum care, and Chlamydia screening. o Kings County exceeded the 90th percentile for Postpartum visits. o Fresno and Madera Counties exceeded the 75th percentile for Prenatal visits. o Disparity exists for Black/African American members, and CVH will refer all pregnant women to Black Infant Health (BIH). 7. Preventive Health/ Cancer Prevention: 9/12 Objectives Met (Preventive Health): 75% Rate o Efforts to improve preventive health screening performance included: ▪ Mobile mammography services ▪ Comprehensive provider education on updated screening guidelines paired with updated clinic flow and action planning. ▪ Building effective relationships with screening partners. ▪ Creating culturally responsive patient education and outreach material to support informed participation in preventive care. 8. Provider Engagement: 9/13 Objectives Met: 69.23% Rate o Quality Evaluating Data to Generate Excellence (EDGE): ▪ By 12/15/25, 91 Quality EDGE requests were approved. ▪ Provider Engagement increased operational oversight, and Providers were encouraged to participate in the DHCS Equity and Practice Transformation Payments Program. ▪ A standardized data reconciliation process was fully implemented to address challenges related to data workflows, provider coding practices, and system issues impacting the timely receipt of evidence of member care. 9. Continuity/Coordination of Care (Non-BH/BH) o CVH utilizes NCQA as a roadmap for improvement on how an organization can deliver high-quality care.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Physical Health: CVH has been focused on enhancing member and provider education and utilizing available resources. o Behavioral: Throughout 2025, CVH has emphasized opportunities to support the seamless transfer of information between medical and behavioral care to promote safe, high-quality care into 2026. 10. Access, Availability, and Service and Satisfaction ▪ 87.5% of PAAS measures overall met the goal. • Access to Psychiatry: Urgent care services within 96 hours did not meet the 70% goal. • Other BH metrics met the goal. ▪ 50% (3/6) of the Telephone Access Survey measures met goals. ▪ 60.98% (25/41) of Provider Satisfaction Survey (PSS) measures met goals. ▪ 21.74% (5/23) of Enrollee Experience Survey (EES) measures met goals. ▪ 100% (6/6) of Provider After-Hours Availability Survey (PAHAS) measures met goal. 11. Health Education o Health Education programs were aimed at increasing participation in: ▪ Well Care Visits ▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Childhood Immunizations and Well Child Visits. o Providers and members can order health education materials on many topics. o In 2025, the most ordered topics included: lead poisoning, diabetes, nutrition, and weight management/exercise. o Health Education Information Phone line remained available in 2025 and received a total of thirteen (13) calls. **FINAL HEDIS® Results RY2025 (MY2024)** **Quality of Care – MCAS (HEDIS®):** Overall, CalViva achieved 76% of MCAS measures above the MPL for MY 2024. **CVH MCAS Measure Results by County RY2021 to RY2025*** • Fresno County did not meet the MPL for measures FUM, FUA, W30-6+, and W30-2+, but met or exceeded HPL for measure G-SD for 2025 (MY2024*).	

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<tr><td></td><td>Kings County did not meet the MPL for measures CIS-10, DEV, WCV, W30-6+, and W30-2+ but met or exceeded HPL for measures BCS-E, AMR, CBP, PPC-Pre, and PPC-Post for 2025 (MY2024*).
Madera County did not meet the MPL for measures FUM, FUA, but met or exceeded the HPL for measures CCS, G-SD, IMA-2, LSC, and W30-6+ for 2025 (MY2024*).
No further questions or comments were made by Committee members.</td><td></td></tr>
<tr><td>#4 QI/UM/CM Business
- UM/CM Work Plan End-of-Year Evaluation & Executive Summary 2025

(Attachment W)

Action
Patrick Marabella, MD, Chair</td><td>The 2025 Utilization Management/Care Management Work Plan End-of-Year Evaluation and Executive Summary were presented and reviewed.
All Accreditation & Regulatory Requirements Objectives Met Except for:
1.4 Periodic Audits for Compliance with Regulatory Standards (DMHC issued final results from the 05/05/25 Audit and identified that the Post Stabilization CAP was not corrected).
1.7 Annually review, approve, and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making (CVH issued a CAP to HN because annual review of BHT/CASP utilization review criteria was not completed.)
Monitoring the UM Process Objective Met Except for:
2.2 Timeliness of processing authorization requests
Deferral Cases did not meet turnaround time standards for > 6 months. CAP was issued for HN –still open.
Other measures were inconsistent with meeting timeliness standards.
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making.
World Professional Association for Transgender Health (WPATH) SOC8 training or IRR testing was not administered in 2025.
Annual initial testing period was extended by six (6) weeks due to competing priorities.
Anticipate completion by the end of Q1 2026.
Monitoring Utilization Metrics Objectives Met:
3.3 PPG Profile – PPG Performance:
Some variation in performance noted throughout the calendar year for two (2) PPGs.
However, actions taken expeditiously, including hiring new staff, shifting</td><td>Motion: Approve
- UM/CM Work Plan End-of-Year Evaluation & Executive Summary 2025

(Faulkenberry/Waugh)
5-0-0-3</td></tr>
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AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	resources, and modifying team assignments, resulted in a return to acceptable rates, and objectives were met by year-end. 4. Monitoring Coordination with Other Programs and Vendor Oversight Objectives Met: • All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end-of-year evaluation. • Work plan activity 4.6 Behavioral Health (BH) Care Coordination & work plan activity 4.7 BH Performance Measures. These plans will be evaluated for expansion in 2026. 5. Monitoring Activities for Special Populations Objectives Met: (All monitoring activities for this section met goals.) • CCS Tracking ongoing • SPD Tracking ongoing • CBAS Tracking ongoing • Mental Health Tracking ongoing 6. Adequacy of UMCM Program Resources: • CVH has determined that program resources did not fully meet the needs of CVH 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 turnaround times for prior authorizations. • During the calendar year, new clinical staff were onboarded to ensure turnaround time requirements are met going forward. 7. Program Scope, Processes, and Information Sources: • The scope of services offered to CVH members meets the state of California requirements for Medi-Cal Managed Care Plans • Ongoing outreach and monitoring efforts have successfully engaged members in preventive care and services. • Annual DHCS survey (2025) had only two (2) areas with deficiencies identified (Early and Periodic Screening, Diagnosis & Treatment-EPSDT and Enhanced Care Management - ECM). • CVH and HNCS continually strive to identify opportunities to improve processes, care, and service.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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. *No further questions or comments were made by Committee members.*	
#4 QI/UM/CM Business - CM Program Description and Change Summary 2026 (Attachments X) **Action** Patrick Marabella, MD, Chair	The **2026 Care Management Program Description and Change Summary** were presented, and changes for this year include: • Pages 10. Updated CVH Org Chart. • Page 13. Updated Caseload requirements for the perinatal team as the team will move from blended perinatal and first year of life caseloads to staff having only perinatal cases or only first year of life cases. • Page 23. Added 'alternative language format' to one of the data types utilized. *No further questions or comments were made by Committee members.*	Motion: *Approve* - CM Program Description and Change Summary 2026 (Quezada/ Faulkenberry) 5-0-0-3
#4 QI/UM/CM Business - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 2025) (Attachments Y) **Action** Patrick Marabella, MD, Chair	The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 2025)** was presented and reviewed. The report provides a summary of key quality, regulatory, satisfaction, and performance measures for SNFs serving CVH members for oversight monitoring and identification of opportunities for improvement. The Dashboard will capture data from multiple sources, including but not limited to claims (ED and inpatient), publicly available data, and MCAS/HEDIS® Long Term Care measures. The Dashboard monitors eight (8) different issues/events, including preventable ED/hospital admissions, infections, complaints, etc. Member Utilization and SNF Performance: • There are thirty-six (36) licensed SNFs in the CVH designated service area. • In the last twelve (12) months, CVH members were admitted to ninety (90) different nursing homes statewide.	**Motion:** *Approve* - Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q3 2025) (Cardona/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	A weighted five (5)-point scale is used to evaluate each CalViva facility for quality of care and outcomes by assigning an overall score for quarterly comparisons and ranking over time. Charts presented provided the Quarter 3 2025 results and identified the overall top-performing and bottom-performing SNFs in the CVH Region based on the weighted five (5)-point scale including: o Top Ten (10) SNFs in CVH Service Region by Unique Member Utilization. o Overall Top and Bottom Performing SNFs in CVH Region. o Lowest and Highest Five (5) Performing SNFs serving CVH members. o Lowest and highest rates of preventable ED visits. o Lowest and highest rates of preventable acute inpatient admissions. Based upon these results, the following three (3) SNFs were selected as having the greatest opportunity to impact care and services provided to CVH members: 1. Manning Gardens Care Center (managed by Cambridge Health): Analysis of publicly available data shows a higher-than-state-average use of Antipsychotic Medications and Falls. They have shown improvement in their rate of UTIs. This facility is implementing the following to improve its quality outcomes: • Hydration Rounds started on 9/1/25. • Pharmacy Education (scheduled). • Physical Therapy Team Rounds started on 9/1/25. 2. Madera Rehabilitation & Nursing Center: Analysis of publicly available data shows a higher-than-state-average use of Antipsychotic Medications and Falls. They have shown improvement in the prevalence of Pressure Ulcers. This facility is implementing the following to improve its quality outcomes: • Emergency Department Companion Program (Q4) • Pharmacy Education (11/6/26). • Physical Therapy Team Rounds (twice monthly). 3. Community Subacute & Transitional: Analysis of publicly available data shows a better-than-average Fall rate and Antipsychotic Medication use. Rates of UTI and Pressure Ulcers are higher than the state averages, resulting in higher-than-expected ED utilization and inpatient admissions. This facility is implementing the following to improve its quality outcomes:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Hydration Rounds started on 9/1/25. • Physical Therapy Team Rounds (twice monthly). • All new admits are assessed by PT within 48 hours. Barrier Analysis: • Staffing Challenges in the Central Valley: Facilities report challenges with recruiting and retaining qualified Certified Nursing Assistants. • Unreported Falls: "Nursing Homes Failed to Report 43% of Falls." MDS 3.0 assessments are used to capture patient changes in conditions. Quarterly monitoring and analysis of trends will continue, and new opportunities for improvement identified with facilities and interventions reprioritized and modified as more data is gathered. The impact of these initial interventions will also be evaluated and modified as indicated by the data.	
#4 QI/UM/CM Business - NCQA Non-Behavioral Health Member Experience Report MY 2024 - NCQA Behavioral Health Member Experience Report MY 2024 (Attachments Z-AA) **Action** Patrick Marabella, MD, Chair	**NCQA Non-Behavioral Health Member Experience Report MY 2024** was presented and reviewed. CVH oversees and monitors member experience and identifies areas of opportunity by conducting required activities to meet the standards and guidelines of accreditation (NCQA ME.7): • Annual satisfaction surveys (CAHPS (Non-Behavioral Health) and ECHO (Behavioral Health)) • Ongoing analysis of grievances and appeals. All appeals and grievances are included, no sampling. NCQA requires Health Plans: 1. Evaluate member satisfaction for physical health at least annually. o Quantitative and qualitative analysis of CAHPS Survey results. Compared to the Medicaid CAHPS National Averages. 2. Evaluate member satisfaction for behavioral health at least annually. o Experience of Care and Health Outcomes ECHO® Survey results. CVH CAHPS Member Survey: • All measures, except Rating of the Health Plan, fell below the 2024 QC 25th percentile goal, and no year-over-year improvement was observed. o Although the rating of the Health Plan declined compared to the previous year, it did reach and exceed the 25th QC percentile in MY24, meeting the goal. • CVH's MY2024 CAHPS® survey results showed declines in overall rating measures and mixed performance across composite measures, highlighting opportunities for targeted	Motion: *Approve* - NCQA Non-Behavioral Health Member Experience Report MY 2024 - NCQA Behavioral Health Member Experience Report MY 2024 (Waugh/Quezada) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	improvement. o Enhancing focus on appeals and grievances related to attitude, service, and billing concerns may help improve the overall member experience. Formal Grievance Issues MY2024 vs. MY 2023 (Formal Grievances can either be Quality of Care (QOC) or Quality of Service (QOS) in nature): • Overall volume increased year-over-year in three out of the five grievance classifications. o MY2024 formal grievances increased above MY2023 volume and PTMPY rate. o Internal goals were not met. • In MY2024: o Access Issues saw a 5.6% decrease in volume o Attitude and Service saw a 102.9% increase year over year. Exempt Grievance Issues MY2024 vs. MY2023 (Exempt grievances are grievances received by the Member Services Call Center that are not coverage disputes or regarding investigational treatment, and that are resolved by the close of the next business day.): • In MY2024, Exempt Grievance volume increased by 21.1%. • Internal goals were not met • The Access grievance category had an increase in volume of 124.7% from the previous year. • The largest Exempt category was Attitude & Service (76%). Appeal Issues MY2024 vs. MY2023: • Total number of appeals increased in volume, PTMPY rate, and Overturn rate in MY2024. • Internal goals were not met. • The Billing and Financial Issues category continues to be the most common classification category in CVH, with a 45.4% increase from the prior year. Some of the Planned Actions that CVH will act on beginning Q2 2026 include, but are not limited to: • Member Dissatisfaction with Staff Attitude and Service Quality: o Deliver ongoing training to providers/staff focused on enhancing member experience, highlighting its impact on CAHPS Survey results, and equipping teams with best practice tools to improve patient interactions. • Grievances Related to Billing and Financial Issues:	

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	○ Deliver ongoing customer service training for all member-facing teams, ensuring alignment with the Ops Manual. • Mixed Performance in Composite Measures: ○ Conduct Quarterly A&G Root Cause Analysis to identify underlying causes, data trends to pinpoint recurring barriers, and share findings with relevant teams to inform process improvements and training needs. ○ Partner with Provider-facing teams to actively disseminate the CAHPS Provider Playbook and promote adoption of Best Practices through targeted engagement and collaboration. • Decline in Overall Rating Measures: ○ Launch Provider webinars that cover how to improve empathy and communication with members. ○ Lead the CVH A&G Workgroup meetings to present transportation-related complaints and facilitate direct resolution by engaging the vendor leadership. ○ Continue efforts to improve transportation services and address balance billing issues. *Discussion:* *Dr. Quezada asked how will we know if the targeted improvement trainings were actually completed?* *Dr. Marabella stated that the trainings are taught in person by members of our Provider Engagement Team, or if the training is online, those taking the training must attest to completing the training.* *Dr. Quezada stated that it would be challenging to have these providers complete the training online and could result in low compliance rates.* *Dr. Marabella indicated that all Appeals and Grievances are monitored, and PCPs that exceed the threshold for the number of Appeals and Grievances within a certain time period are referred to Peer Review. If their behavior or compliance does not improve, there are consequences.* *Amy Schneider stated that tracking grievances helps to target key providers and monitors them over time for continued improvement.* **NCQA Non-Behavioral Health Member Experience Report MY 2024** was presented and reviewed. CVH oversees and monitors member experience and identifies areas of opportunity through	

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	analysis of grievances, appeals, and Experience of Care and Health Outcomes (ECHO®) survey results. Complete results in the full report.
	• Sample size is smaller in MY24.
	• Four (4) measures had statistically significantly lower results for MY24.
	Formal Grievance Issues MY2024 vs. MY 2023 (Formal Grievances can either be Quality of Care (QOC) or Quality of Service (QOS) in nature):
	• Overall volume of formal grievances decreased in MY2024 compared to MY2023.
	  o MY2024 formal grievances decreased below MY2023 volume, but the PTMPY rate increased when compared to MY2023.
	  o Internal goals were partially met.
	• In MY2024:
	  o Attitude and Service increased from nine (9) in 2023 to sixteen (16) in 2024.
	  o Primary drivers included interpersonal complaints about providers and provider staff.
	Exempt Grievance Issues MY2024 vs. MY2023 (Exempt grievances are grievances received by the Member Services Call Center that are not coverage disputes or regarding investigational treatment, and that are resolved by the close of the next business day.):
	• In MY2024, the volume of Exempt Grievances increased.
	• Internal goal not met.
	• The Access grievance category had an increase in volume from three (3) in 2023 to fourteen (14) in 2024.
	• Attitude and Service grievances increased from two (2) in 2023 to six (6) in 2024.
	Appeal Issues MY2024 vs. MY2023:
	• Total number of appeals and PTMPY rate decreased in MY2024. Overturn rate also decreased.
	• Internal goal was met.
	• There were no Quality of Care, Access, Attitude and Service, or Quality of Practitioner Office Site appeals in 2023 or 2024.
	• Billing and Financial Issues appeals decreased from three (3) in 2023 to one (1) in 2024.
	Behavioral Health Opportunities for Improvement MY2024 VS. MY2023:
	• The BH grievances, appeals, and survey data point to similar opportunities:
	  o Attitude and Service Issues is the biggest category of formal grievances for CVH members. (Interpersonal Issues)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Access is the biggest category of exempt grievances (volume is very small) (Availability Issues) o Billing/Financial appeals are the only appeal category • Greatest Opportunity: o Getting Treatment Quickly o How Well Clinicians Communicate o Perceived Improvement o Office Wait Times Planned Actions that CVH will act on beginning in Q1 2026: 1. Access to Care: o Educate and promote provider and member resources: ▪ A Provider Tip/Resource Sheet will be created to define the different types of services available and identify available resources and how they can be accessed. ▪ A Member sheet will be created to define the services available and how they can be accessed. • Attitude and Service: o Educate and improve comfort by addressing mental health issues and referring for services. ▪ A Provider tip sheet on Depression will be created, identifying signs and symptoms, screening tools, and resources that provide treatment. ▪ A Provider Tip Sheet on Anxiety will be created, identifying signs and symptoms, screening tools, and resources that provide treatment. • Our goal is to give providers the necessary resources to connect members to services and improve interactions with members. • In addition, the survey fielding process will return to the previous process utilized in 2023 due to significantly lower response rates for 2024. *Discussion:* *Dr. Marabella asked the Committee whether they felt tip sheets were more helpful than a webinar for this demographic of PCPs, as more BH providers are online.* *Amy Schneider reminded the committee of a previous recommendation to develop resource and*	

<table>
<tr><th>AGENDA ITEM / PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>referral sheets to assist PCPs in the moment with the member explaining the differences between services and how to access them. Our goal is to follow through on the recommendation by Dr. Waugh and this committee.
Dr. Waugh felt that tip sheets used as a tool are more permanent than webinars.
Dr. Quezada felt that looking through printed tip sheets can be cumbersome and that QR codes that link to the most current information would be beneficial.
Amy Schneider agreed that we would want to provide electronic access to all documents as well as offer a handout for patients.

Mary Lourdes Leone arrived at the meeting at 11:19 AM.</td><td></td></tr>
<tr><td>#5 UM/CM Business
- Key Indicator Report (December)
- UM Concurrent Review Report (Q4 2025)

(Attachments BB, CC)

Action
Patrick Marabella, MD, Chair</td><td>The Key Indicator Report December 2025 and the Utilization Management Concurrent Review (CCR) Report Q4 2025 were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness.
• Admissions:
  o MCE (Medicaid Expansion): Acute admissions and utilization remained consistent throughout Q4, with figures closely aligning with 2024 averages and showing no significant variance.
  o TANF (Temporary Assistance for Needy Families): Stability persisted with only minimal decreases in admissions and utilization in Q4 compared to 2024 levels.
  o SPD (Seniors and Persons with Disabilities): Q4 reflected continued downward trends across all acute care metrics.
• Average Length of Stay (ALOS):
  o MCE patients had shorter hospital stays in Q4 2025, with an ALOS of 5.0 days, a 12.3% reduction compared to the annual goal of 5.7 days. This trend again suggests improved discharge planning, more efficient inpatient care, or a shift toward outpatient and short-stay interventions.
  o TANF patients maintained an ALOS of 3.8 days, exactly in line with the annual goal. This stability suggests consistent hospital utilization patterns with no major changes in inpatient management for this group.
  o SPD patients had an ALOS of 5.8 days in Q4 2025, a 10.8% reduction from the 6.5-day annual goal. This decrease may indicate enhanced efficiencies in hospital care,</td><td>Motion: Approve
- Key Indicator Report (December)
- UM Concurrent Review Report (Q4 2025)

(Quezada/ Faulkenberry)
5-0-0-3</td></tr>
</table>

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	improved care transitions, or an increasing reliance on alternative care settings such as outpatient or home-based care.
	• Readmissions:
	  o MCE 30-day readmission rates dropped to 13.1%, a 2.9% reduction from the 2024 average of 13.5%.
	  o TANF readmissions decreased to 3.0%, a 37.5% reduction from the 2024 average of 4.8%.
	  o SPD readmissions improved significantly, moving from a 20.2% 2024 average to 16.3% in Q4 2025.
	• Turnaround Time Compliance Goal 100%:
	  o Routine Pre-Service Authorization w/Extension/Deferral TAT (non-BH) missed the goal of 100% in Q1 – Q3 2025 but had returned to 100% compliance in Q4 2025.
	  o Expedited Pre-Service Authorization TAT (non-BH) missed the goal of 100% in Q3 2025 but has returned to 100% compliance in October and November.
	  o Expedited Pre-Service Authorization w/Extension/Deferral TAT (non-BH) in March and April.
	    ▪ TAT Non-Compliance issues were due to a change in the staffing model from LVNs to RNs as the RNs were being onboarded and have since been resolved.
	  o The CCS rate remains stable.
	• Physical Health Care Management:
	  o The total number of referrals, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed remained steady.
	• Behavioral Health Care Management:
	  o The total number of referrals, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed declined.
	• Perinatal Care Management:
	  o The total number of referrals, outreached, numbers engaged, and engagement rate increased significantly in 2025. The number of cases managed declined.
	• Transitional Care Services:
	  o The total number of referrals, numbers engaged, engagement rate and cases managed increased significantly in 2025.
	• First Year of Life:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ The total number of referrals, numbers engaged, and cases managed increased significantly in 2025. The engagement rate remained steady.	
#5 UM/CM Business - Medical Policies (Q4 2025) (Attachment DD) **Action** Patrick Marabella, MD, Chair	The **Medical Policies (Q4 2025)** were presented to the committee. Dr. Marabella recommended that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback. Medical Policies are compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. Updated policies for Q4 2024 include, but are not limited to: • CP.MP.100 - Allergy Testing & Therapy • CP.MP.168 - Biofeedback • CP.MP.105 - Digital EEG Spike Analysis • CP.MP.106 - Endometrial Ablation • CP.MP.62 - Hyperhidrosis Treatments • CP.MP.180 - Implantable Hypoglossal Nerve Stimulation • CP.MP.91 - Obstetrical Home Care Programs • CP.MP.202 - Orthognathic Surgery • CP.MP.190 - Outpatient Oxygen Use • CP.MP.70 - Proton and Neutron Beam Therapy • CP.MP.174 – Selective Dorsal Rhizotomy for Spasticity in Cerebral Palsy • CP.MP.185 – Skin and Soft Tissue Substitutes for Diabetic Foot Ulcers and Venous Leg Ulcers • CP.MP.117 – Spinal Cord, Peripheral Nerve, and Percutaneous Electrical Stimulation • HNCA.CP.MP.542 – Testing for Drugs of Abuse • CP.MP.55 – Ultrasound in Pregnancy • CP.MP.99 - Wheelchair Seating • CP.MP.145 – Electric Tumor Treatment Fields • CP.MP.248 – Facility-Based Sleep Studies for Obstructive Sleep Apnea • CP.MP.144 – Mechanical Stretching Devices for Joint Stiffness and Contracture • CP.MP.188 - Pediatric Oral Function Therapy • CP.MP.185 - Skin and Soft Tissue Substitutes for Chronic Wounds • CP.MP.247 - Transplant Service Documentation Requirements	Motion: *Approve* - Medical Policies (Q4 2025) (Waugh/Faulkenberry) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The following new policies include, but are not limited to: • HNCACP.MP – Testing for Drugs of Abuse	
#6 Oversight Audit Business - Continuity of Care - Pharmacy (Attachments EE-FF) **Action** Patrick Marabella, MD, Chair	The **2025 Continuity of Care Oversight (COC) Audit** was presented and reviewed. HN provided evidence demonstrating compliance with policies and procedures for COC and Transition of Care (TOC), including call logs and monitoring and tracking reports for TOC, COC, and Out-of-network services provided. Additionally, we reviewed a sample of COC and TOC cases from the audit period of January – December 2024, with 100% compliance noted with audit criteria. The **2025 Pharmacy Services Oversight Audit** was presented and reviewed. CVH conducted an oversight audit of HN Pharmacy Services' (HNPS) pharmacy function, including review of requested policies and procedures, reports, logs, minutes, and other documentation, for compliance with established standards for the audit period covering January through December 2024. • Ten (10) Prior Authorization Denial files were randomly selected that included non-formulary requests, urgent, and routine cases from all three (3) CVH counties. The first ten (10) cases were **100% compliant.** Denial files must meet all required elements (100%) to pass the audit.	Motion: *Approve* - Continuity of Care - Pharmacy (Quezada/ Faulkenberry) 5-0-0-3
#7 Compliance Update - Compliance Regulatory Report (Attachments GG)	Mary Lourdes Leone presented the **Compliance Report** of CVH Oversight Activities of HN in the areas of financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits:** The 2025 UM/CM annual audit is in progress. The following annual audits have been completed since the last Commission report with No CAP: Access & Availability, Call Center, Claims/PDR, Internal Compliance, Continuity of Care, FWA, Marketing, Pharmacy, and Provider Network. Privacy and Security, and Transportation both had a CAP issued to HN. **Fraud, Waste, and Abuse:** There have been fourteen (14) new MC609 filings since the 10/16/2025 Compliance Regulatory Report to the Commission. See the report for case types. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** DHCS advised CVH on 1/30/26 that additional time is needed to review the CAP due to pending Department policy updates, including the forthcoming Transportation APL. DHCS will issue forward-looking guidance on future CAP closure and allow 90 days to implement any required changes. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit** was conducted on	- Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	5/5/25 and issued its Final Report on 12/23/25. The Report confirmed correction of the PQI-related deficiency; however, the post-stabilization deficiency remains uncorrected and may be referred to the Department's Office of Enforcement for further action. **Department of Health Care Services ("DHCS") 2025 Medical Audit** was conducted virtually from 6/2/2025-6/13/2025. DHCS issued its final audit report and CAP on 11/5/25, citing deficiencies related to delegated oversight of HN, 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. CVH submitted its initial CAP response on 12/5/25 and will continue to provide monthly updates until the CAP is formally closed. **2025 Network Adequacy Validation (NAV) Audit** was conducted virtually on 8/21/25 and met all requirements. The audit was closed on 11/17/25. **2026 DMHC/DHCS Joint Medical Survey Audit** will commence on-site at CVH the week of 6/15/26. CVH will submit all required DMHC pre-audit documentation by 2/20/26 and is awaiting DHCS pre-audit requirements. **California Advancing and Innovating Medi-Cal (CalAIM):** DHCS approved CVH's Transitional Rent (TR) Model of Care (MOC) on 1/27/26. As several TR provider agreements were pending at the time of approval, DHCS issued a pre-CAP requiring ongoing status reporting through April 2026; all but one agreement have now been executed. CVH submitted updated MOCs on 2/5/26 for TR and Community Supports. The submissions reflect the Plan's final Community Supports elections and updated provider capacity reports; CVH is currently awaiting DHCS approval of both MOCs. **Memoranda of Understanding (MOU)** for the Local Health Department (Madera County) has been executed and submitted to DMHC and DHCS since the last Commission Meeting. **Annual Network Certifications:** • 2024 Subnetwork Certification (SNC) Landscape Analysis: DHCS closed on 1/15/26. • 2024 Annual Network Certification (ANC): DHCS approved on 12/18/25. • 2025 Subnetwork Certification (SNC) Landscape Analysis: DHCS approved on 12/31/25. • 2024 Annual Network Certification (ANC): Submitted on 2/16/26. • 2025 Subnetwork Certification (SNC): Submitted on 2/11/26. **(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR):** DMHC issued a Network Findings report on 4/18/25. CVH submitted a formal response on 7/17/25 that a separate Material Modification would be submitted to the DMHC to request new time and distance	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	standards for specific zip codes. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** Submitted to DMHC on 5/1/25, awaiting a response. **(RY) 2026 (MY) 2025 Timely Access and Annual Network Submission (TAR):** Submission due 5/1/26. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY2025. **Public Policy Committee (PPC):** The last PPC meeting was held on 12/3/25, and the next PPC meeting will be held on 3/4/26, from 11:30 AM - 1:30 PM, in the CVH Commission Room. See Public Policy Committee minutes for full details.	
#9 **Old Business**	None.	
#10 **Announcements**	The next meeting is on March 19th, 2026.	
#11 **Public Comment**	None.	
#12 **Adjourn**	The meeting adjourned at 11:38 AM.	

NEXT MEETING: March 19th, 2026

Submitted this Day: March 19, 2026

Submitted by: [signature]
Amy Schneider, RN, Senior Director Medical Management

Acknowledgment of Committee Approval:

X [signature]
Patrick Marabella, MD, Committee Chair

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 YTD Total
# of DHCS Filings													
Administrative/ Operational	27	19	16	19	3								84
Member Materials Filed for Approval;	6	3	3	7	1								20
Provider Materials Reviewed & Distributed	16	4	19	13	0								52
# of DMHC Filings	9	2	8	10	2								31

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	4	0	2								10
High-Risk	0	0	1	0	0								1

Summary of High-Risk Privacy & Security Breach Cases: There have been no high-risk privacy and security breach cases reported since the March 19, 2026 meeting.

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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	2	5	2								14
# of Cases Open for Investigation (Active Number)	29	31	34	33									

Report Date 5/21/2026

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 3/19/2026 Compliance Regulatory Report to the Commission, there were 8 new MC609 filings. The filings were related to the following:

- Inappropriate Billing: 2 cases
- Phantom Provider: 2 cases
- Insufficient Documentation: 2 cases
- False Representation: 1 case
- Services not rendered: 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: Call Center, Q4 2025 Claims/PDR, 2026 Credentialing, 2026 Health Education, 2026 Health Equity, 2026 Marketing and the 2026 Provider Network. The following audits that have been completed since the March 19, 2026 report to the Commission: UMCM 2025 (CAP)
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	The Plan submitted its monthly CAP update on April 15, 2026, and will continue to send monthly 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 DHCS pre-audit requirements on May 1, 2026. DHCS sent a Verification Study Sample request on May 7, 2026, and the Plan will submit files by May 19, 2026. DHCS and DMHC will be onsite from June 16, 2026, through June 26, 2026, to conduct audit interviews.
2026 Network Adequacy Validation (NAV) Audit	On May 11, 2026, the Plan received the Audit Document Request Packet from HSAG. The Plan must submit the Information Systems Capabilities Assessment Tool (ISCAT) and corresponding documents by June 18, 2026.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has executed the following MOUs: • DMC-ODS Madera County
Revised ASA and CPSA with Health Net	On April 29, 2026, the DHCS approved the Plan's revised ASA and CPSA. The approved agreement was subsequently filed with the Department of Managed Health Care (DMHC) on May 5, 2026. Upon DMHC approval, CalViva and Health Net will execute the ASA and CPSA thereby making it retroactive from July 1, 2025. As a reminder, the revised ASA and CPSA are complete replacements for the originals. The revisions include essentially the same provisions as the previously approved versions with the addition of newer requirements specified by the current DHCS Contract and more recent legislative requirements.
(RY)2026 (MY)2025 Timely Access and Annual Network Submission (TAR)	On May 1, 2026, the Plan submitted its Annual TAR filing to DMHC. The Plan is awaiting a response.
Plan Administration:	**Status**
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026.
Committee Report:	**Status**
Public Policy Committee (PPC)	There has not been a PPC meeting held since March 4, 2026, meeting. The next PPC meeting will be held on June 3, 2026, 11:30am-1:30pm in the CalViva Health Conference Room, 7625 N. Palm Ave #109, Fresno 93711.

APPENDIX A

2026 DHCS All Plan Letters:

- APL 26-001 IHA
- APL 26-002 NSMHS Rsponsibilities
- APL 26-003 QMED
- APL 26-004 MCP Responsibilities for BH Data Sharing
- APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members
- APL 26-006 Skilled Nursing Facility Workforce Quality Incentive Program
- APL 26-007 Guidance on Network Provider AGreements

2026 DMHC All Plan Letters:

- APL 26-005 Maternal and Infant Health Equity
- APL 26-002 - Delegation of Risk for COVID-19 Testing or Immunizations. .
- APL 26-007 – 2026 Health Plan Annual Assessments (4.15.2026)

Item #7

Closed Session

Item #9

Attachment 9.A

Sub-Committee Members
for Fiscal Year 2027
BL 26-010

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 Reyna-Griffin, At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn
Public Health Department

Tim Haydock, At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: May 12, 2026

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Committee Appointments—Commissioner Representation

BL #: **BL 26-010**
Agenda Item **9**
Attachment **9.A**

DISCUSSION:

In accordance with the Committee Charters, Commissioner representation on committees will be established by the RHA Commission Chairperson on an annual basis at the start of each fiscal year except for the "Public Policy Committee". The Public Policy Committee Commission members will serve coterminous terms with their Commission appointment. Chairperson Hodge has approved the following appointments for the Commissioners listed below.

FINANCE:
The **Finance Committee** meets at 11:30 am prior to the Commission meeting.
Commission members: *Supervisor Neves, Supervisor Rogers, John Frye, Rose Mary Rahn, and Paulo Soares*

QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT:
The **Quality Improvement/Utilization Management (QI/UM) Committee** meets at 10:00am prior to the Commission meeting. This committee must consist of participating providers.
Commission members: *David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.*

CREDENTIALING
The **Credentialing Sub-Committee** meets at 12:00 pm following the QI/UM Committee and prior to the Commission meeting. This committee must consist of participating providers.
Commission members: *David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.*

PEER REVIEW
The **Peer Review Sub-Committee** meets following the Credentialing Sub-Committee and prior to the Commission meeting. This committee must consist of participating providers.
Commission members: *David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.*

PUBLIC POLICY:
The **Public Policy Committee** meets the first Wednesday of every quarter.
Commission member: *Supervisor Neves serves as Chair. His seat is coterminous with his Commission seat.*

Item #10

Attachment 10.A-B

Community Support &
DHCS Reinvestment Program

A. BL 26-011 Community Support & DHCS Reinvestment Program
B. Proposed Grant Recommendations 2026-2027

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

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

DATE: May 21, 2026

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

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

BL #: **26-011**
Agenda Item **10**
Attachment **10.A**

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

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

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

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

Subsequent to these presentation(s) DHCS continues to refine and offer technical changes with one done as recently as April 13, 2026. These technical changes continue to push out the implementation date of the DHCS Community Reinvestment Requirements.

As a result of this, it is recommended for the RHA Commission to continue the current Community Support and Community Reinvestment funding recommendations of: Contingency, Youth Recreation Sports, State/Federal Local Community Support Response, Provider Network and Member Support, Education Scholarships and Community Workforce Support, Community Infrastructure Support, and Community Based Organizations

Grants Budget

Community Support & Community Reinvestment Grant Recommendations 2026-2027

	Fresno County	Madera County	Kings County	**2026-2027 Funding**
Provider Network Support				
Funding for PCPs/Specialists/Extenders/Behavioral Health	X	X	X	$600,000
Provider Infrastructure, Supplies, & Equipments	X	X	X	$75,000
Tzu Chi-See 2 Succeed Vision Program (Mobile Clinic)	X			$100,000
Member Support				
Enrollment Support	X	X	X	$100,000
Education Scholarships & Community Workforce Support				
California State University Fresno	X	X	X	$100,000
Community Colleges	X	X	X	$100,000
Community Regional Medical Centers Nursing Scholarships	X			$150,000
Image Church Certified Nursing Assistant Program	X			$25,000
Community Infrastructure Support				
Food Bank Funding	X	X	X	$100,000
Outdoor Play and Green Space	X	X	X	$100,000
Community Based Organizations				
Big Brother Big Sisters Fresno and Madera Counties, CASA Fresno and Madera Counties, Every Neighborhood Partnership, Exceptional Parents Unlimited, Fresno Cradle 2 Career, Generation Changers, Habitat for Humanity Acts of Kindness, Kings County Action Organization, Marjaree Mason Center, Poverello House, Reading Heart	X	X	X	$930,000
DHCS Community Reinvestment				
Cultivating Neighborhoods and Built Environment	X	X	X	
Cultivating a Health Care Workforce	X	X	X	

Grants Budget

Cultivating Well-Being for Priority Populations	X	X	X	
Cultivating Local Communities	X	X	X	
Cultivating Improved Health	X	X	X	
DHCS Community Reinvestment Categories Combined				$2,295,000
Other				
Recreation Sports	X	X	X	$110,000
State/Federal Local Community Support Response	X	X	X	$1,000,000
Contingency	X	X	X	$215,000
				$6,000,000

Item #11

Attachment 11.A-C

Health Equity Program

A. 2025 End of Year Evaluation and Executive Summary
B. 2026 Program Description and Change Summary
C. 2026 Work Plan and Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist Sia Xiong-Lopez, MA, Health Equity Officer
COMMITTEE DATE:	May 21, 2026
SUBJECT:	Health Equity 2025 Work Plan End of Year Evaluation – Executive Summary

Summary:

This report provides information on the Health Equity Department work plan activities, which focus on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The Health Equity Work Plan is organized into four sections: 1) Language Assistance Services (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of December 31, 2025, all work plan activities have been completed.

Purpose of Activity:

To provide a summary report of the Health Equity Work Plan End-of-Year Evaluation. CalViva Health (CVH) has delegated all language services to Health Net's Health Equity Department.

Data/Results (include applicable benchmarks/thresholds):

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

1) Language Assistance Services

a. Completed a behavioral health and health equity audit in Q1 & Q2.
b. Updated and amended contracts with 8 vendors. Amendments included TGI and DEI training requirements for subcontractors, contract extensions, and rate updates.
c. A newsletter informing members how to access language services was completed and disseminated.
d. One hundred and twenty-five staff completed their bilingual assessment/re-assessment.
e. Completed and updated Health Equity Policy and Procedures in August.
f. MY2024 Geo Access report completed in November.
g. Twenty-six translation reviews were completed in 2025.
h. Attended quarterly CAHPS Action Plan meetings and provided feedback for health equity interventions.
i. Ten health education materials field tested.

2) Compliance Monitoring

a. HEQ reviewed 8 interpreter complaints and 29 grievance cases (27 medical/physical and 2 behavioral health) with 3 interventions identified.
b. 2024 grievance trending report was completed in Q2.
c. 2024 Mid-Year Work Plan was approved by committee and completed in Q3.
d. Attended QI/UM Workgroup, weekly and Public Policy Committee (PPC) meetings, quarterly.
e. Launched findhelp and Cozeva integration in 2025.
f. Two findhelp trainings were completed for staff with 245 attendees and two provider trainings with 86 attendees. Two hundred and eighty-eight new programs added to the platform.

3) Communication, Training and Education

a. One A&G training was completed on coding and resolution of grievances.
b. Two trainings conducted for 47 new call center staff.
c. Providers were updated on cultural practices, LAP services, and health literacy, as well as the online cultural competency/Office of Minority Health (OMH) training.
d. Language identification poster for provider office was remediated and posted in provider library.

4) Health Literacy, Cultural Competency and Health Equity

a. English material review completed for a total of 58 materials.
b. Conducted Plain Language training to 9 staff; posted updated version online.
c. Implemented DEI and TGI trainings for providers to meet APL 24-017 and 24-018. Cultural competency training extended to be completed by providers by 12/31/2026.
d. Delivered DEI training for staff, 2,246 staff completed the training.
e. Completed cultural competency education through CLAS Month.
f. Submitted documents for NCQA Accreditation: Defining the Community, Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis, and Disparity Project Report.
g. Successfully co-led and supported the completion of quality projects. Projects target measures: W30-6+ and SUD/MH.
h. Completed 3 focus groups to better support and address the needs of members experiencing perimenopause/menopause; a Perimenopause and Menopause Awareness Campaign completed in October.

Analysis/Findings/Outcomes:

All work plan activities in 2025 were completed.

Next Steps:

Obtain approval on the 2025 End of Year Work Plan evaluation report and proceed to implement the 2025 Work Plan upon committee approval.

2025
Health Equity
End-of-Year Work Plan

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

Mission:

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

Goals:

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

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

Objectives:

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

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

Selection of the Cultural and Linguistics Activities and Projects:

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

Strategies:

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

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

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

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	Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/25 - 6/30/25)	Year-End Update (7/1/25 - 12/31/25)
	Language Assistance Program Activities					
1	**Rationale**	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2	**Responsible Staff:**	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3	Audit	Assure Health Equity/C&L audit readiness to support DMHC and DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: review of TAG to identify risk areas, collecting requested documentation, submitting documents to regulator as requested, preparing all supporting documents for on-site visit by regulator, fill out DHCS C&L questionnaire Conduct internal audit to ensure compliance with Medi-Cal and LAP requirements (ensure systems are capturing provider and office language capabilities per SB137 for HN)	Vary by year	4 audits completed: CalViva Behavioral Health Oversight CalViva Health Equity Oversight CalViva QM Oversight CalViva DHCS	Completed in Q1 and Q2.
4	Contracted Vendors	Conduct language assistance vendor management oversight. Review and update vendor contracts to ensure alignment with requirements; participate in vendor oversight calls; align and submit reports as needed. Ensure risk assessments are completed, annually.	Number of vendor contracts updated or amended; date of JOC meetings; number of risk assessment completed	Ongoing	Amended contracts to include TGI and DEI trainings for 3 vendors. Updated rates for 1 vendor. Renew contracts for 1 vendor. Completed annual risk assessment for 11 vendors.	Renew 3 translation vendor contracts and 2 interpreter vendor contracts.

5	Data	Collect and conduct analysis of language utilization and demographic data to identify emerging language needs and threshold languages.	Updated LAP utilization report to contain: monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log. Production of report showing emerging language need and threshold languages.	Semi-annual	Ongoing; data received and input on a monthly basis. Data used to analyze findings for LAP reports.	Data received and input on a monthly basis. Data used to analyze findings for LAP reports. 2025 EOY LAP report will be completed in April 2026, and data was discussed during quarterly Call Center oversight meetings
6	Operational	Document emerging and threshold language for fiscal year and deploy process and timeline for incorporation of languages into member materials. Specifically identify whether new languages meet threshold criteria and write on document that threshold analysis was completed.	Documentation of notification to impacted departments; documented process and timeline for incorporation of emerging and threshold languages	March	Completed in March. Ongoing deliverables for 8/1 (Q3) implementation date.	Completed in August for APL 25-005 requirements.
7	Data	Conduct membership data pulls. Facilitate alignment and collection of demographic data. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly	Ongoing; data received and input on a monthly basis.	Data received and input on a monthly basis. EOY data will be analyzed in January of 2026.
8	Operational	Gather and upload reports to the Member Preferred Written Format SharePoint site. Upload files to Unified Member View (UMV) through the PREFAPI Wrapper Tool.	Weekly reports posted on SharePoint site. Monthly upload to UMV.	Weekly	These reports were uploaded and posted weekly for a total of 25 weeks.	These reports were uploaded and posted weekly until 9/22/25.
9	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing	Four criteria were reviewed with the following providers who were audited and their respective compliance rate 29 audits at 97% (Office Mgmt. D_1), 26 audits at 100% (Office Mgmt. D_2), 29 audits at 97% (Format F), and 23 audits at 77% (Format G).	Four criteria were reviewed with the following providers who were audited and their respective compliance rate 16 audits at 100% (Office Mgmt. D_1), 10 audits at 100% (Office Mgmt. D_2), 13 audits at 97% (Format F), and 6 audits at 46% (Format G).

10	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials.	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint. Also maintain inventory and organization of public and working files.	June and December	Updated tagline to include traditional Chinese	No updates during this period
11	Member Communication	Write/review articles for LAP, Findhelp, Privacy, and other content as needed to assure Cultural and Linguistic appropriateness and to meet NCQA HEA Plus requirements for members' newsletter Annual LAP mailing to survey REAL and SOGI.	The member newsletters are mailed to members once a year for each LOB.	Annual	Newsletters are on track to be mailed to members in Q4.	Member newsletter was mailed on Oct. 27.
12	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified or recertified annually	Annual	52 staff completed a bilingual assessment	73 staff completed a bilingual assessment
13	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis	Report to summarize utilization of LAP services, number of bilingual staff and provide year over year trends for the utilization of LAP services	Q2 & Q3	2024 EOY Work Plan, 2024 EOY LAP report, 2025 Program Description, 2025 Work Plan were completed accepted by committee in April 2025.	2025 Mid-Year LAP and 2025 Mid-Year Work Plan report submitted and approved by committee in September.
14	Operational	Coordinate Health Net LAP Oversight operational meetings with Centralized Unit and Behavioral Health.	Quarterly meetings and review of metrics, interpreter and translation issues, grievances discussion, billing and invoice changes and system upgrades	Quarterly	Completed Q1 (1/28/25) and Q2 (4/21/25) quarterly oversight meetings. One additional ad hoc meeting (6/18/25).	Completed Q3 (7/21/25) and Q4 (10/20/25) quarterly oversight meetings.

15	Operational	Request interpreter service complaint/exempt grievance logs from call center and conduct trend analysis. Provide complaint information to impacted area for resolution, e.g., vendor, internal process.	Monitor interpreter service vendors through service complaints.	Biannual (trend)	Ongoing collection of logs. On track for trend analysis.	Ongoing collection of logs. 2025 trend analysis on track to be completed in Q2 2026.
16	Operational	Coordinate and facilitate quarterly Health Equity Department/LAP meetings to review requirements and department procedures for language and health literacy services	Minutes of meetings	Quarterly	Completed Q1 (3/6/25) and Q2 (6/26/25) meetings. On track for Q3 and Q4.	Completed Q3 (9/4/25) and Q4 (11/19/25) meetings.
17	Operational	Support Population Health Management (PHM) with completing the PNA report every three years in collaboration with Local Health Departments (LHD) and community stakeholders. Support PNA data collection and report writing as well as action plan update. Provide Population Analysis Report with demographic and social needs data for presentation by PHM.	PNA report/updates completed according to DHCS requirements. Submit to compliance for filling. Data provided to PHM. Next PNA Report is in 2025.	May	N/A for Mid-Year.	No updates during this period
18	Access and Availability	Implement activities to meet the 2025 PNA and Geo Access action plans.	Report on PNA and Geo Access action plan activities and metrics	May	N/A for Mid-Year.	N/A for Q3 & Q4
19	Member Experience	Provide consultation and support on reasonable accommodation requests.	Number of reasonable accommodation requests supported	Ongoing	No reasonable requests were received during this timeframe.	No reasonable requests were received during this timeframe.
20	Operational	Develop, update and maintain translation, alternate formats, interpreter services, bilingual assessment, and all Health Equity policies and procedures (P&Ps)	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual and as needed	Completed in March. Ongoing revisions for select P&Ps per DHCS feedback through June.	CA.CLAS.10 and CA.CLAS.13 updated in August.
21	Operational	Collect and review LAP P&Ps from other departments to assure compliance with use of tagline, NDN, translation process and interpreter coordination	P&Ps will be reviewed and placed in Health Equity LAP compliance folder	Annual	N/A for mid-year	Quarterly reminders posted during department meetings (9/4; 11/19)
22	Operational	Complete Health Equity Geo Access report including cultural analysis to meet NCQA requirements. To be completed every two years	Data collection and data analysis for Health Equity GeoAccess report.	Q3 2025	Geo Access report is on track to be completed in November 2025.	Geo Access completed in Nov. 2025

23	Operational	Attend workgroup meetings and contribute to solutions for improving Access and Availability, produce annual or quarterly (as needed) and annual TAR reports	Annual TAR report completed and Access and Availability meetings attended	Quarterly/Annually	Completed, presented, and committee accepted report in June 2025.	Completed, ongoing meeting attendance
24	Operational	Manage the translation review process and resources	Number of translation reviews completed	Ongoing	1 translation reviews requested in Q1 and 6 were received in Q2 of 2025. Translation review requests were completed in Arabic, Hmong, Chinese and Spanish.	12 translation reviews were requested and completed in Q3; 7 were requested in Q4
25	Training	Review, update and/or assign LAP online training	Number of staff who are assigned training and percentage of completion	Annual	On track to be completed in Q4.	Bridging Cultural Gaps to Equitable Healthcare (LAP): 2,266 attendees
26	Operational	Lead IT projects related to language assistance services such as standing request and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories.	Successful implementation of IT projects	Ongoing	Ongoing participation and contributions to REAL/SOGI/DOH Leads meetings.	Tracking removal of SOGI-related requirements across Federal, State, and NCQA requirements.
27	Operational	Participate in CAHPS Action Plan Meeting with Health Equity to identify potential actions to improve member experience	CAHPS Action Plan Meetings attended and action plan/activities implemented	Quarterly	Completed. CAHPS action plan meeting occurred on 03/31/2025 and in June 2025 to review Q2 findings.	Participated in CAHPS action plan meeting on 09/2025. Moreover, CAHPS data was requested and will be analyzed in Q1 of 2026 in order to support HEQ Disparity projects. Q4 data will be analyzed and discussed in Q1 2026.

28	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Monitor strategic partners and specialty plans for compliance with LAP program. Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing	Specialty plan oversight monitoring checklist received in Q2.	Specialty plan oversight for EOY 2025 will be collected in Q1 of 2026
29	Translation and Alternate Format Management	Vital documents management inclusive of annual reminders to dept. managers, confirm placement of vital docs info on TAFT master spreadsheet, request annually from departments which vital documents they produce (including adverse benefit determination notices) and request desktop/policy from departments (when appropriate) on vital document process. Use information obtained from business unit to update the vital document spreadsheet and glossary. Oversee implementation and management of TAFT master spreadsheet.	Master spreadsheet of Vital Documents	Ongoing	Completed collecting updated spreadsheets in Q1.	Completed collecting updated spreadsheets in Q1.
30	Compliance and Accreditation	Manage the Health Education material field testing process and resources for the Field Testing Workgroup.	Number of materials field tested completed annually	Ongoing	There were a total of 4 Health Education material field tests completed. There was 1 completed in Q1 and 3 completed in Q2.	There was a total of 6 Health Education material field tests completed. There were 6 completed in Q3 and none completed in Q4.
31	Compliance and Accreditation	Provide oversight to translation projects and coordinate ad hoc multi department requests and provide overall coordination support between the vendor and internal departments	Number of materials translated	Ongoing	2 materials coordinated and translated/remediated, this includes taglines and a provider training	No translations coordinated this period.
	Compliance Monitoring					
32	**Rationale**	**Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.**				

33	**Responsible Staff:**	**Primary: P. Lee, A. Said**	**Secondary: I. Diaz**			
34	Complaints and Grievances	Oversight of complaints received on LAP or C&L services, including monitoring and responding to C&L grievances. Develop and maintain desktop for grievance resolution process. Collect grievance and call center reports. Maintain quarterly contact with the call center to ensure they monitor C&L complaints. Conduct monthly reconciliation meetings with A&G.	Number of grievances, complaints, and interventions.	Quarterly	A total of 15 cases were referred to C&L (14 medical and 1 behavior health). These included 1 Cultural: Non-Discrimination (ND), 9 Cultural: Perceived Discrimination (PD), 5 Linguistic: ND Of all cases, 1 required corrective action and/or provider intervention. Tailored information, tools, and resources were provided to the respective providers through targeted engagement. Reviewed and responded to 5 complaints.	A total of 14 cases were referred to C&L (13 medical and 1 behavior health). 3 Cultural ND, 4 Cultural PD, 3 Linguistic ND, 4 Linguistic PD. Of all cases, 2 required corrective action and/or provider intervention. Tailored information, tools, and resources were provided to the respective providers through targeted engagement. Reviewed and responded to 3 complaints
35	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers to gauge the effectiveness of the LAP program	Production of trend analysis report	August	MY 2024 grievance trend analysis completed in Q2.	MY2025 grievance trend analysis to be completed in Q2 2026.
36	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December	Made updates to the grievance desktop in Q2.	No updates were made to the grievance desktop for Q3 and Q4.

37	Oversight	Complete all CalViva required Health Equity/C&L reports	Develop Health Equity CalViva work plan, write/revise and submit Health Equity CalViva Program Description. Prepare and submit work plan, LAP mid-year and end of year reports	Ongoing	2024 EOY Work Plan, 2024 EOY LAP report, 2025 Program Description, and 2025 Work Plan were completed and accepted by committee in April 2025.	2025 Mid-Year Work Plan and 2025 Mid-Year LAP report completed and accepted by committee in August 2025.
38	Oversight	Participate in CalViva required work groups and committees	Participate in the ACCESS workgroup, QI/UM workgroup, QI/UM committee, monthly operations management meetings. Provide support for Regional Health Authority meetings as needed or requested.	Ongoing	Attend weekly QI/UM meetings and quarterly Access Workgroup meetings. Attended annual provider visits.	Completed, ongoing meeting attendance.
39	Member Support	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings with presentations and/or materials as needed.	Quarterly	Attended both PPC meetings in March and June. Developed PPT for committee meeting in Q2.	Attended PPC meetings in September and December. Developed PPT for committee meeting in Q4.
40	SDoH/Community Resources	Work with Marketing to develop new/rebrand findhelp materials for member and findhelp website, as needed	Rebranding findhelp materials and websites	Ongoing	Completed member flyers. On track to finish member how to guide.	Completed translations and remediations for member flyers and posted to the respective websites. On track of rebranding members how-to guide.
41	Operational	Collaborate with community and health plan partners on SDoH and social needs support programs, including biweekly meetings with findhelp.	Attend meetings, conduct presentations and support activities	Biweekly As needed	Attended bi-weekly meeting and supported the testing and launch of findhelp Cozeva integration.	Attended biweekly meeting and monitored the findhelp Cozeva integration.

42	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal departments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Update training to align with Cozeva integration by creating an online findhelp course for staff and an on-demand recording for providers. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within Findhelp to address social risks within each month.	Ongoing	Conducted 1 staff training in April where 222 staff members attended. Providers' training is on track to be completed in Q3 and Q4. 136 SNA completed 1,279 referrals 157 closed loops 37 members got help 375 programs were added.	Conducted one staff training in July where 23 staff members attended. Completed two provider training. In Q3 conducted a training in August where 58 providers attended and in Q4 conducted another training in December where 28 providers attended. 77 SNA completed 1,277 referrals 289 closed loops 89 members got help 288 programs were added

43	Collaboration-External	HN collaboration and consultation to external forums such as DHCS HECL workgroup, AHIP health equity workgroup, NCQA expert workgroup on health equity and other SDoH collaborative forums, as needed.	Minutes of meetings that reflect HN consultation and shared learning	Quarterly	Attended collaboartive meetings with various stakeholders and workgroups, which includes: Fresno, Madera, Kings Counties DEI Workgroup California Association of Health Plans for TGI training HICE SB923 ad hoc AIDS Healthcare Foundation AHIP Health Equity Workgroup QTI/QAMS Governance Meeting slides/presentation	Ongoing collaborative meetings with various stakeholders and workgroups, which includes: Fresno, Madera, Kings Counties DEI Workgroup HICE SB923 ad hoc AHIP Health Equity Workgroup Feedback for NCQA revised requirements
	Communication, Training and Education					
44	**Rationale**	**To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.**				
45	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, M. Quan**			
46	Training and Support	Train and provide support to A&G on coding and resolution of grievances; re-align coding per 1557 non-discrimination reporting	Development of scripted responses and/or training for A&G associates regarding grievance responses, coding, when to send to Health Equity	Annually	On track for Q3.	Completed in Q3 2025

47	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations). Update training deck with specific data slides at mid-year and EOY. Update interpreter and translation quick reference guides with any system updates or process changes and collect the reference guides from the call center.	Create and post to share drive: curriculum, power point, list of participants from Call Center and Provider Relations who attended the in-service. Ensure material is shared with attendees post trainings. Update and collect interpreter and translation quick reference guides with any system updates or process changes	Ongoing	Ongoing; hosted a training in Q1 with no new hires and in Q2 a total of 24 staff received the training.	Ongoing: 23 new staff were trained, 16 in Q3 and 17 in Q4
48	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing	Ongoing	Promoted site for updates in Q3 and Q4
49	Provider Communication	Provider Update to cover the following required topics: 1. LAP services 2. Race/ethnicity and language diversity of members 3. Culture and health care topic 4. Promote on-line cultural competence/OMH training 5. Health literacy	Provider Updates distributed and fax/email distribution proof from Marketing	Ongoing	1. LAP Provider Update pending for Q3. 2. LAP Provider Update pending for Q3. 3. Culture and Health Care N/A 4. LAP Provider Update pending for Q3. 5. Health Literacy pending for Q4.	LAP Provider updated completed and distributed in July.
50	Provider Communication and Training	Promote C&L flyer and provider material about Health Equity Department consultation and resources available, inclusive of LAP program and interpreter services.	Provider material made available on provider's library.	Ongoing	Flyers updated on provider library	Completed in Q2
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
51	**Rationale**	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**				
52	**Responsible Staff:**	**Primary: A. Kelechian**	**Secondary: A. Schoepf**			

53	English Material Review	Conduct English Material Review (EMR). Include: review content and layout of materials for reading grade level and cultural and linguistic appropriateness.	All EMRs are completed within a 5 business day turnaround as tracked through Workfront. Exception: Content heavy and high-volume requests are completed within 7 business days.	Ongoing	7 EMRs were completed in Q1 and 24 completed in Q2.	22 EMRs were completed for CalViva in Q3 and 5 completed in Q4.
54	Training	Review and update of Health Literacy Toolkit. Implement provider plain language materials and resources through webinars and online platforms when requested.	Production and distribution of toolkit. Distribution of provider plain language resources.	Q3	Toolkit completed in Q2. Providers' materials are scheduled for Q4.	No requests were received from providers during this period.
55	Operational	Review and update Health Literacy materials as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials.	Update and post materials on Health Literacy SharePoint	Ongoing	Materials completed in Q2.	Updated SharePoint in September.
56	Training	Quarterly training and resources for staff on how to use the C&L database and write in plain language, including online training.	Number of staff trained. Quarterly training and resources production.	Quarterly	7 staff members joined the Q1 training. In Q2, training was not completed because no one registered.	2 associates attended this training in Q3. In Q4, no training was completed as no one registered.
57	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities completed.	October	On track for Q4.	Completed in October. As an activity for Health Literacy month, a staff survey was sent to associates for feedback on our Health Literacy Month where 55 responses were obtained.
	Cultural Competency Training Program					
58	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**				
59	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, I. Diaz**			

60	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) external workgroup. Attend ad hoc/subgroups on training requirements and shared resources (where applicable) per APLs (SB923; DEI)	Minutes of meetings that reflect consultation and shared learning	Ongoing	Participation in HICE C&L Workgroup (and SB923) meetings (1/6; 1/13; 1/21; 2/3; 2/24; 3/10, 3/24; 4/7, 4/22, 5/5, 5/19)	Participation in HICE C&L and Ad Hoc meetings (7/7; 10/13)
61	Provider Training	Conduct cultural competency, implicit bias, and gender identity training/workshops for contracted providers and provider groups upon request. Training content to include access to care needs for all members from various cultural and ethnic backgrounds, with limited English proficiency, disabilities, and regardless of their gender, sexual orientation or gender identity (TGI training APL 24-017/SB923). Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented. Work with provider communication to implement ICE for Health computer based training through provider update(s) and/or provider newsletters and/or medical directors, promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates. Work with provider engagement to publish invites for trainings and as warranted create on-demand trainings. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	Output number of providers who received cultural competency training by type of training received. Number of attendees/participants and training evaluation and meeting minutes	Annual	Language Assistance Programs and the Use of Plain Language for Health Literacy (OnDemand 1/1/25) 112 attendees Strengthening Cultural Humility, Dismantling Implicit Bias in the Healthcare Setting (Implicit Bias) (OnDemand 1/1/25) no attendees Special Needs and Cultural Competency (OnDemand 1/1/25) 344 attendees Transgender, Gender Diverse, & Intersex Affirming Care & Equity 1/22/25: 6/30/25 33% of PPGs have attended/completed training 6/30/25 100% of Vendors have attended/completed training	Implement Cultural Humility, Competency, and Equity in Healthcare (DEI APL training) 12/17/2025 All LOBs combined, Medi-Cal = 3.46% DHCS extended provider completion deadline on 12/2025 to 12/31/2026 Provided and supported responses for PE/PR for training outreach and CAP letter increasing interdepartmental collaboration to achieve PPG completion rates of 100% by 10/25 Developed tracking grid for coordination with PE Dept and follow-up with contracted PPGs for TGI training attestations from PPG staff with delegated Health Net functions to maintain compliance with DMHC/DHCS (APLs 24-017 and 24-018)

62	Provider Training	Coordinate with HE team lead SME to track implementation of Language Assistance Programs and the Use of Plain Language for Health Literacy training for providers. Topics: Language Assistance Program, health literacy, plain language communication, health literacy/plan language resources	Number of attendees/participants and training evaluation	Q4	Expecting training in Q4	Completed trainings (10/22 and 11/19). 10/22: no attendees 11/19: 52 attendees Recorded training for on-demand. Training go-live date pending.
63	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles/webinars that educate staff on culture, linguistics and the needs of special populations. Deploy online Cultural Humility and Health Equity training during August's CLAS month celebration.	Attendance record and online tracking. Event summary and activity specific participation totals	Q3	CLAS Month Kickoff meeting took place on June 3rd and 5th 2025, with an additional QI Engagement Committee meeting taking place on 07/17 2025	DEI training went out to staff on demand in October 2025. 2,246 staff have completed the training out of 2248 staff assigned.
64	Accreditation	Obtain NCQA Health Equity Accreditation and HEA Plus	Procurement of Health Equity Accreditation and Health Equity Accreditation Plus and lead collection and preparation of materials during non-renewal years	Ongoing	Assisted in accreditation submissions with document delivery. N/A for HEA Plus in 2025 (in lookback period).	Tracking changes to NCQA accreditation program for document preparation.
65	Report	Complete reports for NCQA Health Equity Accreditation and HEA Plus. Reports includes Defining the Community, Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis.	Timely completion of reports. Submitted to NCQA HEA Plus.	Q1	Completed Q1 2025.	Completed Q1 2025.
	Health Equity					
66	**Rationale**	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				

67	Responsible Staff:	Primary: P. Lee, D. Fang,	Secondary: N. Chand			
68	Operational	Lead quarterly Health Equity Collaborative Workgroup. Workgroup aligns QI, population health, SDoH, cultural competency and disparity initiatives across departments. It is inclusive of reporting out and supporting disparity reduction projects, Health Equity updates and reporting to support NCQA and other regulatory requirements.	Facilitate at a minimum quarterly meetings and intra departmental collaboration on Health disparities. Take minutes and attendance and share out workgroup presentation decks.	Quarterly	Health Equity Collaborative Workgroup 4/21, 7/14 Provide consult for data request from HE Strategic Dept Provide consult for Disability grant	Health Equity Collaborative Workgroup 7/14, 10/20/25 12/8 Internal Health Equity Governance Committee Cultural Competency trainings presentation Provide consult for data request from HE Strategic Dept Final review of Disability Voices United Health Net grant
69	Operational	Implement disparity model for PIP projects (W30-6+) include formative research, community, member and provider interventions. Partner with Fresno Black Infant Health to improve compliance rate among Black infants 0-30 months. By 12/31/2025, use targeted interventions for CalViva Health Black or African American members in Fresno County: 1. To improve the rate of at least six infant well care visits by 15 months of life from a baseline rate of 27.98%* to a goal rate of 38.99%. 2. To improve the rate of three or more infant well care visits within 120 days of life from a baseline rate of 26.60%* to a goal rate of 37.23%.	Development of modules; Support with barrier analysis and interventions to help meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing	Data Reconciliation: 49 Black/African American members engaged BIH enrollment rate of 16.55%. 23 (15.54%) members self-reported taking their babies to their IWC visit. CDC's Milestone Tracker App scan, BIH members: 50 Apple Store, 28 Google Play Member incentives:- up to June 2025 cohort includes 287 gift cards, 36 gift baskets.	The MY2024 remeasurement year rate for W30-6+ was 48.6%, representing statistically significant improvement in the Black/African American rate in Fresno County. The MY2024 remeasurement year rate for three or more infant well-care visits by 120 days was 39.45% and was not statistically significant. Year-end intervention updates reflected 603 members identified/referred to BIH, 259 reached, 46 newly enrolled, and 51 members self-reporting completion of infant well-child visits. BIH Fresno Milestone Tracker scans totaled 219 (144 App Store; 75 Google Play).

70	Operational	Provide support for SUD/MH non-clinical PIP project. Partner with hospitals to ensure timely notification for providers. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage of provider notifications for members with SUD/MH diagnoses following or within 7 days of an emergency department visit in Fresno and Madera Counties.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Support with barrier analysis and interventions such as cultural competency training. Attend bi-weekly meetings.	Ongoing	Interventions included using Smart Phrases to capture provider (SAMC) notification, referring members to a CBO (Resiliency Center), and training providers on serving the Latino/Hispanic members.	Year-end intervention updates included refinement of SMART Phrase and cultural competency training activities to better align with hospital workflow and project needs, as well as discontinuation of the Resiliency Center intervention due to no referrals.
71	Operational	Provide support for Madera Lean FUA/FUM QMIP project. Partner with local hospitals to improve rates among members' follow up care after 30 days of an emergency visit. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage (from MY2023 9.84% to 24.51% for FUA and 40.59% for FUM) of members who receive follow up services after an ED Visit for SUD/MH diagnoses following or within 7 days of an emergency department visit for Madera County members.	Support with barrier analysis and interventions such as cultural competency training. Development of modules; meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing	Onboarded Camarena Health as a provider to support project. Will use Lanes Data to measure performance.	Year-end updates reflected improved FUM/FUA performance in Madera County through provider participation, CHW follow-up activities, refined LANES reporting, and completion of cultural competency/findhelp training.

72	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project to improve W30-6+ rates. The CVH/CSV IHI Collaborative Team will use targeted interventions to improve the W30-6+ rate at the combined CSV-Elm St. clinics for Hispanic children 0-15 months by 20% (from 41% to 61%) by March 2025.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Attend internal meetings and IHI/DHCS learner bi-weekly calls.	Ongoing	Phase 1 concluded in March, Phase 2 to resume in September. CSV's current rate is 40.24%, (11/27) while for Fresno County overall, the rate is 56.68% (1485/2620).	Phase 2 resumed in September 2025, and by year end CalViva and Clinica Sierra Vista completed the baseline assessment, confirmed Fresno County and CSV pilot sites, and advanced planning to improve well-child visit rates for the Hispanic/Latino population.
73	Operational	Provide consultation to departments on cultural competency and improving health care outcomes (including enrollment) for key demographics and key metrics to support health equity	Consultation and /or trainings provided	Ongoing	Ongoing. Provide consultation in QI POD meetings and disparity project meetings.	Ongoing support during POD meetings and disparity project meetings.
74	Report	Conduct annual disparities analysis for each county.	Conduct disparities analysis for NCQA and DHCS measures by REL and share with internal stakeholders.	Q4	Annual analysis completed and presented in Q1.	Completed in Q1.
75	Report	Complete Disparity Project Report. Report is inclusive of disparity reduction projects annual write ups. Report is completed annually or bi-annually.	Report for NCQA including annual disparity gap analysis and prioritized opportunities for intervention. Disparity reduction project write-ups demonstrating implementation of member, community and provider level initiatives and evaluation.	Q3	On track to be completed in July.	Submitted and approved by committee in Aug.
76	**Responsible Staff:**	**Primary: S. Xiong-Lopez**	**Secondary: J. Nkansah**			

77	HEQ Project/ Activity	Distribute DEI survey to CVH Leadership, and Staff Members to identify opportunities/ improvement needed surrounding DEI	**Survey completed 8/2024 -** 61.05% of staff and leadership Disagreed/Strongly Disagreed that CVH took time to celebrate/ acknowledge most celebrated cultures. **Goal:** Decrease the percentage of staff disagreement (CVH takes time to acknowledge/ celebrate most celebrated cultures) to below 50% by Q3 2025 Implement Cultural celebration and heritage month 2x a year Rearrange settings of staff meeting with ice breakers and team activities to promote inclusiveness.	Annually	On track to be completed in Q4.	Training was completed for all staff 12/2025
78	HEQ Project/ Activity	Distribute DEI survey to CVH Board, Committee, to identify opportunities/ improvement needed surrounding DEI	**Survey Completed**- No major concerns as it relates to DEI. **Action:** Review of CVH Bylaws to account for changes such as equity, inclusion, or cultural humility for governance bodies. **Goal:** Implementation of new Bylaws to include HEQ initiatives Q3 2024	Annually	On track to be completed in Q4.	Survey is currently on hold, for further review based on NCQA Standards Requirements for this element.

79	HEQ Project/ Activity	Assist and/or serve as consultant with Fresno County Network Improvement Committee Pilot to address leading health indicators focusing on upstream measures such as risk factors and behaviors, rather than disease outcomes (focusing on pregnant moms, families with children ages 0-9)	**Data:** 39% of the 53 identified students are reading grade level. Identified impact of reading level influenced by, poverty, socioeconomically disadvantage, access to health care. **Goal:** 100% of the 53 identified students are reading at grade level by 6/2025 **Action:** Children and families are set up with trained CHW to assist in community navigation. School liaison, Social workers, representative will receive training to become CHW. CBOs, and policy makers to identify strategies to help with SoDH, improve health, wellness and academics outcomes	Ongoing	Closing Activity: In May 2025, data showed that 89% of the total identified students, or 32 students, were tested and are reading at their grade level. **CVH Contribution:** CVH participated in the NIC pilot as a community and strategy partner to identify more effective ways to assist families. They initiated a gathering of Community-Based Organizations (CBOs) to align services and resources, making them more accessible to school sites. CVH also participated in and presented Cal Aim Services at the Central Valley Regional Assistance Center for Community Schools, aiming to address key challenges such as access to healthcare (including mental health and behavioral health), as well as food and economic insecurities through Enhanced Case Management, Community Supports, and Community Health Workers (CHWs). The pilot cohort proved to be effective. By providing families with resources to tackle these key challenges, school staff could focus solely on meeting the reading level goals for each student. There were many trials and errors throughout the year. For future initiatives, it would be beneficial for all stakeholders to clearly identify their community partners and define their roles with the schools to ensure better quality support. No new project launches have been identified yet.	Project completed in Q2.
80	HEQ Project/ Activity	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations	Q3	DEI training has been scheduled for all staff December 5, 2025	Completed as planned

81	HEQ Project/ Activity	HE Project Pilot- (Kings County) Focused on perimenopause and menopause in women ages 40-60	**Data:** Kings County has 4,079 CVH members who identify as a woman between the ages of 40-60. Kings County has a total of 8 providers with specialty in OB/GYN in network with CVH. Of the 8 providers only 4 of have an assessment in place for perimenopause and menopause, however members have to specifically ask for an assessment or have symptoms present. **Goal:** Bring perimenopause/menopause awareness to women ages 40-60, through health education. **Action:** A work group has been established in Kings County Q1, 2025 to identify champion provider and group to provide health education and promote awareness by end of Q2.	Q3	The workgroup has identified Pear Suite as the community health worker (CHW) provider to deliver health education for members interested in perimenopause and menopause. Additionally, they will assist in streamlining the referral system for those who meet the criteria for these conditions. The Department of Behavioral Health and Department of Public Health Pear Suite, and CVH, developed a flyer, survey, and pre-screening assessment, and will be launching the Perimenopause and Menopause Awareness Campaign on September 1. Kings Community Action Organization (KCAO) will also be supporting the project by hosting three focus groups at their facility in late September and October.	3 focus group were hosted in in Hanford, Corcoran, and Avenal. A total of 172 participants ranging from ages 35 and up. Provided 98 in-person interpretation services. 119 participants completed a perimenopause/menopause risk assessment. 36 participants were identified as medium or high risk and were referred to a specialist. All participants were referred to their primary care provider for follow-up questions or support. Delivered 140 service referrals related to Social Determinants of Health. Housing stability was the most common referral needed.

[1] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^ **Indicates revision.**

* **Indicates new.**

Fresno-Kings-Madera Regional Health Authority Commission Approval

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

_______________________________ _______________________________

David Hodge, MD
Regional Health Authority Commission Chairperson

Date

_______________________________ _______________________________

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

Date

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Pao Houa Lee, MBA, Senior Health Equity Specialist

COMMITTEE DATE: May 20, 2026

SUBJECT: Health Equity Program Description 2026 CalViva Health – Change Summary

Program Description Change Summary:

Redline Page #	Section/Paragraph Name	Description of Change	New Page #
Page 4	Vision, Mission, Goals and Objectives	Change/add new NCQA Accreditation name	Page 4
Page 8	Health Equity Work Plan	Change/add new NCQA Accreditation name	Page 8
Page 10	Interpreter Services	Update DHCS APL number (25-005)	Page 10
Page 10	Translation Services	Update tagline term to Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (NOA)	Page 10
Page 12	Cultural Competency Training Program	Removed list of topics from Cultural Competency Training and provided reference to the CalViva Health P&P CA.CLAS.10 instead.	Page 12
Page 14	Cultural Competency Education for Providers	Included information on training completed by providers, which can be found in the provider directory.	Page 14
Page 15	Health Literacy	Update health literacy process to include Content and Layout Review checklist to streamline EMRs.	Page 14
Page 15	Clear and Simple Guide	Change title of section to expand on the Clear and Simple Education, rather than Guide.	Page 15
Page 15	Clear and Simple Education	Describe and expand on clear and simple training.	Page 15
Page 16	English Materials Review (EMRs)	Change checklist name from Cultural Competency and Plan Language checklist to Content and Layout Review checklist.	Page 16
Page 17	Health Equity Interventions	Update Health Equity Interventions to new intervention strategies.	Page 16
Page 22	Population Needs Assessment	Remove PNA from the Health Equity's Program Description as responsibility has moved to the Population Health Management team.	
Page 26	Health Equity Department Staff Roles and Responsibilities	Removed Director of Program and added VP of Quality Management	Page 25

2026
Health Equity
Program Description

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1.0 EXECUTIVE SUMMARY

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

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The HNCS Health Equity Department develops programs and services to facilitate understanding, communication and cultural responsiveness between members, providers, and Plan staff.

The Health Equity Department, on behalf of CalViva Health, utilizes the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services. Health Equity's objective is to promote effective communication with limited English proficient members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in-person interpreter services, and through trainings, and in-services on a wide range of health equity and cultural and linguistic (C&L) topics that impact health and health care.

Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings 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 cultural responsiveness education.

Health Equity services are part of a continuing quality improvement endeavor. The Health Equity program description, work plan, language assistance utilization and end of year reports are all submitted to the CalViva Health Quality Improvement/Utilization Management (QI/UM) committee for review and approval.

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2.0 Staff Resources and Accountability

2.1 Staff Roles and Responsibilities

A detailed description of staff roles and responsibilities is included in Appendix 1.

3.0 VISION, MISSION, GOALS AND OBJECTIVES

The organization's health equity mission and vision are led by the Chief Health Equity Officer and are implemented through cross-functional collaboration and partnership. The mission and vision are aligned with regulatory requirements and implemented across the plan.

The Health Equity program structures are organized to meet program goals and objectives through formal processes that objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and services to meet the needs of multicultural populations, reduce social risks in the community, and address social needs of individuals. The program's multidimensional approach enables the organization to focus on opportunities for improving operational processes, services, health outcomes, experiences, and community partnerships. The Health Outcomes and Community-Focused Care Accreditation (formerly Health Equity and Health Equity Plus, respectively) program is formulated and operated based on foundational structures that include the program description, an annual work plan, and an annual evaluation. Programming focus and initiative development is based on assessment of the population and individuals' personal characteristics (race/ethnicity, preferred languages, gender identity, sexual orientation, age, socio-economic status, geographic location), social risks, and social needs through community-level and individual-level data collection to determine high volume, high risk, and problem-prone clinical and service bias and discrimination issues leading to uneven care outcomes. Performance goals and thresholds are established for all measures and are trended over time. At a minimum, the Health Outcomes and Community-Focused Care Accreditation program monitors and evaluates CLAS, individual demographic/personal characteristic data, network responsiveness, individual experience, practitioner experience, staff feedback, service performance, stratified clinical performance measures (i.e., HEDIS), and stratified individual experience measure (i.e., CAHPS).

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3.1 Vision

To help all the people and communities we serve achieve the highest level of health by advancing equity in health and health care.

The organization implements an overarching vision of diversity, equity, and inclusion that works to:

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- Eliminate disparities and improve quality of care and health outcomes.
- Eliminate systemic organizational marginalization.
- Promotes inclusion and anti-racist practices, that will be evidenced through our structures, customs, and leadership.
- Driving systemic strategy to ensure all of our members have access to equitable health outcomes.
- Expanding current and develop new community partnerships to elevate the health of the communities we serve.
- Informing policy discussion as well as investments to close the gap in equity.

3.2 Mission

CalViva Health's Health Equity mission is to:

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

3.3 Goals

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

1. Ensure language services meet regulatory requirements and achieve metric goals.
2. Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
3. Complete staff and provider trainings for required topics.
4. Address health disparities through targeted cross-collaborative projects.
5. Implement social needs assistance strategies with integrated approaches for mitigating social risks.

3.4 Objectives

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

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A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).

- Develop and implement Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services.
- Utilize and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities.
- Collect and analyze health equity and C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities.
- Adhere and implement HHS guidelines for Section 1557 of the ACA for C&L services and requirement for non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
- Collect, analyze and report membership language, race and ethnicity data.
- Inform members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually.
- Maintain information links with the community through Public Policy Committee (PPC) meetings, Population Needs Assessment (PNA) and other methods.
- Inform contracted providers annually of the health equity and C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources.
- Monitor the use of taglines and Non-Discrimination notices in all required communications.

B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.

- Provide C&L information and support for HNCS and CalViva Health 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.
- 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, quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers.

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- Address health equity through development and implementation of an organizational and member level strategic plan to improve health disparities.
- Sustain efforts to address health literacy in support of CalViva Health members.
- Provide oversight for the assessment of bilingual capabilities of bilingual staff and provide ongoing education and support.

C. To be champions of cultural and linguistic services in the communities CalViva Health serves.

- Continue involvement with local community-based organizations, coalitions, and collaborative efforts in counties where CalViva Health members reside and to be a resource for them on C&L issues.
- Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE), and America's Health Insurance Plans (AHIP).
- Participate in employee inclusion groups (EIG) for veterans, military families, women, LGBTQ community, MOSAIC (multicultural network), and people with disabilities. The EIG's help expand sharing of knowledge and resources.

D. To promote and be champions for diversity of CalViva Health members, providers, and Plan staff. This includes:

- Provide C&L services that support member satisfaction, retention, and growth.
- Provide subject matter expertise and training resources to meet the needs of seniors and persons with disabilities (SPD) and other population groups.
- Increase cultural awareness of Plan staff through trainings, newsletter articles, annual "Heritage / CLAS Month", and other venues.

4.0 HEALTH EQUITY WORK PLAN

The goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities. The work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements. The CLAS standards represent 15 different standards that serve as the foundation for the development of the Health Equity Department strategic plans. CLAS standards are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States" (Think Cultural Health).

CLAS Standards ensure that services comply with the Office of Civil Rights Guidelines and Section 1557 of the Affordable Care Act (ACA) for culturally and linguistically

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appropriate access to health care services (Title VI of the Civil Rights Act), which cover three major areas: 1) Culturally Competent Care; 2) Language Access Services; and 3) Organizational Supports. In addition to CLAS, Health Net on behalf of CalViva Health, ensures implementation activities and compliance with National Council on Quality Assurance (NCQA) Health Outcomes Accreditation and Community-Focused Care Accreditation guidelines and multiple requirements from the state and federal government, including 2 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights) of our contract with the State of California, and DHCS APL 25-005.

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The work plan also supports information-gathering through PNA updates, data analysis, and participation in the CalViva Health Public Policy Committee (PPC). In addition, the Plan interacts with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The work plan is divided into the following areas:

- Operational Areas Subject Matter Experts
- Language Assistance Program
- Health Literacy
- Cultural Competency
- Health Equity, Social Determinants of Health, & Social Needs
- General Compliance Activities

The work plan activities are evaluated twice a year by CalViva Health's QI/UM committee. The work plan activities are also shared as information to CalViva Health's PPC. The mid-year review monitors the progress of each activity and assesses if it meets the established objective. The end of year evaluation assesses if the activity has met the objective, its successes, identifies the challenges and barriers encountered and how they were addressed, and is also an assessment for the future direction of health equity and C&L services. This work plan review and approval process assures that a standard of excellence is maintained in the delivery of cultural and linguistic and health equity services. The work plan has more detailed information and activities in these areas.

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5.0 SCOPE OF PROGRAMS AND SERVICES

The Plan is committed to ensuring quality care and services that meet the needs of diverse communities within the CalViva Health service area. CalViva Health, in collaboration with the Health Net Community Solutions (HNCS), ensures that all services provided to members are culturally and linguistically appropriate. There are some aspects of language assistance services that are delegated to HNCS with oversight by CalViva Health. The collaboration and coordination between both plans ensure that there is dedicated staff providing overall support and guidance to health equity and C&L program and services.

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5.1 Language Assistance Program

The Plan established and monitors the Language Assistance Program (LAP) for members and providers. The LAP is a comprehensive program that ensures language assistance services are provided for all members and that there are processes in place for training and education of Plan staff and providers. The LAP ensures equal access to quality health care and services for all members. The Health Equity Department provides oversight for LAP operational activities and directly provides LAP services related to member and provider communication.

The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. The mandated standards (4, 5, 6, and 7) provide the basics for language support services for CalViva Health members.

The LAP main elements include:

- **Demographic Data Collection for Members**

The standards for direct collection of members' race, ethnicity, preferred pronouns and name, alternate format, spoken and written language need consist of informing members of the need to collect information, requesting information from members, capturing the information accurately in the membership databases and monitoring the information collected. Members are informed of the need to collect this information through a variety of methods such as the member newsletter. Providers may request the information collected for lawful purposes.

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- **Interpreter Services**

Interpreter services range from ensuring contracted vendors are in place, monitoring the provision of services and annual communication with members and providers on how to access these services. Interpreter services are available in over 150 languages supported by the contracted vendors and bilingual staff. Interpreter services are guided by the Interpreter Services and Assessment of Bilingual Staff policies and procedures and meet the national quality standards for interpreter support. Interpreter services facilitate communication with members with limited English proficiency (LEP) to speak with Plan staff and/or its contracted providers. Bilingual staff and contracted telephone interpreter services vendors are used to assist members with LEP.

Providers and members may request an interpreter 24 hours a day, 7 days a week at no cost. Interpretation services may be delivered either through telephone, face-to-face, video remote interpreting, closed caption services or sign language (SL) depending on the nature of the appointment and need. As a result of COVID-19 changes in patient care delivery, the Plan continues to provide direct access to telephone interpreters for pre-

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scheduled interpreter requests and video remote interpreting services are available on the same day of the appointment. Interpreter services also include oral translation services of print documents upon request from a member, which may be provided by either a bilingual staff or contracted interpreter vendor. Quality standards for contracted interpreter services are incorporated into the vendor scope of work agreements and include demonstrating that the interpreter is versed in health care and medical terminology as demonstrated by a validated test instrument, familiarity with interpreter ethics, and verification process for basic interpreter skills such as sigh translation, listening and memory skills, commitment, confidentiality, and punctuality. Interpreter quality standards are fully compliant with the interpreter quality definitions from the federal requirements in Section 1557 of the ACA and with CA SB223, Language Assistance Services, and DHCS APL 25-005.

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The Plan also supports provider groups and individual providers' efforts to supply interpreter services for CalViva Health's members with LEP. Providers may call the Provider Services toll free number and request interpreter assistance. Updates on Health Equity and C&L services available are sent regularly to all contracted providers.

- **Translation Services**

Translation services are guided by the Translation of Written Member Informing Materials P&P and are based on industry translation standards. Translation services includes quality standards for translators, a style guide to promote consistent translation quality, a glossary of common terms in each threshold language, provision of materials in Alternate Formats, a review process to prepare English documents for translation, and a process to monitor translations for quality, timely delivery, and accuracy. Translation services ensure that member informing documents are provided in the threshold languages of English, Spanish and Hmong and that a Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (NOA) and Non-Discrimination Notice (NDN) are included in member mailing when required. The translation services include oversight of the use of the Non-Discrimination Notices and taglines (or NOA) with English and translated documents as required by federal rules (DHCS APL 25-005, Section 1557, 45 CFR 155.205).

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- **Alternate Formats**

CalViva Health provides alternate formats of member informing documents to members as required by regulation, law, and upon member request. Alternate formats include but are not limited to Braille, large print, and accessible PDF documents. The quality of the documents and the time to fulfill member requests for these documents are monitored to ensure timely access of benefit information to CalViva Health members. The provision of alternate formats is compliant with Section 1557 of the ACA and DHCS All Plan Letters 25-005, 22-002, and 22-011. This consists of informing members of the need to collect information on their preferred alternate format, requesting the information, capturing the information accurately in the membership databases and monitoring the information

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collected. For example, if a member states their preferred alternate format is Braille, CalViva Health will provide all required member information material to this member in this format moving forward.

- **Oversight of Contracted Specialty Plans and Health Care Service Vendors**

The Health Equity Department is responsible for monitoring its Language Assistance Program (LAP), including plan partners, specialty plans and delegated health care service vendors, and to make modifications necessary to ensure full compliance. Monitoring includes assurance that all language assistance regulations are adhered to for members at all points of contact.

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- **Staff Training on LAP**

All Plan staff who have direct routine contact with members with LEP and whose duties may include elements of CalViva Health's language services must be trained on the LAP and the P&Ps specific to their duties. Training is conducted annually and is done either live, and/or on-demand online learning.

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- **Monitoring for LAP Quality**

The quality of the LAP is assured through quarterly monitoring of the utilization of language services such as interpreter requests by language, telephone interpreter utilization by language, and the number of members requested translations. All translation vendors are provided with a translation and alternate format style guide and a glossary of preferred terms in each of the threshold languages. The quality of Spanish, Hmong, Armenian, Chinese, and Arabic translations are additionally monitored by reviewing translated documents. Languages available vary depending on recruitment and retention of translation reviewers. Quality of translations and interpreters is monitored through quarterly review of linguistic grievances and member complaints that are related to language.

The Health Equity Department also oversees and monitors the delegation of LAP services with our specialty plans and ancillary vendors. The Health Equity Department in collaboration with other departments ensures LAP services are available to all members at all points of contact and that the specialty plans and ancillary vendors have processes in place to adhere to the regulations. To assure that all language assistance regulations are adhered to members at all points of contact, Health Equity requests/obtains a semi-annual report from each specialty plan or health care service vendor. The Health Equity Department provides consultation services to these plans and vendors as necessary.

- **Communication for LAP**

The Plan has implemented processes to assure routine member and provider communication promoting the LAP. The Plan advises members annually of no-cost

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language services (including interpreter and translation support) that are available to them. Methods of member communication are inclusive of PPCs, community-based organizations, member service representatives and/or other Plan staff, member newsletters, call center scripts, and provider relations representatives.

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Providers receive an annual reminder of the language assistance services that are available to them in support of CalViva Health members which includes how to access the LAP at no cost to members. Methods for communication are inclusive of the online Provider Operations Manual, Provider Updates, Operational Toolkits (including the Rainbow Guide), mailings, in-person visits, and/or trainings/in-services.

5.2 Cultural Competency Training Program

CalViva Health integrates culturally competent best practices through provider and Plan staff in-services, training, education, and consultation. The training program offers topic specific education and consultation as needed by Plan staff and contracted providers. The cultural competency training program topics are available in the CalViva Health P&P CA.CLAS.10.

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- **Services in Support of Staff**

Cultural Competency trainings and services for staff are designed to help support staff in meeting our diverse members' needs in a culturally sensitive, empathic and efficacious manner. Support services focus on resources, such as, trainings, in-services, scripts, and language access services available through SharePoint, on demand trainings, and trainings by request.

- **Cultural Competency Training for staff**

Support for staff includes workshops, training, in-service, and cultural awareness events. Training and education on C&L services and/or cultural competency is provided on ongoing basis to Member Services, Provider Engagement, Health Education, Quality Improvement department staff, etc. The goal of these trainings is to provide information to staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L and health equity resources, and membership diversity.

Annually, the Plan hosts a Best in CLAS Month event for Plan staff as the main cultural competency training activity. Staff engage in training, interactive learning and events related to cultural competency. CLAS Month events also highlight current and emerging needs of our members across populations most impacted by health inequities as well as special health care needs populations. Cultural competency training courses include content on access to care needs for all members regardless of their gender, sexual orientation or gender identity. The event demonstrates CalViva Health's commitment to being a culturally competent organization by providing a forum for Plan staff to learn about diverse cultures, which increases their understanding of the diverse cultures represented

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in CalViva Health's membership. This understanding also serves to build sensitivities that promote a non-discrimination environment.

- **Cultural and Linguistic Consulting Services**

Each Health Equity staff member has a cultural subject matter area of expertise that includes: cultural issues that impact seniors and persons with disabilities, cultural issues that impede health care access for Lesbian, Gay, Bisexual & Transgender (LGBT+) populations, cultural disconnects that may result in perceived discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, health status, and the cultural issues that impede accessing health care services for recent arrivals to the United States. Health Equity staff also offer specialized consultation on many other areas including:

- Case managers to assist in building trust with patients who are recently arrived immigrants and refugees
- Quality improvement coordinators to help identify cultural issues and strategies to help improve preventative access to care
- Grievance coordinators and provider relations representatives to address perceived discriminations including but not limited to those due to members' gender, sexual orientation or gender identity
- Care coordinators trying to obtain medical information for patients hospitalized outside of the U.S.

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- **Cultural Competency Education for Providers**

The Plan supports contracted providers in their efforts to provide culturally responsive and linguistically appropriate care to members. The services that are offered to contracted providers are intended to:

- Encourage cultural responsiveness and awareness
- Provide strategies that can easily be implemented into a clinical practice
- Foster improved communication and health outcome for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, regardless of their gender, sexual orientation or gender identity
- Foster non-discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or language.

Trainings for providers and their office staff include the following:

- Advancing Health Equity: Cultural Humility, Diversity and Equity in Healthcare
- Language Assistance Program/Services and Health Literacy
- Gender Inclusive/Affirming Care
- Community Connect Program- Social Needs Support

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- By request trainings on specialty topics

To identify the cultural needs of providers, the Plan collects information from providers using a variety of methods, including the annual provider survey conducted by the Quality Improvement Department.

Cultural competency services are also promoted to providers through the provider website, the HICE provider toolkit, "Better Communication - Better Care" and tailored cultural competency workshops. Many topic areas for presentations on cultural aspects of health care, and provider group in-services on interpreter services, cultural and linguistic requirements and working with Specialty Healthcare Needs populations are available to providers upon request. Cultural Competency training completed by providers is documented in the provider directory by displaying a "Cultural Training Completed Yes" icon.

Additionally, the Plan has developed materials for use in provider offices that specifically address cultural background and clinical issues. CalViva Health recognizes that diverse backgrounds include culture, ethnicity, religion, age, residential area, disability, gender, sexual orientation and gender identity. Because diversity is complex and an important component for individuals as they access and utilize services, emphasis is placed on developing materials that are researched and field-tested to assure quality and cultural appropriateness. Providers may access the materials by calling the Health Equity Department toll free number during business hours at (800) 977-6750 or emailing their inbox Cultural.and.Linguistic.Services@healthnet.com.

- **Collaborations**

Representatives of the Plan have been an active participant and co-chair/lead on the Health Industry Collaboration Efforts (HICE). Participation on this collaboration has provided the Plan with suggestions to implement new cultural or linguistic legislation. It has also provided a forum to discuss language assistance program challenges faced by providers and other health plans that result in a more consistent experience for members with LEP.

5.3 Health Literacy

The Plan continues to make strides in the promotion of health literacy through the implementation of the health literacy initiative *Clear and Simple.* The Initiative offers: a) Plain Language and Readability Studio online training b) Plain Language tip sheets, c) Support in writing documents at appropriate grade level, d) Access to plain language readability software, e) Content and Layout review checklists for materials production, f) A review process that streamlines the English Material Review (EMRs), h) Deployment of participation in National Health Literacy Month, and i) Provider training on motivational interviewing/reflective listening and plain language resources.

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- **Plain Language 101 Training**

The available training provides Plan staff with a basic understanding of health literacy and its impact on health care access. For example, trainings cover useful tips on how to write in plain language such as avoiding jargon, using simple words, and giving examples to explain difficult concepts. This ensures that communications available to members are clear and easy to understand.

- **Readability Software and Training**

To sustain the Clear and Simple initiative, the Readability software was made available to staff developing member informing materials. The software supports staff in editing written materials so that they are easily understandable for members. Staff that produces written materials for members are required to utilize readability studio, edit their documents and provide the grade level analysis to the Health Equity Department prior to a request for English Material Review.

The Health Equity Department has developed and implemented Readability Studio training so that staff have the support to effectively navigate the software and produce member materials developed following the plain language guiding principles. The training is delivered utilizing adult learning theory and provides hands-on experiential learning in operating the software and editing written materials to a 6th grade reading level.

- **Clear and Simple Education**

Our training, "Understanding Health Literacy and Plain Language", provides staff with a basic understanding of health literacy and its impact on health care access. It also goes over useful tips on how to write in plain language such as avoiding jargon, using simple words, and giving examples to explain difficult concepts. This ensures that letters and materials sent to members and information Health Net posts on websites are clear and easy to understand.

Health Literacy Toolkit: The Health Equity Department produces a Health Literacy Toolkit that consists of

- Clear and Simple Plain Language Guide
- Readability Studio Tips and Tricks
- Content and Layout Review Checklists
- Health Equity Review Grid
- Many other resources

The guide is provided during training and is available on the Health Literacy SharePoint site.

- **English Materials Review (EMRs)**

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The Health Equity Department 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 and supports stigma reduction. Readability levels are assessed on the original document and revised accordingly to ensure they comply with required readability levels mandated by regulatory agencies. The review process ensures that document layouts are clean, easy-to-read, well organized, and that images are appropriate and culturally relevant and prepares vital documents to be ready to be translated, when indicated. Content and Layout Review checklists are required to be submitted with all EMR requests.

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- **National Health Literacy Month**

National Health Literacy Month is promoted internally by Plan staff every October and offers an opportunity for staff to participate in various contests to exemplify how they are using the Clear and Simple principles in their everyday work.

5.4 Health Equity

CalViva Health is committed to supporting the health of our members and promoting the reduction of health disparities across our membership. To accomplish this, Plan staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.

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- **Health Equity Interventions**

The Health Equity Department coordinates organization-wide strategies to support the reduction of health disparities. The department facilitates the Health Equity workgroups, which are responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures. The workgroups look systematically and deliberately at resources and the development of strategies to reduce targeted health disparities. The workgroups are aligned with requirements to address health disparities from NCQA Accreditation programs, the state, internal directives, and DHCS Performance Improvement Project (PIP) requirements. Disparity reduction efforts are implemented through a model that integrates collaboration across departments, e.g., Quality Improvement, Provider Engagement, Health Equity, Health Education, Medical Directors, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach and media, provider interventions and member level initiatives. The following highlights the core components of the disparity reduction model:

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- Assessment inclusive of member data analysis and member, community, and provider barrier analyses. These include key informant interviews, literature reviews, and focus groups.
- Development of community and internal advisory groups
- Budget development

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- Implementation of efforts are targeted at 3 core levels:

  1. Community: Partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions.
  2. Provider: Interventions targeting high volume, low performing groups and providers who have disparate outcomes.
  3. Member: Internal programs to improve disparities in identification, engagement and outcomes in Care Management and Disease Management.

- Evaluation and improvement of health disparity reduction efforts.
- Social needs and social risks all play into determining appropriate partners, selecting, engaging, and taking initiatives with partners.

- **Consultation**

Plan staff collaborate across departments to provide consultative services for cultural competency and linguistic perspectives in order to improve health disparities. Examples of consultations include partnership on QI intervention development and support of care management programs.

- **Collaborations**

To support the reduction of health disparities, Plan staff interact with community-based organizations (CBOs) to identify C&L related concerns, obtain feedback on health equity and C&L service needs of the community and promote C&L services to community members.

5.5 Public Policy Committee (PPC)

CalViva Health maintains a Public Policy Committee, as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care, and to establish and maintain community linkages. "Public policy" means acts performed by the Plan or its employees and staff to assure the comfort, dignity and convenience of members who rely on the Plan's facilities to provide health care services to them, their families, and the public.

The Public Policy Committee meets four times a year. The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care by:

- Obtaining local level feedback, insights and perspectives to inform and address our quality and health equity strategy.
- Providing the Plan with the community's perspective on health equity and disparities, population health, children's services, and relevant plan operations and programs.

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- Informing the Plan's cultural and linguistic services program.
- Identifying and advocating for preventive care practices.
- Gathering feedback, develop, and update cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
- Advising on necessary Member or Provider targeted services, programs, and training.
- Making recommendations to the Plan regarding the cultural appropriateness of communications, partnerships, program design and services.
- Reviewing Population Needs Assessment (PNA) results, discuss and provide input into opportunities to improve performance with an emphasis on Health Equity and Social Drivers of Health.
- Providing input on the selection of targeted health education, cultural and linguistic, and QI strategies.
- Ensuring findings, recommendations and actions to/from the QI/UM Committee and Public Policy Committee (PPC) connect to holistic decisions and programming.
- Recommending strategies to effectively engage members, including but not limited to consumer listening sessions, focus groups, and/or surveys.
- Reviewing and approving meeting minutes from previous sessions.
- Providing input and advice, including, but not limited to, the following:
    a. Culturally appropriate service or program design;
    b. Priorities for health education and outreach program;
    c. Member satisfaction survey results;
    d. Findings of the Populations Needs Assessment (PNA);
    e. Plan marketing materials and campaigns.
    f. Communication of needs for Network development and assessment;
    g. Community resources and information;
    h. Population Health Management;
    i. Quality;
    j. Health Delivery Systems Reforms to improve health outcomes;
    k. Carved Out Services;
    l. Coordination of Care; and
    m. Health Equity;
    n. Accessibility of Services

The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for Health Net to understand that perception, experience, and satisfaction of services.

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The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers.

The PPC consists of no less than seven (7) members, who are appointed as follow:

- One member of the RHA Commission who serve as Chairperson of the PPC;
- One member who is a provider of health care services under contract with the Plan; and
- All others are 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 comprised of the following:
    - Two (2) from Fresno County
    - One (1) from Kings County
    - One (1) from Madera County
    - One (1) At-Large from either Fresno, Kings, or Madera Counties
- Two (2) Community Based Organizations (CBO) representatives 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 above.
    - The alternates 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.
    - Two (2) alternates from the same CBO not be appointed to serve concurrent terms.
- The Plan members and CBO representatives are 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.

In selecting the members and/or CBO representatives of the PPC, the RHA selection committee 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 is 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 are conducted on a fair and reasonable basis.

6.0 OVERSIGHT AND MONITORING

CalViva Health and HNCS collaborate to ensure that CalViva Health members receive consistent, high quality health equity and C&L services. The collaboration also forms a

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unity among the plans that permits a uniform message to be delivered to contracted providers and members. This collaboration is an avenue that increases services for the community and increases the impact that Health Equity programs can make. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity programs and services delegated to HNCS and the internal monitoring conducted by HNCS.

6.1 CalViva Health Monitoring and Evaluation

CalViva Health receives, reviews, and if necessary, approves numerous key reports in a calendar year. More information about the RHA Commission and structure is in Appendix 1.

The RHA Commission and QI/UM Committee reviews progress on Health Equity activities and initiatives at least annually. Committee responsibilities include:

- Review and approve the annual Health Equity documents:
  - Program Description
  - Work Plan
  - Work Plan Evaluations (Mid-Year and End of Year)
  - Health Equity End of Year Report
- Provide feedback and approval for program outcomes.
- Review program goals and semi-annual progress.
- Receive/review/analyze status reports from core areas
- Submit reports to the governing body (Board of Directors)
- Health Equity Oversight, including:
  - Monitors, approves, supports, and evaluates the activities for this program, and makes recommendations for improvement.
  - Conducts an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from the Department of Health Care Services (DHCS).

CalViva Health ensures C&L services, programs, and activities are meeting the required regulatory and compliance requirements through the following methods:

- **Member and Provider Communications Review**

CalViva Health reviews and approves all member materials before distribution to CalViva Health Members. The review process includes but is not limited to ensuring member materials have been approved by HNCS as culturally appropriate and the appropriate reading level. In addition, CalViva Health reviews and approves Health Equity provider communications prior to release to contracted providers.

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- **Reports**

CalViva Health reviews and approves key Health Equity reports produced by HNCS including, but not limited to the LAP utilization report, annual work plan and program description, PNA, Geo Access Report, and mid-year/annual evaluations. The reports are reviewed, discussed, and if necessary approved by CalViva Health's Quality Improvement (QI) workgroup, QI/UM Committee, Access workgroup and the RHA Commission. In addition, reports are also shared as information to CalViva Health's Public Policy Committee.

- **Audits**

CalViva Health conducts an oversight audit of health equity and C&L activities delegated to HNCS. The main elements covered in the audit include but are not limited to: C&L/language assistance policies and procedures, assessing the member population, language assistance services, staff training, provider contracts, training and language assistance program, and evaluation and monitoring. The results of the audit are shared with HNCS, the QI/UM Committee, and the RHA Commission.

6.2 HNCS Health Equity Department Internal Monitoring and Evaluation

The Health Equity Department produces numerous key reports in a calendar year. The reports are an integral part of the regulatory and compliance requirements and are used to help identify areas where modifications and corrective measures may be needed. The key reports include but are not limited to the following:

- **Language Assistance Program Utilization Report**

The Health Equity Department summarizes the Language Assistance Program (LAP) utilization data on a monthly and quarterly basis. The monthly LAP utilization report summarizes the non-English call volume to the member service call center, interpreter vendor (telephone, face-to-face, ASL) call volume per language, and requests for oral and written translations from member service representatives. Language call volume and identified language preferences are tracked to identify developing trends and possible future member language needs. The Health Equity Department produces a LAP report biannually that summarizes LAP data and assesses utilization and usage trends. The end of the year LAP Utilization report compares current usage by language and type of request to previous year's data to allow the Plan to project future language trends. Any notable trends will be reported to the Plans' QI/UM Committee.

- **Geo Access Report**

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The Community Health Education and Health Equity Departments conduct a Population Needs Assessment (PNA) every three years to improve health care outcomes for members. The PNA is conducted through an analysis of CAHPs survey data and follows the DHCS guidance provided in APL 19-011. CalViva's Public Policy Committee members will provide input to the PNA and review the PNA results.¶
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The results of the PNA are used to identify Health Equity program strategies to improve health outcomes and to reduce health disparities. The Health Equity work plan is adjusted biannually to include all strategies that have been identified to improve health outcomes and reduce health disparities for members. The Health Equity work plan serves as the PNA action plan that is submitted to DHCS every 3 years.

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The Health Equity Department prepares a report to identify the need for linguistic services using a spatial analysis software program. The purpose of the Geo Access report is to determine if members have access to provider locations where either the provider or office staff speak the preferred language. This analysis is conducted for both PCP offices and Specialist offices. The locations of members and providers are compared across language preferences. Using predetermined time and distance parameters, the software measures the time and distance for each member to each provider's office by language and by county. Time and distance standards vary by type of place: urban, suburban, and rural. The language capabilities of the provider network are compared to the language needs of CalViva Health members. The availability of linguistic services by contracted providers for members with LEP is analyzed and recommendations made for provider network development. The Geo Access report is produced by the Health Equity Department every two years for review and comment and submitted to the QI/UM Committee.

- **Data Collection**

The Health Equity Department monitors the demographic composition of members for each CalViva Health county. Demographic information is used to assess the language needs of members; to identify possible cultural and socio-economic background barriers to accessing health care; and to understand the range of diversity within the communities that CalViva Health serves. Collected and analyzed on a regular basis, data is based on existing member language needs, race and ethnicity. The Health Equity Department holds the list of all races, ethnicity and language codes and categories used by all data systems. The Health Equity Department collaborates with IT to assure that all new databases and modified databases can share member race, ethnicity, and language information.

Member individual-level data is collected either directly or indirectly by multiple sources.. Protected electronic data system databases enable collected member race, ethnicity, sexual orientation, gender identity, preferred pronouns, and social needs data to be received, stored, and retrieved. When collecting data directly from patients or members, a direct data collection framework that includes when data will be collected, where data will be collected, how and by whom data will be collected, and what questions will be used to collect data as well as response options that include option to “decline” or “choose not to answer”.

The Health Equity Department also maintains a log of all cultural or linguistic related grievances received. The logs for culture or language-related grievances and complaints are analyzed to determine if members' cultural and communication needs are being met and/or addressed by contracted providers. Information from the Appeals and Grievances Department, in conjunction with information from the community demographic profile, helps to identify cultural and/or linguistic issues that may act as barriers to accessing health care. Should a communication need be identified, the Health Equity Department develops a provider or member education intervention or program to meet that need.

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7.0 SUMMARY

CalViva Health, in collaboration with Health Net Community Solutions (HNCS), is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, diverse provider networks, and CalViva Health and HNCS. CalViva Health's goals and objectives are based on providing support, maintaining compliance, and creating cultural awareness through education, consultation, and support. In addition, the programs and services encompass how we communicate to our members and contracted providers about the health equity and C&L program and services available.

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Appendix 1

STAFF RESOURCES AND ACCOUNTABILITY

1. CalViva Health Committees

A. Governing Body/RHA Commission

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

B. QI/UM Committee

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

C. Public Policy Committee (PPC)

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

2. CalViva Health Staff Roles and Responsibilities

A. Chief Medical Officer

CalViva Health's Chief Medical Officer's responsibilities include assuring that CalViva Health's programs are compatible and interface appropriately with the provider network and the overall scope of CalViva Health's QI program. A medical management team is under the direction of the Chief Medical Officer.

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B. Chief Compliance Officer

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

C. Equity Officer

CalViva Health's Equity Officer's responsibilities include assuring that CalViva Health's programs prioritize and address Health Equity where possible and also carrying out the strategic work of Equity throughout the organization. The Equity Officer will provide leadership on equity, diversity, and inclusion issues affecting the organization. The Equity Officer will also work collaboratively with the Chief Medical Officer to achieve the goal of equitable access and to reduce disparities in clinical care and quality outcomes. The Equity Officer will also engage and collaborate with internal and/or external stakeholders to advance Health Equity efforts and initiatives.

3. HNCS Health Equity Department Staff Roles and Responsibilities

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

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A. HNCS Leadership Team

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

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

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A. 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 | Date

Regional Health Authority Commission Chairperson

_________________________________ ____________________________

Patrick Marabella, MD, Chief Medical Officer | Date

Chair, CalViva Health QI/UM Committee

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REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist Sia Xiong-Lopez, MA, Equity Officer
COMMITTEE DATE:	May 21, 2026
SUBJECT:	Health Equity 2026 Work Plan – CalViva Health Executive Summary

Purpose of Activity:

Present CalViva Health's Health Equity Work Plan for 2026, to obtain the committee's approval, and evaluate the progress against services to meet the end of the year goals.

Summary:

The Health Equity Work Plan 2026 supports and maintains excellence in Health Equity and C&L Services through the following strategies: provide oversight of Language Assistance Program (LAP), integration and expansion of targeted health disparity efforts, health literacy and plain language standards, supporting CalViva Health in being a culturally competent Health Plan, expanding on consulting services, and maintaining compliance with regulatory, accreditation, and contractual requirements.

The 2026 Work Plan is consistent with the 2025 Work Plan while incorporating and enhancing the following activities:

1. Removed manual collection of members' preferred alternate format as report are now auto-generated (Row #8).
2. Updated NCQA's new accreditation name to Health Outcomes Accreditation and Community-Focused Care Accreditation Standards (Row #10 and #64).
3. Updated measurable objectives for LAP trend analysis (Row 12).
4. Removed PNA from workplan as the Health Equity Department no longer completes this report nor implement activities but instead provides data for the report (Row #16 and #17).
5. Removed activity from Row #21 as it's been incorporated in other activities (Row #19 and #42).
6. Added role as Health Equity SMEs for other departments (Row #22),
7. Added SOGI data collection and act as supporter for enterprise (Row #23).
8. Removed duplicate activity Row #25, as it's been added to Row #61.
9. Removed Row #37, as it is a duplicate activity from Row #36.
10. Added community support as a new activity (Row #37).
11. Added Cozeva integration as a new topic in findhelp provider training guide (Row #39).
12. Removed Row #50 as activity has been added to Row #48.

13. Consolidated health literacy activities into one row (Row #53).
14. Updated description of provider training activity, moving activities to multiple lines (Row #58, 61, and 62).
15. Expand on provider oversight role with other departments (Row #59).
16. Edited W30-6+ indicators to better reflect PIP submission (Row #69).
17. Moved Row #63, CLAS Month Activity, to Row #77, as the staff responsible has changed from Health Net to CalViva Health.
18. Update project goal for Phase 2 for the IHI/DHCS Child Equity Sprint project (Row #72).
19. Remove activity as staff who used to oversee activity is no longer with the Health Equity Department, activity has been moved to Row #22.
20. Removed activities from Row #77-81 as activities ended in 2025.
21. Added new activities to section for 2026 (Rows #76-79).

Next Steps:

Once approved, implement and adhere to the Health Equity Work Plan 2026, and report to the QI/UM Committee.

2026
Health Equity
Work Plan

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

Mission:

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

Goals:

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

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

Objectives:

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

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

Selection of the Cultural and Linguistics Activities and Projects:

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

Strategies:

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

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

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

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	Language Assistance Program Activities					
1	**Rationale**	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2	**Responsible Staff:**	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3	Audit	Assure Health Equity/C&L audit readiness to support DMHC and DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: review of TAG to identify risk areas, collecting requested documentation, submitting documents to regulator as requested, preparing all supporting documents for on-site visit by regulator, fill out DHCS C&L questionnaire Conduct internal audit to ensure compliance with Medi-Cal and LAP requirements (ensure systems are capturing provider and office language capabilities per SB137)	Vary by year		
4	Contracted Vendors	Conduct language assistance vendor management oversight. Review and update vendor contracts to ensure alignment with requirements; participate in vendor oversight calls; align and submit reports as needed. Ensure risk assessments are completed, annually.	Number of vendor contracts updated or amended; date of JOC meetings; number of risk assessment completed	Ongoing		
5	Data	Collect and conduct analysis of language utilization and demographic data to identify emerging language needs and threshold languages.	Updated LAP utilization report to contain monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log. Production of report showing emerging language need and threshold languages.	Semi-annual		

6	Operational	Document emerging and threshold language for fiscal year and deploy process and timeline for incorporation of languages into member materials. Specifically identify whether new languages meet threshold criteria and write on document that threshold analysis was completed.	Documentation of notification to impacted departments; documented process and timeline for incorporation of emerging and threshold languages	March		
7	Data	Facilitate alignment and collection of demographic data for reports. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly		
8	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing		
9	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials.	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint. Also maintain inventory and organization of public and working files.	June and December		
10	Member Communication	Coordinate, write/review articles for LAP, findhelp, Privacy, and other content as needed to assure Cultural and Linguistic appropriateness and to meet NCQA Health Outcomes Accreditation and Community-Focused Care Accreditation Standards requirements for members' newsletter Annual LAP mailing to survey REAL and SOGI.	The member newsletters are mailed to members once a year.	Annual		
11	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified or recertified annually	Annual		

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12	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis. Report to summarize utilization of LAP services, number of bilingual staff and provide year-over-year trends for the utilization of LAP services.	Reports submitted to committees	Q2 & Q3		
13	Operational	Coordinate Health Net LAP Oversight operational meetings with Centralized Unit and Behavioral Health.	Quarterly meetings and review of metrics, interpreter and translation issues, grievances discussion, billing and invoice changes and system upgrades	Quarterly		
14	Operational	Request interpreter service complaint/exempt grievance logs from call center and conduct trend analysis. Provide complaint information to impacted areas for resolution, e.g., vendor, internal process.	Monitor interpreter service vendors through service complaints.	Biannual (trend)		
15	Operational	Coordinate and facilitate quarterly Health Equity Department/LAP meetings to review requirements and department procedures for language and health literacy services.	Minutes of meetings	Quarterly		
16	Operational	Support Population Health Management (PHM) with Population Analysis Report with demographic and social needs data for presentation.	Data provided to PHM.	Annual, as needed		
17	Access and Availability	Implement activities to meet the 2027-Geo Access action plans	Report on Geo Access action plan activities and metrics	May		
18	Member Experience	Provide consultation and support on reasonable accommodation requests.	Number of reasonable accommodation requests supported	Ongoing		
19	Operational	Develop, update and maintain Health Equity P&Ps including LAP, translation, alternate formats, interpreter services, bilingual assessment, and others.	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual and as needed		

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	20	Operational	Complete Health Equity Geo Access report including cultural analysis to meet NCQA requirements. To be completed every two years.	Data collection and data analysis for Health Equity GeoAccess report.	Q3 2025		
	21	Operational	Attend workgroup meetings and contribute to solutions for improving Access and Availability, produce annual or quarterly (as needed) and annual TAR reports.	Annual TAR report completed and Access and Availability meetings attended	Quarterly/Annually		
*	**22**	Operational	Provide subject matter guidance to other departments on LAP content and review of materials.	Materials reviewed and consultation provided			
*	**23**	Operational	Oversee SOGI data collection tracking; Maintain Member Portal data collection expertise; Contribute to SOGI data collection planning throughout the Enterprise.	Update P&P (CA.CLAS.14) with SOGI collection information, as needed; Track SOGI data by line of business			
^	**24**	Operational	Manage the translation review process and resources.	Number of translation reviews completed annually	Ongoing		
	25	Operational	Lead IT projects related to language assistance services such as standing requests and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories.	Successful implementation of IT projects	Ongoing		
	26	Operational	Participate in CAHPS Action Plan Meeting with Health Equity to identify potential actions to improve member experience.	CAHPS Action Plan Meetings attended, and action plan/activities implemented	Quarterly		
	27	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Monitor strategic partners and specialty plans for compliance with LAP program. Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing		

28	Translation and Alternate Format Management	Vital documents management is inclusive of annual reminders to dept. managers, confirm placement of vital docs info on TAFT master spreadsheet, request annually from departments which vital documents they produce (including adverse benefit determination notices) and request desktop/policy from departments (when appropriate) on vital document process. Use information obtained from business unit to update the vital document spreadsheet and glossary. Oversee implementation and management of TAFT master spreadsheet.	Master spreadsheet of Vital Documents	Ongoing		
29	Compliance and Accreditation	Manage the Health Education material field testing process and resources for the Field Testing Workgroup.	Number of materials field tested completed annually	Ongoing		
30	Compliance and Accreditation	Provide oversight to translation projects and coordinate ad hoc multi department requests and provide overall coordination support between the vendor and internal departments	Number of materials translated	Ongoing		
	Compliance Monitoring					
31	**Rationale**	**Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.**				
32	**Responsible Staff:**	**Primary: P. Lee, A. Said**	**Secondary: I. Diaz**			

	33	Complaints and Grievances	Oversight of complaints received on LAP or C&L services, including monitoring and responding to C&L grievances. Develop and maintain desktop for grievance resolution process. Collect grievance and call center reports. Maintain quarterly contact with the call center to ensure they monitor C&L complaints. Conduct monthly reconciliation meetings with A&G.	Number of grievances, complaints, and interventions.	Quarterly		
	34	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers to gauge the effectiveness of the LAP program	Production of trend analysis report	August		
	35	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December		
^	**36**	Oversight	Participate in CalViva required workgroups and committees. Attend weekly QI/UM meetings. Write and present annual work plan and program description, mid-year work plan evaluation, LAP report, end of year work plan evaluation, and end of year LAP report. Support PNA report and updates. Assist with DHCS and DMHC Cultural and Linguistic Services audits.	Dates documents were submitted and approved by Committee. Number and dates of QI/UM Committee and ACCESS Workgroup meetings attended.	Ongoing		
*	**37**	Liaison to Plan Partner	Attend community events and providers meetings as needed to sustain local relationships and develop partnership with CVH staff.	Document and provide details of meetings and community events, number and dates of meetings.			
	38	Member Support	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings with presentations and/or materials as needed.	Quarterly		
^	**39**	SDoH/Community Resources	Work with Marketing to develop new/rebrand findhelp materials for members and findhelp website, as needed. Update provider training guide to include the latest Cozeva integration.	Rebranding findhelp materials and websites	Ongoing		

40	Operational	Collaborate with community and health plan partners on SDoH and social needs support programs, including biweekly meetings with findhelp.	Attend meetings, conduct presentations and support activities	Biweekly As needed		
41	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal departments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Update training to align with Cozeva integration by creating an online findhelp course for staff and an on-demand recording for providers. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within Findhelp to address social risks within each month.	Ongoing		
42	Collaboration-External	HN collaboration and consultation to external forums such as DHCS HECL workgroup, AHIP health equity workgroup, NCQA expert workgroup on health equity and other SDoH collaborative forums, as needed.	Minutes of meetings that reflect HN consultation and shared learning	Quarterly		
	Communication, Training and Education					
43	**Rationale**	**To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.**				
44	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, N. Buller**			

^ **45**	Training and Support	Train and provide support to A&G on coding and resolution of grievances related to C&L codes; re-align coding per 1557 non-discrimination reporting	Development of scripted responses and/or training for A&G associates regarding grievance responses, coding, when to send to Health Equity	Annually		
46	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations). Update training deck with specific data slides at mid-year and EOY. Update interpreter and translation quick reference guides with any system updates or process changes and collect the reference guides from the call center.	Create and post to share drive: curriculum, power point, list of participants from Call Center and Provider Relations who attended the in-service. Ensure material is shared with attendees and post trainings. Update and collect interpreter and translation quick reference guides with any system updates or process changes	Ongoing		
47	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing		
48	Provider Communication	Provider Update to cover the following required topics: 1. LAP services 2. Race/ethnicity and language diversity of members 3. Culture and health care topic 4. Promote on-line cultural competence/OMH training 5. Health literacy	Provider Updates distributed and fax/email distribution proof from Marketing	Ongoing		
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
49	**Rationale**	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**				
∆ **50**	**Responsible Staff:**	**Primary: A. Kelechian**	**Secondary: A. Said, M. Quan**			
51	English Material Review	Conduct English Material Review (EMR). Include: review content and layout of materials for reading grade level and cultural and linguistic appropriateness.	All EMRs are completed within a 5 business day turnaround as tracked through Workfront. Exception: Content heavy and high-volume requests are completed within 7 business days.	Ongoing		

52	Operational	Review and update Health Literacy materials and toolkit as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials.	Update and post materials on Health Literacy SharePoint	Ongoing		
53	Training	Training and resources for staff on how to use the C&L database and write in plain language. Update online training as needed.	Quarterly training and resources production.	Quarterly		
54	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities completed.	October		
	Cultural Competency Training Program					
55	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**				
56	**Responsible Staff:**	**Primary: A. Said, L. Espinoza**	**Secondary: D. Fang, A. Kelechian**			
57	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) external workgroup. Attend ad hoc/subgroups on training requirements and shared resources (where applicable) per APLs (SB923; DEI)	Minutes of meetings that reflect consultation and shared learning	Ongoing		
58	Provider Training	A. Conduct cultural competency training for contracted providers. B. Trainings to address required cultural competency topics per regulations and contracts. C. Update trainings as warranted. D. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	A. Cultural Competency Core meeting minutes B. Training curricula, training tracker regulations and contracts met, P&P updates C. Updated training curricula D. Relias provider training lists	Annual		

*	**59**	Provider Training Program Oversight	A. Work with provider engagement to publish invites for trainings and as warranted create OnDemand trainings. B. Work with provider communication to implement available computer-based trainings through provider update(s) and/or provider newsletters and medical directors. C. Promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates (to be included in annual provider LAP update).	A. Training invites B. Provider updates, newsletters, and communications C. Provider update, operational manual			
*	**60**	Staff Training Program Oversight	A. Coordinate and conduct cultural competency training series for staff. B. Trainings to address required cultural competency topics per regulations and contracts (APL 24-018 training and SB923 DMHC training). C. Update trainings as warranted. D. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required departments are represented.	Cultural Competency Core meeting minutes A. Training schedule for the year along with attendance # B. Cultural competency/DEI training deck C. Any changes/updates that were made to training D. Attendance for Bridging and DEI trainings from WDL			
*	**61**	Provider Training	Implement *Cultural Humility, Competency, and Equity in Healthcare* (DEI APL 24-016 training) for all LOB providers annually to include downstream sub-contractor and vendor.	Number of attendees/participants and training evaluation			
*	**62**	Provider Training	Implement *Transgender, Gender Diverse, & Intersex Affirming Care & Equity* (TGI/SB923) training to downstream PPG and Vendor STAFF with delegated HN functions that are member facing.	Number of attendees/participants and training evaluation			

63	Provider Training	Implementation of Language Assistance Programs and the Use of Plain Language for Health Literacy training for providers. Topics: Language Assistance Program, health literacy, plain language communication, health literacy/plan language resources	Number of attendees/participants and training evaluation	Q4		
64	Accreditation	Obtain NCQA Health Outcomes Accreditation and Community-Focused Care Accreditation	Procurement of NCQA Health Outcome Accreditation and Community-Focused Care Accreditation (renewal) and lead collection and preparation of materials during non-renewal years	Ongoing		
65	Report	Complete reports for NCQA Health Equity Accreditation and HEA Plus. Reports include Defining the Community, Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis.	Timely completion of reports. Submitted to NCQA HEA Plus.	Q1		
	Health Equity					
66	**Rationale**	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				
67	**Responsible Staff:**	**Primary: P. Lee**	**Secondary: N. Chand**			
68	Operational	Lead quarterly Health Equity Collaborative Workgroup. Workgroup aligns QI, population health, SDoH, cultural competency and disparity initiatives across departments. It is inclusive of reporting out and supporting disparity reduction projects, Health Equity updates and reporting to support NCQA and other regulatory requirements.	Facilitate at a minimum quarterly meetings, take minutes and attendance and share out workgroup presentation decks.	Quarterly		

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69	Operational	Implement disparity model for PIP projects (W30-6+) include formative research, community, member and provider interventions. Partner with Fresno Black Infant Health to improve compliance rate among Black infants 0-30 months. By 8/31/2026, use targeted interventions for CalViva Health Black or African American members in Fresno County that lead to statistically significant improvement: 1. To the percentage of at least six infant well care visits by 15 months of life from a baseline rate. 2. To the percentage of three or more infant well care visits within 120 days of life from a baseline rate.	Development of modules; Support with barrier analysis and interventions to help meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing		
70	Operational	Provide support for SUD/MH non-clinical PIP project. Partner with hospitals to ensure timely notification for providers. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage of provider notifications for members with SUD/MH diagnoses following or within 7 days of an emergency department visit in Fresno and Madera Counties.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Support with barrier analysis and interventions such as cultural competency training. Attend bi-weekly meetings.	Ongoing		

71	Operational	Provide support for Madera Lean FUA/FUM QMIP project. Partner with local hospitals to improve rates among members' follow up care after 30 days of an emergency visit. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage (from MY2023 9.84% to 24.51% for FUA and 40.59% for FUM) of members who receive follow up services after an ED Visit for SUD/MH diagnoses following or within 7 days of an emergency department visit for Madera County members.	Support with barrier analysis and interventions such as cultural competency training. Development of modules; meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing		
72	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project to improve W30-6+ rates. By September 2026, we will increase the W30-6+ WCV rate for non-Spanish-speaking children aged 0–15 months at CSV-Elm Clinics (2) & CSV-RMC Clinic in Fresno County from 61% to 78% and the W30-2+ WCV rate for non-Spanish-speaking 15–30 months from 71% to 88%, in alignment with the overall collaborative goal.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Attend internal meetings and IHI/DHCS learner monthly calls.	Ongoing		
73	Report	Conduct annual disparities analysis for each county.	Conduct disparities analysis for NCQA and DHCS measures by REL and share with internal stakeholders.	Q4		
74	Reprt	Complete Disparity Project Report. Report is inclusive of disparity reduction projects annual write ups. Report is completed annually or bi-annually.	Report for NCQA including annual disparity gap analysis and prioritized opportunities for intervention. Disparity reduction project write-ups demonstrating implementation of member, community and provider level initiatives and evaluation.	Q3		
75	**Responsible Staff:**	**Primary: S. Xiong-Lopez**	**Secondary: J. Nkansah**			

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	#	Category	Activity	Measure	Timeframe		
*	**76**	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles/webinars that educate staff on culture, linguistics, and the needs of special populations	Attendance record and tracking. Event summary and activity specific participation totals	Annually		
*	**77**	HEQ Project/ Activity	Partner with Kings County Department of Public Health to advance Community Health Improvement Plan (CHIP) priorities within the Access to Care, Maternal and Child Health, and Community Health Worker (CHW) workgroups by implementing community-driven, culturally responsive interventions that improve preventive care access and outcomes.	Measure success through consistent monthly participation in CHIP workgroup meetings to identify and advance collaborative opportunities, increased engagement of priority populations, and demonstrated improvements in access and maternal and child health outcomes.	Ongoing		
*	**78**	HEQ Project/ Activity	Participate in FCHIP to support development and administration of a provider-facing survey to identify system-level health gaps in developmental services and convene a Community Advisory Council by Q3 to elevate community voice and inform improvement strategies.	By Q2, develop a Needs Survey for providers and/or their member participants to assist in identifying health or service gaps.	Ongoing		
*	**79**	HEQ Project/ Activity	Co-lead the Diabetes and Heart Health workgroup within the Madera County Department of Public Health Live Well Madera initiative to design and implement community-driven strategies that improve prevention, early detection, and management of chronic conditions among priority populations.	Consistent monthly participation, active co-leadership of workgroup initiatives and activities that result in direct community impact and demonstrated increases in engagement and access to diabetes and cardiovascular health services.	Q3		

[1] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^ **Indicates revision.**

* **Indicates new.**

Fresno-Kings-Madera Regional Health Authority Commission Approval

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

________________________________ ______________________________

David Hodge, MD
Regional Health Authority Commission Chairperson

Date

________________________________ ______________________________

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

Date

Item #12

Attachment 12.A

Population Health

- 2026 Population Health Management Program Strategy Description & Change Summary

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Tarjani Padmani, Manager, Clinical Pharmacy Services

COMMITTEE DATE: May 21, 2026

SUBJECT: PHM Strategy Description Change Summary

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated year from 2025 to 2026.
Throughout	Multiple	Made spelling, grammatical and punctuational changes.
Throughout	Multiple	Updated tenses from past to present tense.
Throughout	Multiple	Updated footer to reflect updated revision date.
1	Table of Contents	Updated Table of Contents to reflect updated page numbers and sections.
2	Population Needs Assessment (PNA)	Added reference to rename of Population Needs Assessment to “Local Planning”.
3	Population Needs Assessment (PNA)	Added Local Planning requirements including participation in each LHJ’s Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process and data sharing.
4	Stakeholder Engagement	Removed requirement for PNA report to be available on health plan’s website.
4, 5	Population Stratification	Updated definition of Population Stratification and PHM Risk Stratification, Segmentation and Tiering (RSST) methodology.
5	Population Stratification	Added Housing data and relevant information to PHM model.
5,6	Population Stratification	Added Medi-Cal Connect and relevant information to PHM model.
7	Population Stratification	Changed “SdoH Mini screen” to “SdoH screening”.
7	Population Stratification	Added Adverse Childhood Experiences (ACEs) screening to ways in which SdoH needs are identified.
7	Population Stratification	Added description of Micro Strategy.
10	Population Stratification	Updated ImpactPro Population Health Categories to reflect current categories.
13	Basic Population Health Management (BPHM)	Added information on First Year of Life program.
13	Basic Population Health Management (BPHM)	Added statement on Care Management availability to members at any time and any age to support with physical health, behavioral health, or SDoH needs.
14	Transitional Care Services	Changed “Conducting an initial outreach call within 72 hours of inpatient referral to complete an inpatient discharge risk assessment” to “Care Manager is responsible for successfully connecting with the member within 7 days of discharge to complete an inpatient discharge risk assessment”.
14	Transitional Care Services	Removed “A minimum of 2 follow up calls are made to the Member within 15 days of discharge”.
15, 16	PHM Programs and Services: Improve	Updated eligibility criteria to Members 6 months to 64 years old.

	Preventative Health: Flu Vaccinations	
15	PHM Programs and Services: Improve Preventative Health: Breast Cancer Screening	Fixed eligibility criteria to 40-74 years.
15	PHM Programs and Services: Improve Behavioral Health: Depression Screening and Follow up Care	Added program and eligibility criteria.
15	PHM Programs and Services: Improve Behavioral Health: Follow-Up Care after Substance Use Disorder Emergency Department Visits	Added program and eligibility criteria.
15, 21	PHM Programs and Services: CalViva Pregnancy Program	Updated eligibility criteria to Pregnant Members at risk for adverse material and neonatal outcomes using the new Pregnancy Prioritization logic.
15, 25	PHM Programs and Services: Care Management	Fixed eligibility criteria to include clinical analytics population health group 8b.
16	PHM Programs and Services: Teladoc Mental Health (Digital Program)	Updated program name and eligibility criteria information to reflect correct verbiage.
16	PHM Programs and Services: Disease Management/Health Coaching- Be In Charge!	Added program and eligibility criteria.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Updated Program goal to Medicaid 50% Minimum Performance level (MPL) for Childhood Immunization Status (CIS-10)- Influenza and 25% Minimum Performance level (MPH) for Adult Immunization Status (AIS-E)- Influenza measures.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Added program services and updated verbiage. Added: Fluvention Texts, Me+U Member Immunization Outreach, Pfizer Immunization IVR messaging, Well-Child Visits in the First 15 Months of Life (W30-15) POM-short automated messaging, and Childhood Immunization Status (CIS)-10 POM- short automated messaging.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Added supplemental data from the California Immunization Registry (CAIR) to methods and data sources used to identify the eligible population.
17	PHM Programs and Services Focus Areas: Tobacco Cessation	Updated Program goal to increase the number of eligible members successfully contacted and offered tobacco cessation support by 5% annually.
18	PHM Programs and Services Focus Areas: Tobacco Cessation	Updated Relevance information to reflect current state.
18	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Updated goal to meet directional improvement from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: Breast Cancer Screening (BCS-E): MPL is 55.87%.

19	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Added high-risk breast cancer screening e-project to Providers for appropriate member outreach, scheduling, and follow-up to program services.
19	PHM Programs and Services Focus Areas: Diabetes Management Program	Removed value of directional improvement of 1-5% from program goal.
19	PHM Programs and Services Focus Areas: Diabetes Management Program	Updated detail of Program goal to explain that a lower rate indicates better performance for GSD.
19	PHM Programs and Services Focus Areas: Diabetes Management Program	Added share root cause analysis (RCA) hBA1c data with providers to identify factors contributing to non-compliance, including uncontrolled cases, missing data, or lack of service evidence to program services.
20	PHM Programs and Services Focus Areas: Diabetes Management Program	Updated Relevance information to reflect current state.
21	PHM Programs and Services Focus Areas: CalViva Pregnancy Program (CPP)/High-Risk Obstetrics (OB) CM	Updated Program services to include Trimester Based Assessment, Edinburgh Postnatal Depression Scale and Patient Health Questionnaire-9, Education Materials via website or mailers, and Text & Email program
22	PHM Programs and Services Focus Areas: Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Added phobia, anxiety and additional self-harm diagnoses to the denominator in the event/diagnoses.
22	PHM Programs and Services Focus Areas: Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Added "including real-time ADT reports" to methods and data sources used to identify the eligible population.
22, 23	PHM Programs and Services Focus Areas: Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Updated Relevance information to reflect current state.
23	PHM Programs and Services Focus Areas: Improve Behavioral Health: Depression Screening and Follow up Care	Added section with all relevant information.
23, 24	PHM Programs and Services Focus Areas: Improve	Added section with all relevant information.

	Behavioral Health: Follow-Up Care after Substance Use Disorder Emergency Department Visits	
25	PHM Programs and Services Focus Areas: Care Management	Added Enhanced Care Management (ECM) to supplemental support for Members
28	External Partnerships	Within Local Health Departments, removed COVID-19 information and added community-based vaccination events.
30	Data and information sharing with practitioners	As bidirectional data exchanges with three counties focused on sharing Behavioral Health data through the Behavioral Health Quality Improvement Program (BHQIP) ended, added information on developing new partnerships and data exchange options to facilitate this type of bidirectional data exchange and options for bidirectional data exchange with 25-30 organizations across California through the MOU process.
32	Ability to view evidence-based practice guidelines on demand	Removed Centene Corporate Clinical Policy Committee (CPC) and added CalViva QIUM Committee and Medical Advisory Committee (MAC).
36 to 61	Appendix C	Updated ImpactPro Population Health Categories to reflect current categories and updated all relevant information.

Population Health Management Strategy Program Description

HEALTH NET – CALVIVA HEALTH

2026

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Introduction

The CalViva Health robust population health framework leverages community partnerships, clinical programming, and data analytics to strategically deploy resources to enhance the Member and provider experience, improve whole-person care, mitigate social determinants of health (SDoH), and match Members with clinical programs designed to serve their unique clinical, cultural, social, functional, and behavioral health needs.

This document describes the strategy for managing the health of the CalViva Health enrolled population. It provides an overview of how the needs of the population are identified and stratified for intervention, summarizes the population health management (PHM) programs used to address the needs of the population across the entire health and wellness continuum, and explains enabling strategies used to promote the transition to value-based care in its contracted network. We contract with providers to conduct assessments and integrate the results with care and care management processes.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for population health 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.

Population Needs Assessment (PNA) (Local Planning)

In 2026, the Population Needs Assessment (PNA) has been formally renamed and reframed as "Local Planning". "Local Planning" aligns MCP responsibilities with Behavioral Health Services Act (BHSA) reforms and Community reinvestment and stakeholder engagement requirements.

We evaluate the needs of the enrolled population and use that information to assess whether current programs need modification to better address the needs of our Membership. We examine data to evaluate the needs of Member subpopulations, including:

- Evaluation of the characteristics and needs of the Member population, including an analysis of the impact of relevant SDoH:
  - We assess the SDoH impacting our Membership through a geographic analysis using external data sources
  - We use an external SDoH tool, The California Healthy Places Index to create a custom selection using counties where we have Members.
  - We use the Healthy Places Index to determine regional SDoH performance on the following categories:
    - Economics
    - Education
    - Transportation
    - Social
    - Neighborhood
    - Clean Environment
    - Housing
    - Healthcare Access

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- Evaluation of health status and risks by using utilization data broken out into cohorts based on NCQA and DHCS age-based stratification guidance.
- Evaluation of the needs of Members with disabilities:
  - Annually, a cohort of Members with disabilities are identified and assessed for needs to determine the appropriateness and adequacy of available clinical programs. A disabled Member is defined as needing assistance with Activities of Daily Living (ADL).
  - Identification criteria example: Members with one or more of the following: 1) Power Wheelchair 2) Home Hospital Bed 3) Hoyer Lift 4) In Home Supportive Services.
  - Analysis of this cohort consists of diagnostic categories and utilization trends for acute inpatient admits, readmits, and emergency department utilization.
- Evaluation of the needs of Member with Severe and Persistent Mental Illness:
  - Annually, a cohort of Members with severe and persistent mental illness are identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. Severe and persistent mental illnesses are defined as diagnosis such as schizophrenia, psychosis, and bipolar disorder.
  - Identification criteria example: Members prescribed one or more of the medications on the Health Effectiveness Data and Information Set (HEDIS) schizophrenia, schizoaffective disorder (SSD) National Drug Code (NDC) list (See attachment in "Appendix A").
  - Analysis of this cohort consists of diagnostic categories and rates of acute inpatient readmits, emergency department utilization, and those receiving at least 2 outpatient medication management visits in 12 months.

As required by Local Planning requirements, the Plan continues to meaningfully participate in each LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process for every service area where Plan operates. The Plan shares relevant data with LHJs to support local planning activities.

PNA Activities

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources to meet the unique needs of our population and offer timely services and supports. 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.

Stakeholder Engagement

Public Policy Committee (PPC) participants help serve as advisors to PNA development, and implementation of the PNA action plans. CalViva will continue to employ multiple approaches to inform contracted providers of PNA highlights and recommendations. Communication channels may include:

• Provider Updates: Provider Updates extend immediate information to the provider network, which include Physicians, Participating Physician Groups, Hospitals, and Ancillary Providers. Provider Updates are also available online through the provider portal.

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• Provider On-Site Outreach: The Provider Engagement team conducts site visits regularly, allowing opportunities to discuss with providers PNA findings and recommendations.

• Community Provider Lunch and Learns: Lunch and Learn sessions bring together multiple providers in a community setting, planned regularly throughout the year. Hosted by Provider Engagement, these events provide important health plan program updates and information to support providers in better servicing their patients. PNA findings will be shared with those in attendance. Provider feedback about the PNA and/or proposed action plans will be considered for further enhancement.

- Public Policy Committee (PPC): CalViva Health maintains a Public Policy Committee as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care, and to establish and maintain community linkages. The Public Policy Committee meets four times a year. The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care. The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in the Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs, and Quality Improvement Projects. The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers. We incorporate county or region-specific Population Needs Assessment per PHM Policy Guide to build community partnerships and improve Member participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as social drivers of health.

Deleted: • Available Online: For easy access to our members and community stakeholders, the PNA report will be available on the health plan's website.¶

Population Stratification

Population stratification is a foundational component of Population Health Management (PHM), supporting clinical decision-making at the point of care, resource allocation, and healthcare management efforts aimed at improving patient outcomes. The PHM Risk Stratification, Segmentation, and Tiering (RSST) methodology incorporates clinical and sociodemographic variables, measures of healthcare utilization, and quantitative bias testing (e.g., Delta methodology) to promote equitable and data-driven risk identification. Data sources, clinical criteria, and stratification tiers are reviewed on a routine basis to ensure ongoing alignment with organizational goals and regulatory standards. This review process incorporates feedback from medical directors, provider engagement teams, and member engagement teams, enabling continuous quality improvement across departments. In addition to its internal PHM framework, CalViva has adopted the Risk Stratification, Segmentation, and Tiering (RSST) algorithm developed by the California Department of Health Care Services (DHCS) and deployed through Medi-Cal Connect. This statewide methodology provides a consistent and equitable approach to identifying risk among Medi-Cal members across California. The RSST model is specifically designed to enhance equity by identifying not only high-risk individuals but also members who may be underutilizing necessary healthcare and social services—an indicator of unmet or hidden needs. This dual focus on clinical risk and service underutilization supports proactive outreach and targeted interventions to close gaps in care. The data elements and standards used within the RSST framework are compliant with National Committee for Quality Assurance (NCQA) PHM standards. PHM data integration is supported through enhancements to the organization's Management Information System (MIS), ensuring

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alignment with Centers for Medicare & Medicaid Services (CMS) requirements and applicable data exchange standards.

The RSST approach and Health Equity Improvement Model (HEIM) is designed to avoid and reduce biases to prevent the exacerbation of health disparities and address inequities in a variety of ways, including urban versus rural; race, ethnicity, and language; and the unhoused and special needs population. We combine data from multiple sources and multiple data points (like race, ethnicity, primary language, disability data, social risk information, social determinants of health, comorbidities, and mental health issues) for RSST of the population and obtain a 360 view of population needs and strengths. Our bias tested PHM model considers:

- **Screening or assessment data**
  - Screenings and assessments data is captured by our Health Information Form and additional screening conducted by the Plan including SDoH survey, CalViva Pregnancy Program (perinatal/postpartum program including maternal risk: history, age, or SUD) screening data etc. The inputs from the form are incorporated into member level data to assign members based on RSST model as well as at an aggregate population health level data set.
- **Claims and Encounter data, including Fee-For-Service data**
  - Claims and encounter data, including Fee-For-Service data is captured by various sources of data and based on member's utilization pattern (High Utilizer, Prospective High Utilizer) members are assigned into appropriate category and that flows into our RSST model.
- **Available social needs data**
  - CalFresh, WIC, CalWORKs, In Home Services, Z-Codes and Supports (IHSS), Safety risk factors (e.g., available caregiver support and environment) are captured from various sources of data and incorporated into our RSST model.
- **Housing data**
  - Data from Housing Transition Navigation Services and U.S. Department of Housing and Urban Development (HUD) sources are utilized to identify members who are experiencing homelessness or are at risk of homelessness.
- **Electronic health records**
  - Electronic Health Record (EHR) data is captured by EHR integration as well as other data feeds and using that information members are assigned to appropriate category; this data feeds into and informs our RSST model.
- **Medi-Cal Connect**
  - Data from Medi-Cal Connect including Risk Stratification, Segmentation, and Tiering (RSST)) to better identify members who are at risk of poor health outcomes or not engaging in needed care. This algorithm is part of a broader Population Health Management (PHM) strategy aimed at improving equity, care coordination, and outcomes across the state.

- **Referral data**
  - Referral data is captured by Find Help/Community Connect, customer contact center data, provider portal, authorization data, and other sources. Referral data is being used for identifying individuals who are at higher risk for adverse health outcomes or high healthcare costs. Using referral data, the model identifies members who have been referred to specialists or specialty services for high-risk conditions such as cancer, heart disease, or chronic illnesses. Subsequently, based

Deleted: Population stratification is performed to support clinical decision making both at the point of care, as part of resource allocation and healthcare management to improve patient outcomes. PMH risk stratification segmentation and tiering (RSST) algorithms include clinical and sociodemographic variables, bias testing using Delta (quantitative method), and measures of healthcare utilization. Data sources, clinical criteria, and stratification tiers are reviewed periodically to ensure the PHM approach incorporates feedback from different departments including medical directors, provider and member engagement teams which allows for continuous improvement. Data elements and standards used in RSST are compliant with NCQA PHM standards.¶

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on frequency and intensity of healthcare services need, the members are assigned to certain category including members who require more coordinated and managed care of PHM model. Referral data combined with other member data, such as demographics, claims history, and clinical data is being used for risk stratification.

- **Behavioral Health data (including SBIRT and other SUD data)**
  - Behavioral Health data is captured by data exchange agreement to establish secure data exchange with all contracted counties to obtain Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health Services (SMHS) data available through the Short-Doyle/Medi-Cal claims system by use of HIE, secure file transfer protocol (SFTP), or other means to then be incorporated into RSST. We are also capturing Behavioral Claims from our Behavioral Health administrator to capture mental health needs of our members and assigning members to a PHM category based on their need.
- **Pharmacy data**
  - Pharmacy data is captured via data feed from Magellan/Okta portal. Pharmacy data helps to determine a member's adherence to prescribed medications. Poor medication adherence is associated with adverse health outcomes. Using pharmacy data, we identify individuals who are non-adherent to their medications, which may indicate a higher risk for future health complications or hospitalizations and this information is being used for the RSST model. In addition to medication adherence data, pharmacy data is also being used to identify members with chronic diseases who are prescribed specific medications for disease management. By analyzing medication usage patterns, we are identifying individuals with suboptimal disease control, escalating medication needs, or frequent medication changes. These members may require additional support and care management to optimize their disease management and reduce the risk of complications. This information is also being used in the RSST model.
- **Utilization data**
  - Utilization data is captured via claims and encounters data. Utilization data helps to identify individuals with frequent or intensive healthcare service utilization. This includes emergency department visits, hospital admissions, and outpatient utilization. Members with high utilization patterns are often at a higher risk of future healthcare utilization or adverse health events. Utilization data provides us insights into the level of care coordination and management required for individuals.

    Utilization data highlight the extent to which individuals engage in preventive services such as vaccinations, screenings, or wellness visits. Low utilization of preventive services may indicate an increased risk of undiagnosed or unmanaged health conditions. Targeting interventions towards individuals with low preventive service utilization helps us identify and address potential health risks earlier. Utilization data helps to identify individuals who utilize high-cost healthcare services, such as expensive procedures, specialty medications, or complex surgeries. Individuals with high-cost service utilization are more likely to have higher healthcare costs and may require targeted interventions to manage costs and improve outcomes.
- **Disengaged Member reports (e.g., assigned Members who have not utilized any services)**

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    - Disengaged member reports are captured via our zero encounters (zero encounter / no office visit / no utilization members) report. The monthly Zero Encounter enables the Plan to reconnect members to care, tracking disengagement with PCP.
- **Lab results data**
    - Lab results data is captured via EMR integration, quality data, among other sources.
- **Admissions, Discharge and Transfer (ADT) data**
    - ADT data is captured via HIE connections with various facilities and providers.
- **Race/ethnicity data**
    - Race/ethnicity data including disparity data is captured from various sources of data including but not limited to member enrollment data, customer contact center data.
- **Sexual orientation and gender identity (SOGI) data**
    - SOGI data is collected from our customer contact center data and we are in the process of identifying sources for collection of SOGI data.
- **Oral health data:**
    - We receive a data feed from DHCS that includes dental claims.

Our algorithms include bias testing and stratify our entire membership into a Risk Tier (low, medium, and high) and CM level (Level-1 to Level-5) to assign appropriate resources, interventions, and programs. To identify SDoH need, we have used:

- ICD 10 Z-Code from Claim,
- Encounter data,
- Admission discharge and transfer (ADT) data;
- TruCare Assessment including health risk assessment (HRA),
- SdoH screening;
- Adverse Childhood Experiences (ACEs) screening
- Other data feed including State eligibility data, (San Diego (SD)211 etc.)

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The SdoH report allows to drill down into the SdoH needs of selected geographies and/or subsets of membership.

In addition to Risk Tier and level, PHM also include information from Impact Pro, a predictive modeling tool that uses multiple data sources that are stored in the data warehouses (EDW and ODW or Snowflake). In addition to Impact Pro, a web-based customizable report generating system, Micro Strategy® (data analytics and business intelligence platform which is being used to analyze large data sets, build dashboards and reports, and make data-driven decisions), is used to produce adjunctive analytical reports that support tracking of goals of clinical programs. 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 utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information.

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Additionally, we use our system, Impact Pro, to segment and risk stratify the entire enrolled population into meaningful subsets for targeted interventions. These subsets, or levels, are listed below with detailed descriptions in the appendix. This system is used on a regular basis (weekly or monthly) to identify, enroll, track and coordinate eligible Members for clinical programs. Information about the process used is defined in the description of specific programs in the sections which follow.

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We conduct continuous improvement evaluation and the incorporation of inputs that explicitly aim to reduce bias or existing disparities that may exist in basic cost or utilization data (e.g., care gaps, ambulatory care sensitive conditions, underutilization of primary care). We have found and rectified biases in utilization data, for example: prioritization based solely on high utilization, access to care by zip code, or homeless members with no utilization.

Upon enrollment, the Health Information Form (HIF)/Member Evaluation Tool (MET) is completed within 90 days of enrolling new members. Enrolled populations are further broken out into Population Health Analytic Groups designed to segment the entire population into mutually exclusive categories based on their utilization pattern (institutional, pharmacy, behavioral health), acute events, co-morbidity, risk scores and any clinical indications use the Member's most recent 12 months of claims and pharmacy history and care gap information. With each monthly refresh of the Population Health Analytic Grouping, each Member is reassessed based on the most up-to-date utilization information and may be re-classified to a new grouping. 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.

We will provide DHCS, upon request, our processes to identify significant changes in member's health status and appropriate re-stratification via this Strategy Description.

We monitor the penetration rate of PHM Programs and Services by Tier including the number of members by risk tier who need further assessment and received it, and who were enrolled in eligible programs.

We define a significant change in health status and/or a change in a member's level of care monthly. Each Member is re-assessed based on the most up-to-date utilization information and therefore may be re-classified to a new grouping. We also deploy industry leading SdoH data analytics to inform our PNA and PHM interventions. The PNA will be similar to previous years and will include information spanning the needs of our entire Member population.

The goals of PHM are to improve health conditions of current patients, understand patient needs that might have been overlooked, design better health services, make better use of resources, prevent diseases and predict future health issues. To achieve the goal and effect on outcomes, we monitor PHM performance using a Key Performance Indicators (KPI) report. The KPI includes:

- Admit/K,
- Emergency room (ER)/K,
- Readmission %,
- Ambulatory Care Sensitive Admissions (ACSA) %,
- Average Length of Stay (ALOS),
- Days/K,
- Avoidable ER%,
- Per member per month (PMPM) Cost,
- PMPM Cost by Service Category, and
- Pharmacy (Rx) Utilization
- DHCS PHM Monitoring Plan KPI requirements

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Along with that we also use SdoH dashboard to track and trend Member SdoH needs and we align our health equity goals with DHCS' Health Equity Framework within the Comprehensive Quality Strategy (CQS) Report, and stratify DHCS selected MCAS measures by demographics.

We use these reports to set benchmarks, identify outliers and high performing Providers, address performance issues, share best practices, and invest in additional capacity.

- Members are assessed/re-assessed who are/have:
  - Seniors and Persons with Disabilities (SPD)
  - Receiving: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) Services
  - LTSS needs
  - Entering Enhanced Care Management (ECM), Complex Care Management (CCM)
  - Children with Special Health Care Needs (CSHCN)
  - Residing in acute hospital
  - Hospitalized w/in 90 days or 3 + hospitalizations in last year
  - 3 + ER visits in last year w/ high utilization of services (e.g., multiple Rx for chronic diseases)
  - BEH dx or developmental disability and > 1 chronic medical diagnoses or social need (e.g., homelessness)
  - Multiple Outpatient Surgeries
  - Readmission risk
  - Preventable Admit
  - Avoidable Emergency Use
  - Multiple prevalence conditions including end stage renal disease (ESRD), acquired immunodeficiency syndrome (AIDS), or recent organ transplant, Cancer, Asthma, Diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), serious and persistent mental illness (SPMI), serious emotional disturbance (SED), Opioid use etc.,
  - Pregnancy state
  - On antipsychotic medication
  - On 15 or more prescriptions in the past 90 days
  - Self-report of a deteriorating condition
  - Other conditions as determined based on local resources.

- We work with network providers for shared decision making with the members about the services a member needs, including through use of real-time information.

Once the statewide RSST and risk tiers are available through the PHM Service, at a minimum Members who are identified as high-risk through the PHM Service will be assessed.

ImpactPro Population Health Categories* consist of the following:
  - o 01: Pop Health Cat: Healthy
  - o 02a: Pop Health Cat: Acute Episodic - Minor
  - o 02b: Pop Health Cat: Acute Episodic – Major
  - o 03: Pop Health Cat: Healthy - At Risk
  - o 04a: Pop Health Cat: Chronic Big 5 – Stable
  - o 04b: Pop Health Cat: Other Major Chronic – Stable
  - o 04c: Pop Health Cat: Other Minor Chronic – Stable
  - o 04d: Pop Health Cat: Behavioral Health Only - Stable

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- o 05a: Pop Health Cat: Chronic Big 5 - At Risk
- o 05b: Pop Health Cat: Other Major Chronic - At Risk
- o 05c: Pop Health Cat: Other Minor Chronic - At Risk
- o 05d: Pop Health Cat: Behavioral Health Only - At Risk
- o 06: Pop Health Cat: High Risk
- o 07a: Pop Health Cat: Rare High Cost Condition - Stable
- o 07b: Pop Health Cat: Rare High Cost Condition - At Risk
- o 08a: Pop Health Cat: Complex – Dialysis
- o 08b: Pop Health Cat: Complex – Cancer
- o 08c: Pop Health Cat: Complex – Transplant
- o 09a: Pop Health Cat: Dementia
- o 09b: Pop Health Cat: Institutional Custodial Care
- o 10: Pop Health Cat: End of Life

* Definition of each category appears in "Appendix C".

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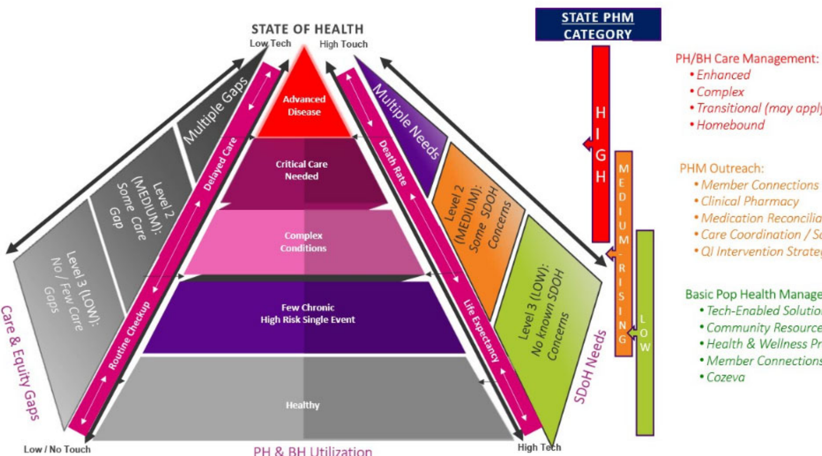
02: Acute Episodic¶
03: Healthy, At-Risk Level and ¶
04A: Chronic Big 5 Stable¶
04B: Chronic Other Condition Stable¶
04C: BH Primary Stable¶
05A: Health Coaching¶
05B: Physical Health CM¶
05C: Behavioral Health CM¶
06: Rare High-Cost Condition¶
07A: Catastrophic: Dialysis¶
07B: Catastrophic: Active Cancer¶
07C: Catastrophic: Transplant¶
08A: Dementia ¶
08B: Institutional (custodial care)¶
09A: LTSS and Medicare-Medicaid Plan (MMP) – Service Coordination¶
09B: LTSS and MMP – High Needs Care Management ¶
10: End of Life¶



A description of subsets and the type of intervention offered to Members is described in the PHM Programs and Services portion of this document below.

PHM Programs and Services Overview

Basic Population Health Management (BPHM)

Health equity is a guiding principle. Population Health Management (PHM) is the framework to achieve health and wellness for all, free from barriers, using the Health Equity (HE) Improvement Model to identify and design community-anchored interventions. We offer BPHM services that promote health

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equity and aligns with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A multi-pronged, non-delegated, empanelment approach is used for BPHM which directly facilitates 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 PCP).

A proactive outreach to Members without a PCP visit in the past year is used 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 MemberConnections® Field Team for 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). Native American Members can select an Indian Health Services (IHS) Provider within the 'network as their PCP. SPD Members may select a Specialist or Clinic as a PCP if they are qualified. PCPs are notified of Member assignments within 10-days from selection/assignment by file sharing and provider web portal.

We use KPIs (e.g., encounters, Member engagement, HEDIS care gaps) and stratifications to address disparities in PCP engagement including identifying Members with open HEDIS care gaps for targeted outreach campaigns. Our Modeling Engagement project predicts levels of Member engagement, stratifies Members into 4-categories of likeliness-to-engage based on engagement history and tracks both PCP and Member engagement. This project informs the 'outreach approach, including monthly Care Gap reports distributed to provider, which helps prioritize and adapt outreach. The monthly Zero Encounter enables us to reconnect Members to care, tracking disengagement with PCP. We also stratify data to identify health disparities and are excited to leverage community health workers and doulas to ensure outreach is targeted with a focus on advancing health equity, and that post-partum Members are supported for their newborn pediatrician visits into the first year of life.

On a monthly basis, we review disengaged Member reports to proactively identify Members who have not established care with their PCP in the last 12 months. Then, we match Members to the level of support needed leveraging our Population Health telephone outreach teams to connect Members to PCP, or MemberConnections Field Team (our field-based team that performs proactive home visits), assigning continuous support, reporting disengaged Member who have not received their IHA to providers, and introducing Member engagement strategies such as Cozeva, quality improvement projects, and discussions during Joint Operations Meetings (JOM). Support is available over the phone, through self-service tools, and in the field, leveraging Member Services, Care Management, Community Engagement, and Health Education staff.

Key aspects of member navigation support include:

- Establishing a relationship with a usual source of care through their PCP that meets Member's geographic, clinical, and cultural needs.
- Ensuring PCPs have successfully engaged Members in ongoing care and are familiar with the holistic needs of the Member, through systematic monitoring of the initial health appointment, ambulatory or preventive visits every 12 months, vaccinations and immunizations (e.g., COVID-19, Flu, Pneumococcal), care gaps, and sharing insights with PCPs. Our provider engagement teams, who

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perform onsite and virtual meetings with providers, regularly encourage providers to leverage engagement strategies, provide them disengaged Member lists with contact information, engage ability scores, and provide routine progress on how well engaged their Member are with required care. Providers can request funding to address specific barriers to engaging Members.
  - As part of the implementation of the Community Health Worker (CHW) benefit, providers are encouraged to leverage new ways to support Members who have significant clinical needs, health equity or SDoH barriers, or are lost to follow up
  - Members and their family are supported with community resources and carved-out services
- The Quality Improvement Team supports systematic evaluations to assess why Members are not engaged with their PCP or other healthcare needs and provide findings to the engagement team and providers for intervention. Providers are not delegated responsibilities, however, are provided with incentive and support tools to engage and outreach to Members.
- We use a quality and health equity framework to ensure all Members under age 21 receive all screening, preventive and medically necessary diagnostic treatment services and immunizations required by early periodic screening, diagnosis and treatment (EPSDT), American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and the ACIP Childhood Immunization Schedule. Our strategy includes 1) service tracking and early identification, 2) connecting to services, and 3) meaningful innovation to continuously improve outcomes with a focus on the life course perspective. To achieve this, we:
  - Invest in preventive programs, coordinate/collaborate with Local Health Departments (LHDs), Local Government Agencies (LGAs), and local organizations to address SDoH and identified health disparities.
  - Support Members with culturally relevant health education, Member incentives; reminder outreach programs; and community engagement to promote prevention, screening, remove SDoH barriers.
  - Activate our plan CHW model to work with families with historical gaps in screenings to proactively outreach and remove barriers.
  - Prioritize partnerships with Providers to support our effective EPSDT program. Our pediatric Providers receive training and support tools to help identify care gaps timely and are audited for adherence to medical record requirements including EPSDT services. We incentivize providers for quality care and provision of preventive services, including EPSDT.
  - Track and report EPSDT screenings, AAP Bright Futures and ACIP Childhood Immunization periodicity adherence and monitor follow-up service needs. Tracking and stratification are at the population, community, subpopulation, and individual Member level. KPIs include annual and monthly HEDIS metrics (e.g., W30 (Well-Child Visits in the First 30 Months of Life), WCV (Child and Adolescent Well-Care Visits), CIS (Childhood Immunization Status), IMA (Immunizations for Adolescents), AAP (Adults' Access to Preventive/Ambulatory Health Services), IHA). Additional claims/encounters codes are evaluated for specific assessments and screenings (e.g., Oral Evaluation, Dental Services (OED), topical fluoride for children (TFC)).
  - Offer First Year of Life program to all members under age 12 months, with goal to help ensure families are able to schedule timely Well Child Visits, complete immunizations, and provide education and support to reduce avoidable emergency room utilization.
  - Care Management available to members at any time and any age to support with physical health, behavioral health, or SDoH needs.

We monitor utilization patterns including preventive services, ER/admissions, PCP visits, ambulatory/preventative visits, and the use of behavioral health services, as well as condition/situation

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specific outcomes by race/ethnicity to evaluate and improve the effectiveness of ECM, CHWs and other PHM programs in improving health outcomes, reducing disparities, and achieving health equity.

We are working with Local Health Jurisdictions (LHJs) in the service area and have developed SMART goals that align with the Bold Goals from DHCS Comprehensive Quality Strategy as well as to promote meaningful participation in the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process.

In 2024, CalViva Health representatives established a collaborative partnership with Fresno, Madera, and Kings counties' LHJs/LHDs to begin "meaningful participation" in their current or future CHA/CHIP cycles. Plan is working with LHJs to determine what combination of funding and/or in-kind staffing the plan will contribute to the LHJ CHA/CHIP process, which includes attending CHA/CHIP meetings and serving on the CHA/CHIP governance structure. CalViva Health representatives also engaged with these LHJs to co-develop joint SMART goals. This collaborative work includes CalViva Health/Health Net partnering and aligning with the other Managed Care Plans (Anthem and Kaiser) providing Medi-Cal services in these three counties.

Plan is partnering with LHJ in the service area to identify priority areas for plan to share data with LHJ. In 2025, the Plan began to share data agreed upon in 2024 with the LHJs in a timely manner. Plan will engage our community advisory committees (CACs) as part of our participation in the LHJ's CHA/CHIP process. Plan will publish CHA/CHIP on our website and complete the MCP/LHJ collaboration worksheet by deadline.

Plan will submit our annual PHM strategy deliverable using the DHCS template for the service area.

Transitional Care Services

The purpose of the Transitional Care Services (TCS) program is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition Interventions may include coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external 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 evidenced based care elements of inter-disciplinary communication and collaboration, Member/participant engagement and enhance post-acute care follow-up.

TCS includes:

- Care Manager is responsible for successfully connecting with the member within 7 days of discharge to complete an inpatient discharge risk assessment
- Initiating Community Support referrals as appropriate
- Focus on 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 of how to respond

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- 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 evaluates 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.

PHM Programs and Services

We offer several PHM programs and services to our enrolled Members to provide comprehensive wellness, prevention, and self-management tools:

Program Name	Eligible Population
Improve Preventive Health: Flu Vaccinations	Members 6 months-64 years old, especially high-risk populations
Improve Preventive Health: Breast Cancer Screening	Women ages 40-74 years
Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
Improve Behavioral Health: Depression Screening and Follow up Care	Members ages 12 years and older who were screened for clinical depression using a standardized instrument
Improve Behavioral Health: Follow-Up Care after Substance Use Disorder Emergency Department Visits	Members ages 13 years and older as of the date of the Emergency Department visit with a principle diagnosis of substance use disorder (SUD), or any other diagnosis of drug overdose
CalViva Pregnancy Program	Pregnant Members at risk for adverse maternal and neonatal outcomes using the new Pregnancy Prioritization logic
Care Management	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b, 8b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health.

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Program Name	Eligible Population
Transitional Care Services	Members with high complexity profile: Member is inpatient with anticipated discharge or recently discharged, hospital readmissions risk, 2 or more admissions within the past 6 months, 3+ emergency department visits within the past 6 months, multiple medications/high cost medications/high-risk medications, recent catastrophic event or illness, unmanaged/poorly managed chronic or behavioral health issues, psychosocial issues/barriers impacting access to care and/or services, history of non-compliance and/or complexity of anticipated discharge
Chronic Condition Disease Management	Members with Asthma, COPD, Diabetes, Cardiovascular Conditions, and Sickle Cell Disease
Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program	SUD-O program timely/effective care in collaboration with providers for members on dangerous combinations (benzodiazepines, opioids, muscle relaxants, other), high doses and prolonged use.
Tobacco Cessation – Kick It California	Members 13 years and older
Diabetes Prevention Program	Members 18 years and older with BMI > 25 (BMI >23 if Asian) and have one of the following within 12 months: HbA1c between 5.7% and 6.4%, Fasting plasma Glucose 100-125 mg/dL. 2-hour plasma glucose of 140-199 mg/dL
Diabetes Management Program	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Cardiac + Diabetes	Members that have diabetes with hypertension and/or cardiovascular disease
Health Information Form	All Members
Initial Health Appointment	All Members
Teladoc Mental Health (Digital Program)	Ages 13 years and above - Mental health educational support for depression, anxiety, substance use, pain management, and insomnia/sleep health
Behavioral Health Care Management	All members
Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma)	Members with Chronic Obstructive Pulmonary Disease or Asthma diagnosis with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both
Emergency Room Diversion Program	High-frequency emergency department utilizers
Chronic Condition: Oncology	Members with diagnosis of breast, prostate, colon cancer, or other cancers with pharmacy claims who are either not adherent to their medications, have ER/IP visits in the last 12 months, or both
Telemedicine	All Members
Disease Management/Health Coaching- Be In Charge!	All members identified from Disease Management Prioritization Reports (DMPR), Case Management Referrals, Provider Referrals, and Self-Referrals

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Focus Areas

Programs related to the four focus areas are described in greater detail below.

Improve Preventive Health: Flu Vaccinations	
Eligible population:	Members 6 months-64 years old, especially high-risk populations
Focus area:	Keeping Members healthy
Program goal(s):	Reach or maintain Medicaid 50th percentile Minimum Performance level (MPL) for Childhood Immunization Status (CIS-10)- Influenza and 25th percentile Minimum Performance level (MPH) for Adult Immunization Status (AIS-E)-Influenza measures
Program services:	Member education promoting flu vaccination through: o Fluvention Texts o Fluvention Emails o Fluvention Proactive Outreach Manager (POM)- short automated messaging o Fluvention Interactive Voicemail Response (IVR) messaging o Provider Flu Flyer o Fluvention Web landing page and web pop-up/notification banner o Me+U Member Immunization Outreach o Pfizer Immunization IVR messaging o Well-Child Visits in the First 15 Months of Life (W30-15) POM- short automated messaging o Childhood Immunization Status (CIS)-10 POM- short automated messaging
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations, enrollment data, and supplemental data from the California Immunization Registry (CAIR)
Relevance	The flu vaccine can prevent contracting the flu and other illness and can decrease health care utilization by reducing risk of going to the doctor or hospital, and keeping the community healthy. It is an important preventative tool for people with chronic health conditions. The ability to get the flu shot can also be an indicator of any health plan/network access barriers.

Tobacco Cessation	
Eligible population:	Members 13 years and older
Focus area:	Keeping Members Healthy
Program goal(s):	Increase the number of eligible members successfully contacted and offered tobacco cessation support by 5% annually.

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Program services:	CalViva Health will cover a minimum of two separate quit attempts per year, without prior authorization, with no mandatory break between quit attempts. Please refer to the Medi-Cal RX contract drug list for individual products and any restrictions to coverage. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_OTC_FINAL.pdf. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless of if they opt to use tobacco cessation medications. 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.
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations using ICD-10 identifiers. Program is opt-in. Members can also be referred by their PCP, or Care Management.
Relevance	Tobacco use is the leading cause of preventable death and disease in the U.S., making it critically important that prevention and cessation programs are available to help people break their tobacco addiction for good. Almost 4 million Californians use tobacco products, including 146,000 adolescents. The cost of smoking in California totaled $43.54 billion in health care costs and lost productivity from illness and premature death. Tobacco cessation is critical to improve members' health outcomes and reduce health care costs by decreasing the rate of tobacco users among CVH membership. Source: CDPH Tobacco Facts and Figures 2022

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Improve Preventive Health: Breast Cancer Screening	
Eligible population:	Women ages 40-74 years
Focus area:	Managing Members with Emerging Risk
Program goal(s):	Meet directional improvement from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: Breast Cancer Screening (BCS-E): MPL is 55.87%
Program services:	Member education promoting breast cancer screenings through: • Mobile mammography events • Multi-gap call outreach to members • Identify opportunities to collaborate with community based organizations Provider education and partnership to promote breast cancer screenings through: • Tipsheets on the Breast Cancer Screening HEDIS measure

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	• Provide Breast Cancer Screening HEDIS measure specific best practices, coding practices, and clinic processes practices in the Provider Best Practices guide • Collaboration with priority Providers to identify opportunities to improve breast cancer screening utilization rates • Host office hours for internal Provider-Facing teams to provide measure specific education on updated recommendations, guidelines, and best practices • High-Risk Breast Cancer Screening e-project to Providers for appropriate member outreach, scheduling, and follow-up
Methods and data sources used to identify the eligible population	HEDIS care gap reports, enrollment data
Relevance	The American Cancer Society cites breast cancer as the second leading cause of cancer-related deaths and the second most common cancer among women in the US.[2] Regular breast cancer screenings (also known as a mammogram) can help detect the cancer while it is still in early stages, which is also when the cancer treatment is most likely to be successful. Breast cancer screening is an important preventative tool that can help keep members healthy and decrease health care utilization.

Diabetes Management Program	
Eligible population:	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Focus area:	Managing Members with emerging risk
Program goal(s):	Meet directional improvement from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • Glycemic Status (GSD) >9 (a lower rate indicates better performance for this indicator- i.e., low rates for glycemic status >9% indicate better care).
Program services:	Member education on diabetes management: ○ Digital Health Education QR Codes on diabetes-related resources. ○ Access to comprehensive diabetes webpages on member portal site. ○ Targeted Community Health Workers (CHW) outreach to members with SDOH barriers. ○ Pharmacy medication adherence outreach by phone. ○ Availability of A1c home kits and follow-up email and/or follow-up calls to encourage completion. ○ Multi-gap live calls encourage members to complete A1c screening and assist in scheduling appointments with provider; bi-directional texting to accompany live calls for targeted populations to promote trust and improve health outcomes. Provider partnerships on diabetes management:

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	○ Targeted outreach to high-volume, low-performing PPGs/PCPs utilizing root cause analysis for uncontrolled A1c to segment population follow-up. ○ Share root cause analysis (RCA) HbA1c data with providers to identify factors contributing to non-compliance, including uncontrolled cases, missing data, or lack of service evidence. ○ Provider tipsheets on HEDIS Diabetes measures: GSD (Glycemic Status Assessment for Patients with Diabetes), EED (Eye Exam for Patients With Diabetes), BPD (Blood Pressure Control for Patients With Diabetes) and KED (Kidney Health Evaluation for Patients With Diabetes).
Methods and data sources used to identify the eligible population	HEDIS care gap reports, pharmacy claims
Relevance	An estimated 40.1 million U.S. residents (12.0%) were living with diabetes in 2023, including 11.0 million adults (27.6%) with undiagnosed disease, indicating persistent gaps in screening and early identification.[1] Diabetes remains a leading cause of preventable morbidity and mortality, ranking as the seventh leading cause of death with 95,190 diabetes-attributable deaths reported in 2023.[2] The condition imposes a substantial economic burden, with $412.9 billion in total U.S. costs in 2022 ($306.6 billion direct medical; $106.3 billion indirect), and per-capita medical expenditures 2.6 times higher for individuals with diabetes compared to those without.[4] Effective diabetes management—defined by sustained glycemic control and adherence to evidence-based monitoring, including retinal eye exams and kidney health evaluation—remains central to improving outcomes and performance on HEDIS® diabetes-related quality measures.[1,3] Optimal diabetes control is operationalized through a multidisciplinary, whole-person care framework that combines glycemic management, risk-stratified intervention, and targeted SDOH remediation with adherence to evidence-based preventive care protocols, resulting in sustained performance across HEDIS® diabetes-related quality indicators, specifically HbA1c control, diabetic retinal screening, and chronic kidney disease evaluation.

CalViva Pregnancy Program (CPP) / High-Risk Obstetrics (OB) CM	
Eligible population:	Pregnant Members at risk for adverse maternal and neonatal outcomes using the new Pregnancy Prioritization logic
Focus area:	Patient safety or outcomes across settings
Program goal(s):	- Members managed in OB program have 8% greater completion of the 1st pre-natal visit within the 1st trimester or 42 days of enrollment than pregnant Members not managed. - Members managed in OB program have 10% greater completion of the post-natal visit between 7-84 days post-delivery than pregnant Members not managed.

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Diabetes control is achieved through effective whole-person approach to care and management, addressing SDOH barriers and clinical preventive care practices that achieve optimal rates for the HEDIS diabetes-related measures, specifically blood sugar control, retinal eye exam, and kidney health evaluation. ¶

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	- High-risk Members managed have 2% lower rate of pre-term delivery than high-risk Members not managed. - Member experience survey – each question and overall >90%
Program services:	Care manager completes the Trimester Based Assessment. The Edinburgh Postnatal Depression Scale and Patient Health Questionnaire-9 have been integrated into the Trimester-based assessments. - Members are provided Education Materials via website (members may request mailers) - Members who received a medium or high score receive outreach to be enrolled in High-Risk OB Program - Text & Email program is available for opt in - The OB Care manager coordinates care with the BH Care manager for Members with behavioral health needs.
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims
Relevance	Pregnancy complications can be harmful for mom and baby. Early and regular prenatal care helps identify conditions and behaviors that can result in preterm and low weight births. Early identification of pregnant women and their risk factors is an important factor in improving birth outcomes. Interventions are aimed at increasing pre-natal visits thereby improving health outcomes and resulting in reducing utilization costs. Pregnancy complications can be harmful for mom and baby. Post-natal care is important in preventing and addressing the health of mom and baby after pregnancy. Interventions are aimed at improving health outcomes and resulting in reduced utilization costs. Pregnancy complications can be harmful for mom and baby. Preterm birth is the leading cause of US infant morbidity and mortality and low birth weight can cause serious and long-term health problems. Interventions are aimed at reducing pre-term deliveries thereby improving health outcomes and resulting in reduced utilization cost. Measuring member experience evaluated the effectiveness of the services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement.

Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	
Eligible population:	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm. Added phobia, anxiety and additional self-harm diagnoses to the denominator in the event/diagnoses.
Focus area:	Patient safety or outcomes across settings

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Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Program services:	Behavioral Health clinical staff conduct live calls to members with a very recent ED visit for Mental illness or Intentional self-harm to conduct assessments and support timely follow-up to outpatient care for members in Fresno, Kings and Madera counties. Clinical staff are able to identify depressive symptoms and provide additional counseling and resources to assist with stress management and avoidance of at-risk alcohol and substance use.
Methods and data sources used to identify the eligible population	Hospital admissions, discharges, and transfers (ADT) including real-time ADT reports, claims or encounter, and membership data
Relevance	Follow-up care after a mental health emergency department (ED) visit is essential for reducing repeat ED visits, supporting recovery, and improving overall physical and mental well-being. Follow-up helps ensure continuity of care by bridging the transition from acute ED treatment to ongoing outpatient services and promoting coordination among healthcare providers. It supports treatment adherence by allowing providers to monitor medication effectiveness, address side effects, and make timely adjustments as needed. Follow-up visits also provide ongoing monitoring and treatment planning, helping members maintain progress, address new or worsening symptoms, and respond to changes in their needs. By promoting timely intervention, adherence to treatment plans, and coordinated care, follow-up care can improve quality of life for members and their families while reducing unnecessary ED utilization.

Improve Behavioral Health: Depression Screening and Follow up Care	
Eligible population:	Members ages 12 years and older who were screened for clinical depression using a standardized instrument
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
Program services:	Members can enroll in Teladoc to complete the PHQ-9 as well as connect with resources to assist them in managing their depression. Positive results on the PHQ-9 are relayed to the Case Management team who follow up with the members and connect them with services. Providers who complete their depression screenings can upload their documentation to Cozeva. The HEDIS team is available to assist providers with uploading their data.
Methods and data sources used to identify the eligible population:	Claims or encounter, membership data, supplemental data

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Deleted: Major depression is one of the most prevalent and treatable mental health disorders. Although antidepressants are considered effective treatment, non-adherence to antidepressants significantly hinders successful treatment of depression. Symptoms associated with major depression can last for years and has been linked to poor treatment outcomes (e.g., relapse occurrence) if left untreated. Conversely, many can improve through treatment with appropriate medications. Measuring antidepressant medication adherence for 84 days (12 weeks) among individuals diagnosed with depression evaluates the impact of the recommended treatment monitoring during the acute phase, during which remission (reduction of depressive symptoms) is induced. This measure ensures patients successfully adhere to treatment plans. ¶
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Successful treatment of patients with major depressive disorder is promoted when patients adhere to the treatment plan through the continuation phase of treatment (six months), the period in which remission is preserved. Ultimately, adherence through the continuation and maintenance phase protects the patient against the recurrence of a subsequent major depressive episode.

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Relevance:	Screening for depression ensures that members receive appropriate care timely. The stigma of mental illness effects the members openness to reach out for help. Screening at routine appointments or when clinically appropriate allows for the opportunity to discuss the members' emotional well-being. Coordination of timely follow up care when a positive result occurs increases engagement by the member. It also decreases the potential of utilization of the emergency department due to symptom severity increasing.

Improve Behavioral Health: Follow-Up Care after Substance Use Disorder Emergency Department Visits	
Eligible population:	Members ages 13 years and older as of the date of the Emergency Department visit for a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Follow-Up After Emergency Department Visit for Substance Use Disorder (FUA)
Program services:	CalViva Behavioral Health clinical staff make live calls to members with a very recent ED visit for substance use disorder or drug overdose to conduct assessments and support timely follow-up to outpatient care for Medi-Cal members. Clinical staff are able to identify, assess risk and provide additional counseling and resources to assist with avoidance of at-risk alcohol and substance use.
Methods and data sources used to identify the eligible population:	Hospital admissions, discharges, and transfers (ADT), including real-time ADT Reports, claims or encounter, and membership data.
Relevance:	Follow-up care after a substance use disorder (SUD) emergency department (ED) visit is essential for improving member outcomes relative to their physical and mental health by preventing future ED visits, rates of relapse and overdose. Following up with a provider (i.e. PCP, Community Health Worker, Mental Health Provider, etc.) allows for a comprehensive assessment of the member's physical and mental health needs, ensuring they receive appropriate medical and behavioral health care, including medication-assisted treatment (MAT) for members with an opioid use disorder. Follow-up care also allows for early identification of potential complications, misdiagnoses, or treatment failures, which can be addressed promptly.

Cardiac + Diabetes (formerly Cardio-Protective Bundle Project – SHAPE)	
Eligible population:	Members that have diabetes with hypertension and/or cardiovascular disease.
Focus area:	Managing multiple chronic illnesses
Program goal(s):	Improve cardio-protective bundle medication adherence by performing successful outreach to high risk members who were flagged for non-adherence,

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	utilization (ER/IP), or both and provide education/counseling to encourage compliance
Program services:	Member education and outreach through - ○ A "live call" by health care coaches to engage the Member and help ensure that they are compliant with their medications. The health care coaches, consisting of pharmacists, diabetes educators, nutritionists, or dieticians, can conduct follow-up visits as needed to address Members' chronic conditions and healthy weight (BMI) maintenance, encouraging physical activity and healthy eating ○ Multimodal communications: online newsletters and mailings. ○ Connecting Members with care management and disease management.
Methods and data sources used to identify the eligible population	Medical claims, encounter data, pharmacy claims
Relevance	Diabetes was the eighth leading cause of death in the United States in 2021.[5] If not properly managed, it can lead to renal, vision, hearing impairment and cardiovascular disease. If complicated with other chronic comorbid conditions like hypertension and CAD, the utilization is very high affecting the quality of life and the challenges to navigate through the healthcare system. In 2022, the total cost of diagnosed diabetes in the United States was $412.9 billion.[5] The utilization is primarily around pharmacy, inpatient and emergency room costs. Timely intervention, focus on prevention and developing wellness into the lifestyles, and implementation of evidence-based strategies to incorporate best practices are the goals of the initiative.

Care Management	
Eligible population:	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b, 8b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health. A predictive modeling tool, reports and health risk screening are used to identify Members who have higher risk and more complex health needs. Members may self-refer and/or be referred to the program by other internal and external entities. The person-centered approach allows us to link Members to a tailored variety of Complex Care Management (CCM) programs and interventions (inclusive of BPHM) to address Members' unique needs. Types of interventions and conditions the Program addresses include: health promotion, disease management, maternal and child health, Behavioral Health (BH), telehealth, transitional care services, palliative care, oncology, nursing facilities, and ED diversion. Depending on the Member's preferences, the CCM program uses a variety of communication modalities to initiate and sustain Member support (e.g., in-person contacts, face-to-face virtually, calls, texts, email).
Focus area:	Managing multiple chronic illnesses

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Program goal(s):	• Member experience survey – each question and overall > 90% • Reduce Non-Emergent ER Visits > 10% annual • Reduce Readmissions > 5%
Program services:	**Care coordination:** Typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to Member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of care management is used for continuity of care transitions and supplemental support for Members managed by the county or Enhanced Care Management (ECM). **Care management (CM):** Services included at this level of care management include the level of coordination along with identification of Member agreed upon goals and progress towards meeting those goals. If the CM program is delegated to the Participating Physician Group (PPG) and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up. **Complex Care management:** Services at this level of complex care management include all coordination and care management services from above, along with a more frequent outreach to the Member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor Members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence. If the CM program is delegated to the PPG and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims, focused Population Health Management reports, referrals
Relevance	One element of the Care Management program evaluation is to assess member satisfaction. Measuring member experience evaluated the effectiveness of Care Management services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement. Use of the emergency room may prevent or interrupt the receipt of coordinated services by the primary care physician. Readmission may reflect a failure of transition of care after hospital discharge. Readmissions not only increase health care costs, but also can signal a setback

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	in member recovery after hospitalization. There are many factors which increase the potential for a readmission including member and caregiver understanding of discharge instructions, member and caregiver understanding of red flags and when to contact a physician and lack of medication reconciliation.

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Care Coordination

We provide care coordination to our members from each of the following populations based on the member needs that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

- Mental Health Plans (or specialty mental health system): We coordinate care through interdisciplinary care team (ICT) discussions with MH resources and with the county Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) to address the holistic needs of members including transitioning between SMHS and NSMHS. Care Management (CM) provides education on and referrals to SMHS and NSMHS. For members who are medically and BH complex, we offer ICT meetings, and work with the county to coordinate care. We monitor individual cases, and we also have enhanced and global reporting on trends across cases for provision to providers. We can now track how many members have been linked to BH Therapist and/or Psychiatrist, as well as how many members we facilitated ICT meetings with county Mental Health Providers for SMI services.
- Drug Medi-Cal or a Drug-Medical Organized Delivery System: CM and Clinical Pharmacy refers members to appropriate level of care/provider for SUD needs. CM staff outreach to Drug Medical provider to ensure member needs are being addressed. ICT meetings scheduled as needed.
- Long Term Services and Supports (LTSS), including 1915(c) waivers and In-Home Supportive Services: CM staff will refer to our dedicated Public Programs team who specialize in supporting LTSS members. In addition, CM staff educate the Member on IHSS and refer the member to the Public Programs team who will support the Member through the IHSS application process. Finally, we outreach to the Member's PCP or specialist to help advocate for member and encourage the provider to complete the remaining components of the IHSS forms as necessary. In 2023 we implemented additional KPIs to improve monitoring and tracking of care coordination outcomes (e.g., coordination with providers, facilitating referrals, linkage to services).

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- CBAS: We measure completion of Face-to-Face assessment within 30 days of notification for CBAS and we review the reassessments completed by CBAS every 6 months to determine program eligibility.
- LTC: We review the assessments at least annually or when the Member experiences a significant change in condition completed by LTC to determine appropriateness and eligibility.
- Waiver Programs: We make referrals to waiver programs, as appropriate, and partner with waiver agencies for all care coordination opportunities.
- Overarching CM supporting: CM staff complete Health Risk Screenings with members to help identify when additional support may be needed. CM staff refer members to any of the programs above including ECM or CS (if member meets criteria and is identified in the population of focus). CM staff outreach to providers to coordinate care, share assessment information as needed, and case conference as appropriate. CM provides members with information for community and social services based on recommendations from the Interdisciplinary Care Team (ICT). CM also assists the members with 3-way calls to those entities or submits referrals on the member's behalf. The CM team primarily interfaces with providers and outside entities telephonically and by secure email.

External partnerships

Entity	Description:
Departments of Social Services and In-Home Supportive Services (IHSS)	CalViva Health will maintain MOUs with Local Departments of Social Services and In-Home Supportive Services (IHSS) programs in all services areas and will meet with these departments/programs quarterly at minimum, as is required under the new State contract.
Departments of Behavioral Health and Substance Use Disorder Services (SUDs)	CalViva Health will maintain MOUs with Local Departments of Behavioral Health and Substance Use Disorder Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Regional Centers	CalViva Health will maintain MOUs with the Regional Center(s) for all services areas and will meet with the Regional Center(s) quarterly at minimum, as is required under the new State contract.
Local Health Departments	CalViva Health will maintain MOUs with Local Health Departments (LHDs) in all services areas and will meet with LHDs quarterly at minimum, as is required under the new State contract. Example of how Plan and LHDs work together include but are not limited to: Collaborating on community-based vaccination events; Collaborating to deliver provider trainings (e.g., CPSP); Collaborating to deliver certain member-facing events (e.g., breastfeeding mom's lunch and learn).
Departments of Child Welfare Services	CalViva Health will maintain MOUs with Local Departments of Child Welfare Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Women, Infants and Children (WIC) Supplemental Nutrition Programs	CalViva Health has an MOU in place with Fresno Economic Opportunity Commission (EOC) concerning the arrangement and coordination of Women, Infant, and Children Supplemental Nutrition Program (WIC) services to CalViva members who are enrolled in Fresno County. CalViva Health will also maintain MOUs

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	with the local WIC programs in all services areas and will meet with the WIC programs quarterly at minimum, as is required under the new State contract.
County Targeted Case Management Programs	CalViva Health will maintain MOUs with Local County Targeted Case Management (TCM) programs *(where applicable)* in all services areas and will meet with the TCM programs quarterly at minimum, as is required under the new State contract.
First Five programs and providers	CalViva Health will maintain MOUs with the local First Five programs in all services areas and will meet with these programs quarterly at minimum, as is required under the new State contract. We participate in coalitions and help establish processes for local programs. We provide First Five with sponsorships as needed or requested.
Justice Departments & Correctional Facility Partners and Programs	CalViva Health will maintain MOUs with the local Justice Departments/Correctional Facility partners and program in all services areas and will meet with the JI/CI partners quarterly at minimum, or as directed by DHCS, as is required under the new State contract.
Schools and Local Education Agencies	CalViva Health has agreements in place with three Local Education Agencies (LEAs), Fresno County Office of Education (FCOE), Fresno Unified School District (FUSD) and Clovis Unified School District (CUSD). We will be working to execute memorandum of understandings (MOUs) with LEAs in all service areas under the new State contract requirements. We meet regularly with FCOE, FUSD and CUSD, and will maintain, at minimum, quarterly engagement with LEA partners in all service areas under the new State contract requirements as well. CalViva Health partnership activities with schools and LEAs include, but are not limited to, participation in on-site health fairs, support for back-to-school events and trainings, etc. We also provide grant support to schools and LEAs for workforce training and development, as well as infrastructure and support for the expansion of telehealth services in schools. We do not currently participate on any School or LEA boards, but this is something in which will look to more involved in the future.
Early Start	Plan works with Early Start through local health departments. We participate in coalitions and help establish processes for local programs. We meet on an as-needed basis. We provide Early Start with sponsorships as needed or requested.
California Work Opportunity and Responsibility to Kids (CalWorks)	Plan provides warm-handoffs and referrals to support our members who can benefit from CalWorks services. Example of warm-handoff: While speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalWorks program, we will 3-way call the CalWorks Customer Service number (California Department of Social Services) and connect our members to a CalWorks representative to ensure our member is connected to CalWorks benefits.

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CalFresh	Plan provides warm-handoffs when possible and referrals to support our members who can benefit from CalFresh services. Example of warm-handoff: While we are speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalFresh program, we will 3-way call the California Department of Social Services and connect our member to a CalFresh representative to ensure our member is connected to CalFresh benefits.
Supplemental Security Income (SSI)	Plan provides warm-handoffs and referrals to support our members who can benefit from SSI services. Warm hand-off Example: While we are speaking to a member on the phone, and we identify through listening to our member that they might be eligible for SSI, we will 3-way call the Social Security Administration and make an appointment for our member to apply for SSI. 2. We do not provide financial support or investments to SSI. 3. We do not have involvement with SSI boards or governance structures.

Activities Which Support PHM Programs and Services

In order to support network providers as they strive to achieve their population health management goals, we provide the following:

Delivery System Supports

Data and information sharing with practitioners

We share an extensive amount of data with provider partners. Data shared with providers includes pharmacy, enrollment, care gaps, claim/encounters, financial, and various utilization (inpatient, outpatient and ED) information. In addition, disease management program enrollment reports are also shared with our strategic provider partners. Data is shared at various frequencies (daily, weekly, monthly, yearly) via the Plan provider portal, secure email, SFTP, fax or mail. The method of data transmission varies based on the data being shared as well as provider preference. We exchange admission, discharge transfer (ADT), Observation Result (ORU), and consolidated clinical document architecture (C-CDA) data through Health Information Exchanges (HIEs).

We previously had implemented bidirectional data exchanges with all three counties focused on sharing Behavioral Health data through the Behavioral Health Quality Improvement Program (BHQIP). However, since that has ended, we are now developing new partnerships and data exchange options to facilitate this type of bi-directional data exchange. Additionally, we are developing options for bi-directional data exchange with 25-30 organizations across California through the MOU process with the hopes of going live with the first county partner by Summer 2026.

We have improved our IT Capabilities under the umbrella of our Cal AIM program including:

1. We've invested CalAIM Incentive Payment Program (IPP) funding in our ECM and Community Supports (CS) providers to:
    1) increase the number of contracted Enhanced Care Management (ECM) providers that engage in bi-directional Health Information Exchange (HIE);

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2) ensure our contracted ECM providers have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan; and
3) ensure our contracted ECM and Community Supports providers have the ability to submit a claim or invoice to the Plan or have access to a system or service that can process and send a claim or invoice to the Plan with the information necessary for the MCP to submit a compliant encounter to DHCS.

2. We are connected to the local Homeless Management Information Systems (HMIS) for member matching and receiving timely alerts when a Member experiences a change in housing status. We also support data sharing with housing-related services Community Supports providers on Member's housing status information.
3. ECM is an end-to-end solution that provides a whole-person approach to care that are medically appropriate and addresses the clinical and non-clinical needs of the member. ECM providers receive a monthly member information file (MIF) and are required to submit a return transmission file (RTF) of enrolled members.
4. Findhelp is an online platform with a network of social programs across the state. We are creating a closed-loop referral system to appropriate Community Supports and other community and social services including financial assistance, food pantries, medical care, transportation, and other free or reduced-cost services. The referral process ensures a seamless experience for the provider and member.

A Closed-Loop Referral (CLR) is a referral initiated on behalf of a member that is tracked, supported, monitored and results in a known closure. A known closure occurs when a member's initial referral loop is completed with a known closure reason such as the member receiving services. The goal of CLRs is to increase members successful connection to the services they need by identifying and addressing gaps in referral practices and service availability. The Plan took steps to collect and report CLR data for ECM and Community Supports beginning 7/1/2025 to ensure more members are connected to needed services.

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Exchange of member information and medical records is done in accordance with professional standards and state and federal privacy laws and regulations.

Value-based payment arrangements

We encourage providers to participate in value-based payment arrangements. Our value-based incentive programs reward both professional and hospital providers who achieve program goals in areas critical to the success of PHM such as quality outcomes, care coordination, access to care, overall medical costs and patient satisfaction. Data used to inform provider performance within incentive programs align with industry standard benchmarks/metrics and is sourced from health plan data. Below you will find incentive program components detail.

Incentive Payments

Description: The Plan offers incentives to network providers who achieve program goals in one or more of the below areas.
Capitation: Pre-paid PMPM payments for professional or professional and hospital services place responsibility for cost management on the providers and hospitals.
Incentive Program Components

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- Quality – Providers delivering high value, quality care, and not just a high volume of care, are eligible to earn an incentive payment for meeting Medicaid thresholds for HEDIS clinical quality measures.
- Encounter Data – Sharing patient encounter data is an essential aspect of assessing patient risk for subsequent clinical intervention as well as assessing providers for the quality of care they are delivering. Providers earn an incentive by meeting encounter data delivery thresholds.
- Access to care – the Plan offers incentives to PPGs to ensure their primary care providers and specialists have appointment availability for both urgent and non-urgent visits.

Ability to view evidence-based practice guidelines on demand

We provide clinical practice guidelines to network providers via access to the Plan's provider portal. The clinical practice guidelines are recommendations intended to optimize patient care for specific clinical circumstances to all network providers. They are based on professionally recognized standards and systemically developed through a formal process with input from practitioners and based on authoritative sources including clinical literature, studies, and expert consensus. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based. Board-certified practitioners who will utilize the guidelines are given the opportunity to review and give advice on the guidelines through the Medical Advisory Committee (MAC) and the CalViva QIUM Committee. Guidelines are updated at least every two years or upon significant new scientific evidence or changes in national standards.

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Providing practice transformation support

We offer provider communication and webinars to support the sharing of updates and best practices. In addition, we offer 1-to-1 training with providers, clinics and medical groups and design integrated workflows to streamline transition of care. We share population health risk data with Medical Groups to support the identification of Member needs. Ultimately, all of this fosters care collaboration, provider engagement and holistic care. Enhancing provider engagement can have a dramatic impact on health plan performance, lead to improved clinical outcomes, quality ratings, member retention, member satisfaction, and overall efficiency.

Coordination of Member programs

We use the following tactics to coordinate across Member programs and services, including programs Members may receive through their provider care team:

Copy of care plan and/or interventional program description sent to Member's practitioner inviting them to participate in the development of the care plan and attend interdisciplinary care team meetings as needed.

- Defining a program hierarchy so Members don't receive outreach from multiple programs. The following hierarchy is used to determine which entity will be the primary point of contact, unless Member specific evaluation demonstrates otherwise:
    1. Delegated Participating Physician Group (PPG) Concurrent Review and Care Management
        a. Example: To avoid duplicative outbound calls, a data analyst reviews potential care management list in Impact Pro and excludes Members who are assigned to a Delegated PPG as well as those already enrolled and engaged with Care Management
    2. Health Plan Concurrent Review (e.g., Inpatient Concurrent Review)

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3. Plan Complex Care Management
4. Plan Care Management
5. Special or Disease Specific Clinical Programs (e.g., Transitional Care Services, First Year of Life)
6. Disease Management
7. Auxiliary services may run concurrently as coordinated and requested by the primary Care Manager with the consent of the Member.
    a. Examples: Wellness Coaching (smoking cessation, weight management), Life Solutions evaluation for home safety, field-based Member Connection outreach for difficult to engage Members, Licensed Clinical Social Worker (LCSW) assessments, special PPG programs, ECM providers, Doulas and CHWs, etc.

EXAMPLE OF HIERARCHY IMPLEMENTATION:

- Care Management participates in Utilization Management inpatient concurrent review rounds to determine if Care management services are needed post discharge.
- Participating Physician Groups (PPGs) and Providers may submit referral directly (via fax/email referral form) to plan CM. If care management is delegated to the PPG, the plan refers the Member to the PPG for follow up.
- While the Member is enrolled in CM, the care manager will look at open care gaps and assist the Member to fulfill them.
- If an enrolled Member enters an inpatient setting the Concurrent Review staff identifies the Care manager involved and keeps the CM updated on status and discharge.

- Clinical program documentation processes are in a single medical management system platform (TruCare): Members actively enrolled in clinical programs are flagged in the common documentation platform to avoid duplication of outreach calls.
  EXAMPLES:
    - Alerts placed Member record in the Medical Management System are visible to staff when the Member record is accessed.
    - Tasks generated within the system from one process to another informing the recipient of activity to complete.
    - Inbound and outbound calls related to CM programs, tasks, notes, assessments, and correspondence are captured and dated within the medical management system and are visible to associates with access to the Member record.
- Assigning a single care coordinator and/or Co-Management to address all of the Member's needs:
    - Integrated Care Management: Integrated Care involves managing the Member's physical, behavioral, and psychosocial needs (including SDoH needs) with the care manager as the primary point of contact for the Member. This holistic approach lessens the complexity for our Members and aligns with our overall population health program.
    - Behavioral Health (BH) and Physical Health (PH) Care Management Coordination: for new BH CM referrals of Members enrolled in open PH CM, the PH Care manager coordinates with the referring party and BH CM to determine which CM staff will be the primary Care manager. Co-management may occur between BH and PH during CM rounds, and by documentation in a common platform. With Member's express permission, both BH and PH CM may work with Member, but always coordinating outreach and discussing during rounds.
    - The BH CM coordinates with Regional Centers to coordinate services falling within their domain.

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        - The Care Manager coordinates with county programs and other external entities to facilitate services and programs available to the Member.

- Multi-disciplinary, cross functional rounds and/or workgroups to develop and maintain strategies for efficient clinical program coordination:
    - Preventative Health Work group QI, Health Education, Medical Management, Health Programs, Care Management, Member Services, Community Grants, Provider Relations, HEDIS, Enrollment Services, Member Experience, Health Equity, and Practice Transformation departments meet regularly to review Member outreach for various health measures, coordinate efforts and minimize duplication.

- Interdisciplinary/Integrated Care Management Team Rounds:
    - Care Management rounds are routinely conducted with a team-based approach, using Care Managers, Social Workers, Registered Dietitian, Pharmacists, Behavioral Health, and Medical Directors to coordinate between departments for specific Members, and develop and/or support a comprehensive care plan. Reports are shared with key internal stakeholders for care coordination.
    - On an annual basis, we report on population health metrics including a population health summary and risk factor analysis based on a Initial Health Appointment.

- CalViva Pregnancy Program:
    - Care Managers may discuss the Member during utilization or care management rounds, the Member will be referred as appropriate when it is identified a Member may benefit from information in another program and/or when care coordination is required across processes.

- Disease Management Reports:
    - Key operational and clinical measures for each Disease Management program are reported annually which summarize key enrollment and engagement metrics by program and describe utilization performance and quality measures for the Disease Management population and population health metrics including a population health summary.

- Sharing of Member outreach data:
    - Information regarding our preventive health programs, such as influenza immunizations, and documentation of member outreach/activities is provided to our Customer Contact Center (CCC) via notification and available in our internal database (Central Point) in order to increase awareness so that Customer Service Representatives can answer incoming questions from our members and direct members to the available resources.

- Standardized Protocols for Unable to Reach Members: Each clinical program follows a standard protocol for the number and frequency of outbound attempts to reach Member to avoid multiple or intrusive calls to Members. All outreach is documented in the common platform.
    - Integrated Care Management: A standard number of outbound call attempts are followed by a letter.
    - Disease Management: Establishes a set number of call attempts for Members with a valid phone number, then sends an outreach letter.
    - Disengaged/housing insecure or homeless member support: Street Medicine providers support in reaching the most difficult to reach populations and provide basic care coordination and connection to PCP.

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- Standardized Protocols for Members opting out of clinical programs:
  - Members wishing to opt out of clinical programs are flagged and set for future outbound calls according to protocol, respecting their wishes while adhering to regulatory compliance guidelines.

Informing Members about Available PHM Programs

We provide Members with information about all available PHM programs and services through the following:

- New Member Welcome letter sent via United States (US) Postal Mail
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification
- Solicited Phone Calls for Members who agree to be actively enrolled in programs
- E-mail
- Plan Website
- Annual Plan Newsletter
- Face to face visits

Informing Members about PHM Programs – Interactive Contact

Staff engage Members that are eligible for programs which include interactive contact with the Plan to notify them of the following key information: See Appendix C

Key Program Attributes Communication Check list

- To inform Member of how they became eligible to participate in the specific program
- How they can opt-in the individual program
- How they can opt-out of the individual program

Key Modes of Communicating Program Information

- Welcome letter to welcome the Member to get them oriented with the program and all of the available program benefits, including all of the aforementioned key program elements.
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification.
- Solicited Phone Calls for Members who agree to be actively enrolled in programs and are identified as eligible for other potential beneficial programs.
- On occasion the CM staff may request a MemberConnections Representative make a face-to-face visit with the Member.
- Members may opt in to an automated texting program to receive reminders, and pregnancy health education.

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Appendix A

This table contains guidance to determine specific HEDIS SSD NDC list

HEDIS SSD NDC list	HEDIS SSD NDC List.xlsx

Appendix B

This table contains guidance to PHM Level and KPI tools Overview

PHM Level and KPI tools Overview	PHM Level and KPI tools Overview.pdf

Appendix C

This table contains guidance to determine specific medical conditions that are included within each population health category

01: Pop Health Cat: Healthy	Includes Members that meet *ALL* of the following criteria:
	No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx Members who were enrolled for at least 3 months AND whose 12-month future total Healthcare Expenditure risk scores are all < 90th percentile: ○ Less than 1.8 for Non-Medicare members aged 0-64 ○ Less than 6.5 for Non-Medicare members aged 65+ and Medicare members AND whose 12-month future Inpatient Stay probability is < 90th percentile (30%) AND whose 3-month future Inpatient Stay probability is < 90th percentile (10%)

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	AND who did NOT have a non-Obstetric, non-Newborn Inpatient Stay in the last 12 months AND who did NOT have an ICU Inpatient Stay in the last 90 days AND who did NOT have a needed Emergency Department visit in the last 12 months AND who did NOT have a chronic ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years AND who did NOT have a behavioral health ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years AND who did NOT have a *Medication Adherence Gap* AND who did NOT have a 'Clinically Important' Care Opportunity AND were enrolled for at least 6 months AND who did NOT trigger a Drug Safety Care Opportunity No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx
02a: Pop Health Cat: Acute Episodic - Minor	Includes Members that meet both of the following criteria: Members who had either a non-ICU, non-Obstetric, non-Newborn Inpatient Stay OR a needed Emergency Department visit in the last 12 months AND who did NOT have a chronic ETG episode (including those

Deleted: Includes Members that meet *ALL* of the following criteria:
No chronic conditions See Attachment
Chronic Conditions.docx
No behavioral health conditions See Attachment
Behavioral Health Conditions.docx
Risk of future costs for the next 12 months:
When age <65 then risk of future costs < 2
When age >= 65 then risk of future costs < 4
Risk of an admission in the next 12 months < 10%
No inpatient stays regardless of reason in the last 12 months
No emergency room visits regardless of the reason in the last 12 months
No medication adherence gaps: See Attachment
Medication Adherence Gaps.do
No 'clinically important' care opportunities See Attachment
Clinically Important Care Opportunities.
No drug safety care opportunities See Attachment
Drug Safety Care Opportunities.docx

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	triggered by the presence of only an Rx claim) in the last 3 years AND who did NOT have a behavioral health ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx
02b: Pop Health Cat: Acute Episodic – Major	Includes Members that meet both of the following criteria: Members who had either an-ICU Inpatient Stay in the last 90 days OR 3 or more All-Cause Inpatient Stays in the last 12 months AND who did NOT have a chronic ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years AND who did NOT have a behavioral health ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx
03: Pop Health Cat: Healthy - At Risk	Includes Members that meet *all* of the following criteria: Members who were enrolled for at least 3 months AND who did NOT have a chronic ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years

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No chronic conditions See Attachment¶
Chronic Conditions.docx ¶
No behavioral health conditions See Attachment¶
Behavioral Health Conditions.docx ¶
AND *one* or more of the criteria below¶
1 or more emergency room visits regardless of the reason in the last 12 months¶
1 or more inpatient stays regardless of reason in the last 12 months

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No chronic conditions See Attachment¶
Chronic Conditions.docx ¶
No behavioral health conditions See Attachment¶
Behavioral Health Conditions.docx ¶
¶
AND NOT in any of the following categories¶
01: Healthy ¶
02: Acute Episodic

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AND
who did NOT have a behavioral health ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years
AND
who did NOT trigger any of the following Pop Health registries:
o * 01: Pop Health Cat: Healthy
o * 02a: Pop Health Cat: Acute Episodic – Minor
o * 02b: Pop Health Cat: Acute Episodic – Major

Medication Adherence Gaps.do
No ‘clinically important’ care opportunities See Attachment

Clinically Important Care Opportunities.
No drug safety care opportunities See Attachment

Drug Safety Care Opportunities.docx
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<tr>
<td>04a: Pop Health Cat: Chronic Big 5 – Stable</td>
<td>
Includes Members that meet all the following criteria:
Members who had an ETG episode for Diabetes, CHF, CAD, COPD or Asthma in the last 3 years
AND
whose 12-month future total Healthcare Expenditure risk scores are all < 90th percentile:
o Less than 1.8 for Non-Medicare members aged 0-64
o Less than 6.5 for Non-Medicare members aged 65+ and Medicare members
AND
whose 12-month future Inpatient Stay probability is < 90th percentile (30%)
AND
whose 3-month future Inpatient Stay probability is < 90th percentile (10%)
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Deleted: Includes Members that meet *all* of the following criteria:¶
Diabetes or COPD or Asthma or CHF or CAD¶
Risk of future costs for the next 12 months:¶
When age <65 then risk of future costs < 2¶
When age >= 65 then risk of future costs < 4¶
Behavioral Health Risk Score < 20¶
Risk of an admission in the next 12 months < 10%¶
No inpatient stays regardless of reason in the last 12 months¶
No emergency room visits with a primary diagnosis of diabetes, CAD, CHF, asthma or COPD in the last 12 months¶
No medication adherence gaps: See Attachment ¶

Medication Adherence Gaps.do ¶
No ‘clinically important’ care opportunities See Attachment ¶

Clinically Important Care Opportunities. ¶
No drug safety care opportunities See Attachment ¶

Drug Safety Care Opportunities.docx ¶
AND NOT in any of the following categories:¶
04b: Chronic, other condition, stable¶
05a: Health Coaching¶
05b: Physical Health Care Management¶
05c: Behavioral Health Care Management¶
06: Rare High Cost Conditions ¶
07a: Catastrophic: Dialysis¶
07b: Catastrophic: Active Cancer ¶
07c: Catastrophic: Transplant¶
08a: Dementia¶
08b: Institutional (custodial care)¶
09a: Long-Term Supportive Services and Medicare-Medicaid Plan – Service Coordination¶
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management¶
10: EOL

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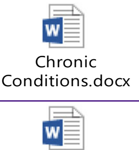
	AND who did NOT have an Inpatient Stay for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months AND who did NOT have an Observation Stay for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months AND who did NOT have an Emergency Department visit for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months AND who did NOT have a *Medication Adherence Gap* AND who did NOT have a '*Clinically Important' Care Opportunity* AND were enrolled for at least 6 months AND who did NOT trigger a *Drug Safety Care Opportunity* AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life  Chronic Conditions.docx Medication Adherence Gaps.do Clinically Important Care Opportunities.

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	Drug Safety Care Opportunities.docx
04b: Pop Health Cat: Other Major Chronic – Stable	Includes Members that meet *all* of the following criteria: Members who had an ETG episode or diagnosis for a major chronic condition in the last 3 years AND whose 12-month future total Healthcare Expenditure risk scores are all < 90th percentile: o Less than 1.8 for Non-Medicare members aged 0-64 o Less than 6.5 for Non-Medicare members aged 65+ and Medicare members AND whose 12-month future Inpatient Stay probability is < 90th percentile (30%) AND whose 3-month future Inpatient Stay probability is < 90th percentile (10%) AND who did NOT have a non-Obstetric, non-Newborn Inpatient Stay in the last 12 months AND who did NOT have an Observation Stay in the last 12 months AND who did NOT have a needed Emergency Department visit in the last 12 months AND who did NOT have a *Medication Adherence Gap* AND who did NOT have a '*Clinically Important' Care Opportunity* AND were enrolled for at least 6 months AND who did NOT trigger a *Drug Safety Care Opportunity* AND who did NOT have any of the Big 5 Conditions (Diabetes, CHF, CAD, COPD, Asthma) AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk

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1 or more non big 5 chronic conditions See Attachment

Chronic Conditions.docx

Risk of future costs for the next 12 months:
When age <65 then risk of future costs < 2
When age >= 65 then risk of future costs < 4
Behavioral Health Risk Score < 20
Risk of an admission in the next 12 months < 10%
No inpatient stays regardless of reason in the last 12 months
No "True" emergency room visits in the last 12 months
No medication adherence gaps: See Attachment

Medication Adherence Gaps.do

No 'clinically important' care opportunities See Attachment

Clinically Important Care Opportunities.

No drug safety care opportunities See Attachment

Drug Safety Care Opportunities.docx

AND NOT in any of the following categories:
05a: Health Coaching
05b: Physical Health Care Management
05c: Behavioral Health Care Management
06: Rare High Cost Conditions
07a: Catastrophic: Dialysis
07b: Catastrophic: Active Cancer
07c: Catastrophic: Transplant
08a: Dementia
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
10: EOL

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	* 07a: Pop Health Cat: Rare High Cost Condition - Stable * 07b: Pop Health Cat: Rare High Cost Condition - At Risk * 08a: Pop Health Cat: Complex – Dialysis * 08b: Pop Health Cat: Complex – Cancer * 08c: Pop Health Cat: Complex – Transplant * 09a: Pop Health Cat: Dementia * 09b: Pop Health Cat: Institutional Custodial Care * 10: Pop Health Cat: End of Life 1 or more behavioral health conditions that are not flagged as high needs See Attachment Behavioral Health Conditions.docx No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx
04c: Pop Health Cat: Other Minor Chronic – Stable	Includes Members that meet both the following criteria: Members who had an ETG episode for a minor chronic condition (including those triggered by presence of only Rx claim) in the last 3 years AND whose 12-month future total Healthcare Expenditure risk scores are all < 90th percentile: o Less than 1.8 for Non-Medicare members aged 0-64 o Less than 6.5 for Non-Medicare members aged 65+ and Medicare members AND

Deleted: Includes Members that meet *all* of the following criteria:
1 or more behavioral health conditions that are not flagged as high needs See Attachment
Behavioral Health Conditions.docx
Risk of future costs for the next 12 months:
When age <65 then risk of future costs < 2
When age >= 65 then risk of future costs < 4
Behavioral Health Risk Score < 20
Risk of an admission in the next 12 months < 10%
No inpatient stays regardless of reason in the last 12 months
No emergency room visits regardless of reason in the last 12 months
No medication adherence gaps: See Attachment
Medication Adherence Gaps.do
No 'clinically important' care opportunities See Attachment
Clinically Important Care Opportunities.
No drug safety care opportunities See Attachment
Drug Safety Care Opportunities.docx
OR
A behavioral health condition that is not flagged as high needs

AND NOT in any of the following categories:
04a: Chronic Big 5, Stable
04b: Chronic, other condition, stable
05a: Health Coaching
05b: Physical Health Care Management
05c: Behavioral Health Care Management
06: Rare High Cost Conditions
07a: Catastrophic: Dialysis
07b: Catastrophic: Active Cancer
07c: Catastrophic: Transplant
08a: Dementia
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination ... [1]

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	whose 12-month future Inpatient Stay probability is < 90th percentile (30%) AND whose 3-month future Inpatient Stay probability is < 90th percentile (10%) AND who did NOT have a non-Obstetric, non-Newborn Inpatient Stay in the last 12 months AND who did NOT have an Observation Stay in the last 12 months AND who did NOT have a needed Emergency Department visit in the last 12 months AND who did NOT have a *Medication Adherence Gap* AND who did NOT have a '*Clinically Important' Care Opportunity* AND were enrolled for at least 6 months AND who did NOT trigger a *Drug Safety Care Opportunity* AND who did NOT have any of the Big 5 Conditions (Diabetes, CHF, CAD, COPD, Asthma) AND who did NOT have a Major Chronic Condition AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.do

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	1 or more 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx
04d: Pop Health Cat: Behavioral Health Only – Stable	Includes Members that meet both the following criteria: Members who had an ETG episode for a behavioral health condition (including those triggered by presence of only Rx claim) in the last 3 years AND who did NOT have a chronic ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years AND whose 12-month future total Healthcare Expenditure risk scores are all < 90th percentile: o Less than 1.8 for Non-Medicare members aged 0-64 o Less than 6.5 for Non-Medicare members aged 65+ and Medicare members AND whose 12-month future Inpatient Stay probability is < 90th percentile (30%) AND whose 3-month future Inpatient Stay probability is < 90th percentile (10%) AND who did NOT have a behavioral health Inpatient Stay in the last 12 months AND who did NOT have a behavioral health Observation Stay in the last 12 months AND who did NOT have a behavioral health Emergency Department visit in the last 12 months AND who did NOT have a *Medication Adherence Gap* AND

Deleted: Includes Members that meet both the following criteria:¶
Diabetes or COPD or Asthma or CHF or CAD or HbA1c over 9¶
Behavioral Health Risk Score < 20¶
AND meet 1 or more of the following criteria:¶
Risk of future costs for the next 12 months:¶
When age <65 then risk of future costs between 2 ¶
When age >= 65 then risk of future costs between 4 ¶
Risk of an admission in the next 12 months between 10% ¶
1 or more inpatient stays with a primary diagnosis of diabetes, CAD, CHF, asthma, or COPD in the last 12 months¶
1 or more "True" emergency room visits in the last 12 months¶
1 or more emergency room visits with a primary diagnosis of diabetes, CAD, CHD, asthma or COPD in the last 12 months¶
1 or more medication adherence gaps: See Attachment ¶
Medication Adherence Gaps.do¶
1 or more 'clinically important' care opportunities See Attachment ¶
Clinically Important Care Opportunities.¶
1 or more drug safety care opportunities See Attachment ¶
Drug Safety Care Opportunities.docx¶
A Big 5 condition with 1 or more diagnosis of:¶
Atherosclerosis¶
Hyperlipidemia¶
Obesity¶
Hypertension¶
¶
AND NOT in any of the following categories:¶
05b: Physical Health Care Management¶
05c: Behavioral Health Care Management¶
06: Rare High Cost Conditions¶
07a: Catastrophic: Dialysis¶
07b: Catastrophic: Active Cancer¶
07c: Catastrophic: Transplant¶
08a: Dementia¶
08b: Institutional (custodial care)¶
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination¶
09b: Long-Term Supportive Services and Medicare-Me ... [2]

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	who did NOT have a '*Clinically Important' Care Opportunity* AND were enrolled for at least 6 months AND who did NOT trigger a *Drug Safety Care Opportunity* AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life 1 or more non big 5 chronic conditions See Attachment Chronic Conditions.docx Behavioral Health Risk Score <20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.do 1 or more 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx PRG risk greater than 10
05a: Pop Health Cat: Chronic Big 5 - At Risk	Includes Members that meet the following criteria: Members who had an ETG episode for Diabetes, CHF, CAD, COPD or Asthma in the last 3 years

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1 or more non big 5 chronic conditions See Attachment ¶
Chronic Conditions.docx ¶
Behavioral Health Risk Score <20¶
AND meet 1 or more of the following criteria:¶
Risk of future costs for the next 12 months:¶
When age <65 then risk of future costs greater than or equal to 2 ¶
When age ≥ 65 then risk of future costs greater than or equal to4 ¶
Risk of an admission in the next 12 months greater than or equal to10%¶
1 or more inpatient stays regardless of reason in the last 12 months¶
1 or more "True" emergency room visits in the last 12 months¶
1 or more medication adherence gaps: See Attachment ¶
Medication Adherence Gaps.do ¶
1 or more 'clinically important' care opportunities See Attachment ¶
Clinically Important Care Opportunities. ¶
1 or more drug safety care opportunities See Attachment ¶
Drug Safety Care Opportunities.docx ¶
PRG risk greater than 10¶
¶
AND NOT in any of the following categories:¶
A Big 5 condition with 1 or more diagnosis of:¶
Atherosclerosis¶
Hyperlipidemia¶
Obesity¶
Hypertension¶
05c: Behavioral Health Care Management¶
06: Rare High Cost Conditions¶
07a: Catastrophic: Dialysis¶
07b: Catastrophic: Active Cancer¶
07c: Catastrophic: Transplant¶
08a: Dementia¶ ... [3]

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	AND who met one or more of the following criteria: o 12-month future total Healthcare Expenditure risk scores are all between 90th and 99th percentiles: ▪ Between 1.8 and 8 for Non-Medicare members aged 0-64 ▪ Between 6.5 and 21 for Non-Medicare members aged 65+ and Medicare members o 12-month future Inpatient Stay probability is between 90th and 99th percentiles (30% and 70%) o 3-month future Inpatient Stay probability is between 90th and 99th percentiles (10% and 33%) o 1 or more Inpatient Stays for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months o 1 or more Observation Stays for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months o 1 or more Emergency Department visits for Diabetes, CHF, CAD, COPD or Asthma in the last 12 months o 1 or more *Medication Adherence Gaps* o 1 or more '*Clinically Important' Care Opportunities* AND were enrolled for at least 6 months o 1 or more *Drug Safety Care Opportunities* AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life
05b: Pop Health Cat: Other Major Chronic - At Risk	Members who had an ETG episode or diagnosis for a major chronic condition in the last 3 years AND who met one or more of the following criteria: o 12-month future total Healthcare Expenditure risk scores are all between 90th and 99th percentiles: ▪ Between 1.8 and 8 for Non-Medicare members aged 0-64 ▪ Between 6.5 and 21 for Non-Medicare members aged

Deleted: Includes Members that meet the following criteria:
Flagged as having a high behavioral health needs status based on either having:
High mental health risk
High substance-use disorder risk

AND NOT in any of the following categories:
06: Rare High Cost Conditions
07a: Catastrophic: Dialysis
07b: Catastrophic: Active Cancer
07c: Catastrophic: Transplant
08a: Dementia
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
10: EOL

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	65+ and Medicare members o 12-month future Inpatient Stay probability is between 90th and 99th percentiles (30% and 70%) o 3-month future Inpatient Stay probability is between 90th and 99th percentiles (10% and 33%) o 1 or more non-Obstetric, non-Newborn Inpatient Stays in the last 12 months o 1 or more Observation Stays in the last 12 months o 1 or more needed Emergency Department visits in the last 12 months o 1 or more *Medication Adherence Gaps* o 1 or more '*Clinically Important' Care Opportunities* AND were enrolled for at least 6 months o 1 or more *Drug Safety Care Opportunities* AND who did NOT have any of the Big 5 Conditions (Diabetes, CHF, CAD, COPD, Asthma) AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life ▪ 1 or more rare, high cost conditions See Attachment Rare High Cost Conditions.docx
05c: Pop Health Cat: Other Minor Chronic - At Risk	Members who had an ETG episode for a minor chronic condition (including those triggered by presence of only Rx claim) in the last 3 years AND who met one or more of the following criteria:

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Rare High Cost Conditions.docx
AND NOT in any of the following categories:
07a: Catastrophic: Dialysis
07b: Catastrophic: Active Cancer
07c: Catastrophic: Transplant
08a: Dementia
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
10: EOL

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	o 12-month future total Healthcare Expenditure risk scores are all between 90th and 99th percentiles: ▪ Between 1.8 and 8 for Non-Medicare members aged 0-64 ▪ Between 6.5 and 21 for Non-Medicare members aged 65+ and Medicare members o 12-month future Inpatient Stay probability is between 90th and 99th percentiles (30% and 70%) o 3-month future Inpatient Stay probability is between 90th and 99th percentiles (10% and 33%) o 1 or more non-Obstetric, non-Newborn Inpatient Stays in the last 12 months o 1 or more Observation Stays in the last 12 months o 1 or more needed Emergency Department visits in the last 12 months o 1 or more *Medication Adherence Gaps* o 1 or more '*Clinically Important' Care Opportunities* AND were enrolled for at least 6 months o 1 or more *Drug Safety Care Opportunities* who did NOT have any of the Big 5 Conditions (Diabetes, CHF, CAD, COPD, Asthma) AND who did NOT have a Major Chronic Condition AND who did NOT trigger any of the following Pop Health registries: o * 06: Pop Health Cat: High Risk o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life
05d: Pop Health Cat: Behavioral Health Only - At Risk	Members who had an ETG episode for a behavioral health condition (including those triggered by presence of only Rx claim) in the last 3 years AND who did NOT have a chronic ETG episode (including those triggered by the presence of only an Rx claim) in the last 3 years AND who met one or more of the following criteria:

Deleted: 1 or more claims indicating dialysis services in the most recent 12 months¶
¶
AND NOT in any of the following categories:¶
07b: Catastrophic: Active Cancer¶
07c: Catastrophic: Transplant¶
08a: Dementia¶
08b: Institutional (custodial care)¶
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination¶
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management¶
10: EOL

Deleted: Level 07b: Catastrophic: Active Cancer

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	○ 12-month future total Healthcare Expenditure risk scores are all between 90th and 99th percentiles: ▪ Between 1.8 and 8 for Non-Medicare members aged 0-64 ▪ Between 6.5 and 21 for Non-Medicare members aged 65+ and Medicare members ○ 12-month future Inpatient Stay probability is between 90th and 99th percentiles (30% and 70%) ○ 3-month future Inpatient Stay probability is between 90th and 99th percentiles (10% and 33%) ○ 1 or more behavioral health Inpatient Stays in the last 12 months ○ 1 or more behavioral health Observation Stays in the last 12 months ○ 1 or more behavioral health Emergency Department visits in the last 12 months ○ 1 or more *Medication Adherence Gaps* ○ 1 or more '*Clinically Important' Care Opportunities* AND were enrolled for at least 6 months ○ 1 or more *Drug Safety Care Opportunities* AND who did NOT trigger any of the following Pop Health registries: ○ * 06: Pop Health Cat: High Risk ○ * 07a: Pop Health Cat: Rare High Cost Condition - Stable ○ * 07b: Pop Health Cat: Rare High Cost Condition - At Risk ○ * 08a: Pop Health Cat: Complex – Dialysis ○ * 08b: Pop Health Cat: Complex – Cancer ○ * 08c: Pop Health Cat: Complex – Transplant ○ * 09a: Pop Health Cat: Dementia ○ * 09b: Pop Health Cat: Institutional Custodial Care ○ * 10: Pop Health Cat: End of Life
• 06: Pop Health Cat: High Risk	Members who met one or more of the following criteria: ○ At least one 12-month future total Healthcare Expenditure risk score > 99th percentile: ▪ Greater than 8 for ages Non-Medicare members aged 0-64 ▪ Greater than 21 for Non-Medicare members aged 65+ and Medicare members ○ 12-month future Inpatient Stay probability is > 99th percentile (70%) ○ 3-month future Inpatient Stay probability is > 99th percentile (33%) AND

Deleted: 1 or more episodes of care indicating active cancer treatment in the most recent 12 months¶
¶
AND NOT in any of the following categories:¶
07c: Catastrophic: Transplant¶
08a: Dementia¶
08b: Institutional (custodial care)¶
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination¶
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management¶
10: EOL

Deleted: Level 07c: Catastrophic Transplants

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	who did NOT trigger any of the following Pop Health registries: o * 07a: Pop Health Cat: Rare High Cost Condition - Stable o * 07b: Pop Health Cat: Rare High Cost Condition - At Risk o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life
07a: Pop Health Cat: Rare High Cost Condition – Stable	Members who had an ETG episode or diagnosis for a rare, high cost condition in the last 3 years AND who did NOT have a rare condition-specific Inpatient Stay in the last 12 months AND who did NOT have a rare condition-specific Observation Stay in the last 12 months AND who did NOT have a rare condition-specific Emergency Department visit in the last 12 months AND who did NOT have a *Medication Adherence Gap* AND who did NOT have a '*Clinically Important' Care Opportunity* AND were enrolled for at least 6 months AND who did NOT trigger a *Drug Safety Care Opportunity* AND who did NOT trigger any of the following Pop Health registries: o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care * 10: Pop Health Cat: End of Life
07b: Pop Health Cat: Rare High Cost Condition - At Risk	Members who had an ETG episode or diagnosis for a rare, high cost condition in the last 3 years AND

Deleted: 1 or more of the following transplants in the most recent 12 months:
Bone Marrow
Heart
Liver
Lung
Pancreas
Renal

AND NOT in any of the following categories:
08a: Dementia
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
10: EOL

Deleted: Level 08a: Dementia

Deleted: 2 or more claims indicating dementia in the most recent 12 months

AND NOT in any of the following categories:
08b: Institutional (custodial care)
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
10: EOL

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	who met one or more of the following criteria: o 1 or more rare condition-specific Inpatient Stays in the last 12 months o 1 or more rare condition-specific Observation Stays in the last 12 months o 1 or more rare condition-specific Emergency Department visits in the last 12 months o 1 or more *Medication Adherence Gaps* o 1 or more '*Clinically Important' Care Opportunities* AND were enrolled for at least 6 months o 1 or more *Drug Safety Care Opportunities* AND who did NOT trigger any of the following Pop Health registries: o * 08a: Pop Health Cat: Complex – Dialysis o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life
08a: Pop Health Cat: Complex – Dialysis	Members who had a procedure or revenue code indicating a dialysis service in the last 12 months AND who did NOT trigger any of the following Pop Health registries: o * 08b: Pop Health Cat: Complex – Cancer o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life
08b: Pop Health Cat: Complex – Cancer	Members who had an ETG episode for cancer in the last 12 months AND who did NOT trigger any of the following Pop Health registries: o * 08c: Pop Health Cat: Complex – Transplant o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life

Deleted: 1 or more claims with a place of service code=33 (Custodial Care Facility)¶
¶
AND NOT in any of the following categories:¶
09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination¶
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management¶
10: EOL

Deleted: Level 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination

Deleted: Includes Members that meet *one* or more of the criteria below:¶
Be enrolled in an LTC or MMP product, that do not have a high-needs condition¶
¶
AND NOT in:¶
09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management

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08c: Pop Health Cat: Complex – Transplant	Members who had a procedure code indicating one of the following transplants in the last 12 months o Bone Marrow o Heart o Liver o Lung o Pancreas o Renal AND who did NOT trigger any of the following Pop Health registries: o * 09a: Pop Health Cat: Dementia o * 09b: Pop Health Cat: Institutional Custodial Care o * 10: Pop Health Cat: End of Life

References

Oversight	Reference	Cross Reference
DHCS	APL 22-024	
NCQA	PHM.1.A.1	Four Focus Areas
	PHM.1.A.2	Focus Areas Programs or Services Offered
	PHM.1.A.3	Activities Which Support PHM Programs and Services
	PHM.1.A.4	Coordination of Member programs
	PHM.1.A.5	Informing Members about Available PHM Programs
	PHM.1.A.6	Basic Population Health Management (BPHM) (Health Equity Improvement Model)
	PHM.1.B	Informing Members about PHM Programs – Interactive Contact
	PHM.2.A	Population Stratification
	PHM.2.B	Population Needs Assessment (PNA)
	PHM.2.C	PNA Activities
	PHM.2.D	Population Stratification, Focus Areas
	PHM.3.A	Activities Which Support PHM Programs and Services

Deleted: Includes Members that meet *one* or more of the criteria below:¶
Be currently enrolled in at least one of the LTSS/MMP products ¶
1 or more claims in the last 12 months with any of the following diagnoses in any position ¶
Traumatic Brain Injury (TBI)¶
Cystic Fibrosis¶
Multiple Sclerosis¶
Hip or Pelvic Fracture¶
Ulcers¶
Spinal Cord Injury¶
Acute Myocardial Infarction (AMI)¶
Muscular Dystrophy¶
Learning Disabilities¶
Spina Bifida¶
Fibromyalgia¶
Intellectual Disabilities¶
Other Developmental Delays¶
Migraine¶
¶
Please refer to attachment for a list of diagnosis codes ... [4]

Deleted: Level 10: End of Life (Non-LTSS)

Deleted: Includes Members that meet one or more of the criteria below:¶ ... [5]

Deleted: Focus Areas

Deleted: Focus Areas

Deleted: Activities Which Support PHM Programs and Services

Deleted: Coordination of Member programs

Deleted: Informing Members about Available PHM Programs

Deleted: Basic Population Health Management (BPHM)

Deleted: Informing Members about PHM Programs – Interactive Contact

Deleted: Population Stratification

Deleted: Population Needs Assessment (PNA)

Deleted: PNA Activities

Deleted: Population Stratification

Deleted: Focus Areas

Deleted: Activities Which Support PHM Programs and Services

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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

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Item #13

Attachment 13.A-B

Long Term Care

A. 2026 Long Term Care Quality Assurance Performance Improvement Plan
B. Skilled Nursing Facility Quality Assurance Performance Improvement Q4 2025 Report

CalViva Health Long Term Care

Quality Assurance and Performance Improvement (QAPI) Plan

April 2026

CalViva Health Long Term Care

Quality Assurance and Performance Improvement (QAPI) Plan

April 2026

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 a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan and is designated as the Local Initiative.

CalViva has an Administrative Services Agreement and a Capitated Provider Services Agreement with Health Net Community Solutions, also an NCQA accredited Medi-Cal managed care plan, for the provision of health care services to CalViva members through Health Net's network of contracted providers, including Skilled Nursing Facilities (SNFs). Unless otherwise specified, for purposes of this Quality Assurance & Performance Improvement (QAPI) program, the terms "CalViva" or "The Plan" will also include Health Net.

CalViva must ensure that Members in need of SNF services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, as outlined in the managed care plan (MCP) contract with the Department of Healthcare Services (DHCS). CalViva covers all medically necessary services for Medi-Cal managed care Members residing in or obtaining care in a SNF including facility services, professional services, ancillary services and the appropriate level of care coordination, including carved-out Medi-Cal services.

In developing this QAPI program for Long Term Care (LTC), CalViva has included the entire network of SNFs accessible to its members, encompassing facilities both within and outside its designated service area. This comprehensive approach ensures that the dashboard reflects all SNFs where CalViva members have received care, providing a more complete picture of long-term care services and facilitating informed decision-making to enhance member outcomes.

Element 1: Design and Scope

CalViva's QAPI program is ongoing and comprehensive, designed to address the full continuum of long-term care services offered to Members. It integrates data-driven strategies with a commitment to improving clinical care, enhancing quality of life, and honoring resident choice and autonomy. The Plan collects and integrates data from internal claims systems and publicly available sources to ensure decisions are based on the best available information.

The QAPI program incorporates data and information from the following:

- Contracted SNFs QAPI programs, which must include the five key elements identified by CMS (when available).
- Claims data for SNF residents, including but not limited to emergency room and inpatient admissions to capture healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- DHCS supplied WQIP data will be included.
- Publicly available data allows the Plan to identify trends cited by the California Department of Public Health (CDPH) during recertification surveys. With a focus on clinical, quality and freedom metrics as defined by Title 22 and Title 42, the Plan's analytics team will download the publicly available data and update our QAPI dashboard on a quarterly basis.
- Processes will be established to assess the quality and appropriateness of care provided to Members using Long Term Services and Support (LTSS), including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan.
- Efforts supporting Member community integration.
- DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents.
- Clinical and quality goals are measured against established benchmarks, (Title 22/42 standards, CMS quality standards, and other relevant metrics).

Key staff representing LTSS, Population Health, Utilization Management, Transitional Care Services, Provider Engagement and Ancillary Contracting collaborate to update our QAPI dashboard at least **quarterly**. This dashboard supports targeted outreach to SNFs needing performance improvement and informs initiatives that promote safety, reduce preventable events, and align with members' preferences and goals of care.

The Plan works closely with SNF partners, the LTC Ombudsman, and CBOs to ensure transparency and stakeholder engagement in quality improvement efforts. Through this comprehensive approach, the QAPI program drives sustained improvement in the delivery of safe, high-quality, person-centered long-term care.

CalViva will identify opportunities, implement actions, and sustain improvements through a structured QAPI process grounded in both internal claims' analytics and publicly available regulatory data. Opportunities for improvement may be identified

through patterns or trends in emergency department utilization, acute inpatient admissions, or preventable readmissions. Opportunities may also be identified through resident/representative grievances or complaints as well as CDPH survey findings, including citations related to infection control, staffing, and abuse or neglect.

With a focus on clinical care, quality indicators, and resident rights, the Plan's analytics team updates the QAPI dashboard on a quarterly basis. This dashboard is reviewed by a multidisciplinary team, including LTSS, Utilization Management, Medical Management, Transitional Care, and Quality Improvement, to identify and prioritize areas for improvement.

Once improvement areas are identified, targeted Performance Improvement Projects (PIPs) are developed following a quality improvement methodology, such as Plan-Do-Study-Act (PDSA) or similar approach. As directed by the DHCS, formal PIPs or other less formal improvement projects will be initiated. These projects are supported by designated leaders and involve direct engagement with SNFs, the LTC Ombudsman, and CBOs to ensure meaningful collaboration and stakeholder input.

Interventions will be implemented and monitored to assess their effectiveness and adjustments made to these interventions based upon these results. Routine monitoring will continue on an ongoing basis to evaluate for sustained improvement and to identify new opportunities for improvement. The QAPI process is ongoing and designed to promote long-term, evidence-based improvements in member care and facility performance.

Element 2: Governance and Leadership

The RHA Commission has overall responsibility for oversight of CalViva's LTC program and delegates responsibility for Quality Improvement activities to the CalViva Quality Improvement/Utilization Management (QI/UM) Committee members who actively support LTC quality improvement through oversight of the QAPI strategy, regular review of the QAPI program findings, and integration of improvement activities into organizational performance improvement priorities. LTC quality is included in the QI/UM Committee reporting cycle as reflected in the Report Inventory (matrix), ensuring leadership visibility and accountability.

While SNFs are not required to share their internal QAPI committee documentation, the Plan collaborates closely with SNF partners, the LTC Ombudsman, and CBOs to incorporate provider-level insights into root cause analyses, trending reviews, and performance interventions. Member and family perspectives are integrated through grievances (health plan or SNF reported) and appeal reviews, case management notes, and satisfaction data. Results and findings are regularly reported per the Report Inventory (matrix) to the Access Workgroup and QI/UM Committee.

The Plan has a designated LTSS liaison accountable for the ongoing training, development and maintenance of the QAPI dashboard who will take the lead on

outreach to SNFs, SNF management entities, the LTC Ombudsman and the California Association of Health Facilities for quality related efforts. Outcome trends are tracked and shared with SNFs as appropriate, and when patterns of concern emerge, the Plan engages in collaborative problem-solving and may offer technical assistance or contract management support. The Plan's Liaison will work with SNF's on root cause analyses and problem solving as necessary. The Plan will be transparent in sharing available information to support quality. The Plan's provider SNFs will not be required to share their confidential Quality Assurance documents.

The RHA Commission provides oversight and ensures adequate resources are allocated to support the effective implementation of the QAPI program. This includes investment in staff capacity, data systems, training infrastructure, and quality analytics to ensure the program meets regulatory and clinical performance expectations.

Element 3: Feedback, Data Systems, and Monitoring

The Plan puts systems in place to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

The systems and data sources used include but are not limited to, claims data, used to monitor care including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions. Adverse events / critical incidents may also be identified through resident/representative grievances or complaints as well as CDPH survey findings, including citations related to infection control, staffing, and abuse or neglect. The Plan ensures appropriate investigation has occurred and actions implemented to prevent future such occurrences when they are identified.

The Plan employs a comprehensive monitoring system that integrates multiple data sources to oversee the quality of care and services provided to members in long-term care settings. This system includes:

- **Claims Data Analysis**: The Plan analyzes claims data to monitor emergency department utilization, acute inpatient admissions for preventable conditions, healthcare-associated infections requiring hospitalization, and potentially preventable readmissions.
- **Publicly Available Data**: The Plan utilizes data from Title 22 and Title 42 survey metrics to assess areas such as infection control, abuse, staffing levels, and other quality indicators.

- **Performance Indicators**: CalViva will report on the LTC measures within the Managed Care Accountability Set (MCAS) of performance measures. Rates will be calculated for each MCAS LTC measure for each SNF within the CalViva Network for each reporting unit (county).
- **Adverse Events and Critical Incidents**: The Plan has a process in place to track, investigate, and monitor adverse events and critical incidents. Each event is thoroughly investigated, and action plans are implemented to prevent recurrence. The Potential Quality Issue (PQI) reporting system encourages staff and providers at all levels to report potential or suspected deviations from expected performance or clinical outcome which cannot be determined or justified without additional evaluation and review. PQIs may be confidentially reported through the Plan's PQI referral process. PQIs are investigated, tracked and clinically evaluated. Appropriate actions are taken with follow-up as indicated to improve future care. Title 22 and Title 42 survey metrics can also identify adverse events and critical incidents.
- **Stakeholder Feedback**: Feedback from staff, residents, families, and other stakeholders is actively sought and incorporated into our quality improvement initiatives.

Element 4: Performance Improvement Projects (PIPs)

Opportunities for improvement are generally identified through ongoing monitoring activities (dashboard) or by assignment, from DHCS, with at least two (2) Performance Improvement Projects (PIPs) in progress for the organization on an annual basis. PIPs may be clinically or non-clinically focused. Other more short-term improvement projects following the Rapid Cycle Improvement process may also be initiated or assigned. The Plan may collaborate with targeted facilities to ~~may~~ implement interventions and monitor improvement to assess the effectiveness of performance improvement plans. Necessary adjustments will be made based on these results.

As directed by DHCS, formal Performance Improvement Projects (PIPs) or other less formal improvement projects will be initiated. These projects are supported by designated leads and involve direct engagement with SNFs, the LTC Ombudsman, and CBOs to ensure meaningful collaboration and stakeholder input.

~~Interventions will be implemented and monitored to assess their effectiveness and adjustments made to these interventions based upon these results.~~ Routine monitoring will continue on an ongoing basis to evaluate for sustained improvement and to identify new opportunities for improvement.

Element 5: Systemic Analysis and Systemic Action

The Plan employs a structured, data-driven approach to identify performance trends, prioritize improvement efforts, and support sustainable quality across its SNF network. Using the QAPI dashboard, the Plan systematically monitors key quality indicators, including outcomes from CDPH certification and recertification surveys, claims-based

metrics, Title 22/42 survey data, Potential Quality Issues (PQIs), and critical incident reports.

The Plan focuses on identifying systemic patterns in areas such as infection control, abuse prevention, staffing adequacy, falls, pressure injuries, medication errors, and other adverse events that impact member health and safety. Key metrics are reviewed quarterly by the QI/UM Committee to ensure comprehensive oversight and informed decision-making.

When performance concerns are identified, especially among lower-performing SNFs across the service area, the Plan engages in proactive root cause analyses and collaborates directly with SNFs to develop targeted improvement strategies. Support may include sharing comparative performance data, offering technical assistance, and providing education on evidence-based best practices.

Corrective actions are implemented, monitored, and adjusted as needed to ensure effectiveness and foster sustained improvement. The Plan remains committed to transparency, accountability, and partnership in driving quality outcomes.

CalViva submits annual QAPI program reports to DHCS, including outcome data, trending analysis, and descriptions of performance improvement initiatives, demonstrating adherence to regulatory expectations and continuous quality advancement.

Element 6: Additional Information

~~*Continuity of Care for SNF Placement*~~

Per APL 22-032, Continuity of Care protections do not extend to certain~~all~~ ancillary providers, including Long Term Care.

~~The Plan ensures robust continuity of care for Members residing in SNFs during their transition from Medi-Cal Fee-for-Service (FFS) to Medi-Cal Managed Care. The Plan guarantees an automatic 12-month continuity period for existing SNF placements, with the ability for Members or their authorized representatives to request an additional 12-month extension when continuity needs persist. To ensure transparency and protect member rights, the Plan provides clear, timely, and culturally appropriate written notifications to Members, their authorized representatives, and SNFs regarding continuity of care rights, eligibility criteria, extension options, and denial reasons in accordance with APL 23-022.~~

~~In collaboration with SNF partners, the LTC Ombudsman and CBOs, the Plan proactively facilitates continuity discussions and care transitions to ensure that members experience minimal disruption in care. Care coordination activities emphasize member choice, provider engagement, and timely transition planning supported by the Plan's care management teams.~~

Community Integration

CalViva implements a robust Population Health Management (PHM) Program designed to ensure that long-term care Members receive a comprehensive set of services aligned with their clinical and social needs. This includes integration of Behavioral Health Management (BHM), Transitional Care Services (TCS), care management programs, and Community Supports to promote stable placement, health improvement, and independence where possible. The PHM approach emphasizes whole-person care by addressing both medical and social determinants of health and prioritizing member engagement, cultural responsiveness, and shared decision-making.

To facilitate successful community integration, the Plan identifies Members appropriate for transition to lower levels of care, supports interdisciplinary care team engagement, and leverages community-based services to address housing, transportation, nutrition, and social support needs.

Additional Policies

Performance improvement activities described within this Plan are coordinated with CalViva's broader Quality Improvement Program and are supported by applicable SNF-related policies:

- QI-005 Quality Improvement and Health Equity Transformation Program
- QI-014 Potential Quality Issue (PQI) Management Process
- AG-001 Member Grievance Process
- AG-002 Member Appeal Process
- UM-011 Long Term Care
- UM-012 Discharge Planning
- UM-014 Long Term Care Transition to Managed Care
- UM-015 Management of Enrollees in Subacute Long-Term Care
- UM-065 Skilled Nursing Facilities
- UM-103 Continuity of Care
- FN-107 Skilled Nursing Facility Workforce Quality Incentive Program
- PH-062 Non-Emergency-Non-Medical Transportation Assistance Coordination
- CMP-107 Care Coordination / Case Management Services
- CMP-109 Transition of Care Services

Fresno-Kings-Madera Regional Health Authority Approval

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

_________________________________ _______________

David Hodge, MD, Fresno County Date

Regional Health Authority Commission Chairperson

_________________________________ _______________

Patrick Marabella, MD, Chief Medical Officer Date

Chair, CalViva Health QIUM Committee

Attachment

REPORT SUMMARY TO COMMITTEE

TO: CalViva QI/UM Committee

FROM: Edward Mariscal, Director, Population Health Strategy
Population Health & Clinical Operations

COMMITTEE DATE: May 21, 2026

SUBJECT: Skilled Nursing Facility (SNF) Quality Assurance Performance Improvement (QAPI) Program – Q4 2025

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

There are 36 licensed SNFs in the CalViva Health designated service area. In 2025, CalViva Health Members admitted to 90 different nursing homes statewide.

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

	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Fresno	870	844	825	806	825	819	822	826	812	837	830	805
Kings	104	99	99	101	104	111	108	113	118	115	110	103
Madera	95	88	100	98	96	93	98	97	91	95	101	95
Other*	62	58	47	47	47	42	42	41	37	37	43	42
Total	1,131	1,089	1,071	1,052	1,072	1,065	1,070	1,077	1,058	1,084	1,084	1,045

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

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

SNF	Unique Members	SNF	Unique Members
1. Madera Rehabilitation	64	6. Sunnyside Convalescent Hospital	54
2. Community Subacute	64	7. Sierra Vista Healthcare	51
3. Healthcare Centre of Fresno	63	8. Fresno Post Acute Care	49
4. Centerpointe Care Center	61	9. Manning Gardens Care Center	49
5. Hanford Post Acute	58	10. Cornerstone Care Center	45

The Top 5 Performing SNFs

The top 5 performing SNFs serving CalViva Health members are:

Q1 2025	Q2 2025	Q3 2025	Q4 2025
1. Selma Convalescent	1. California Home for Aged	1. California Home for Aged	1. Fowler Care Center
2. California Home for the Aged	2. Selma Convalescent	2. Selma Convalescent	2. Selma Convalescent
3. Oakwood Gardens Care Center	3. The Terraces	3. The Terraces	3. The Terraces
4. Willow Creek Healthcare	4. Valley Healthcare Center	4. Dycora Trans - Fowler	4. Horizon Health
5. The Terraces	5. Dycora Trans - Sanger	5. Dycora Trans - Sanger	5. Dycora Trans - Clovis

The Bottom 5 Performing SNFs

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

Q1 2025	Q2 2025	Q3 2025	Q4 2025
1. Healthcare Centre of Fresno	1. Madera Rehabilitation	1. Madera Rehabilitation	1. Oakhurst Healthcare
2. Kingsburg Center	2. Manning Gardens Care	2. Manning Gardens Care	2. Dycora Trans – Fresno
3. Manning Gardens Care	3. Healthcare Centre of Fresno	3. Hanford Post Acute	3. Madera Rehab
4. Rolling Hills Care Center	4. Kingsburg Center	4. Healthcare Centre Fresno	4. Kingsburg Center
5. Madera Rehabilitation	5. Sunnyside Convalescent	5. Oakhurst Healthcare	5. Hanford Post Acute

Avoidable Emergency Department Visits in Q4 2025

In Q4 2025, CalViva had 558 unique members in the top 10 utilizing SNFs. In Q4 2025, those 558 members had **24** avoidable Emergency Department Visits.

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

Avoidable Acute In-patient Admissions in Q4 2025

In Q4 2025, CalViva had 558 unique members in the top 10 utilizing SNFs. There were 4**7** avoidable Acute In-patient admissions during that same time.

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

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

Purpose of Activity:

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

Methodology

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

CalViva Health's comprehensive QAPI program incorporates the following:

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

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

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

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

Table 2 – Q4 2025 Overall Top Performing SNFs in CalViva Health Region based on a weighted 5-point scale using metrics in Summary

Overall Quality Score - Top Ranked	
Skilled Nursing Facility	**Quality Score**
Fowler Care Center	4.65
Selma Convalescent Hospital	4.47
The Terraces at San Joaquin Gardens Village	4.43
Horizon Health & Subacute Center	4.43
Dycora Transitional Health – Clovis	4.32
North Pointe Healthcare Centre	4.30

Valley Healthcare Center	4.16
Oakwood Gardens Care Center	4.16
Kings Nursing & Rehabilitation Center	4.08
Avalon Health Care - Madera	4.03

Source: Publically available data, claims data

Note: Top ranked SNFs saw quarter over quarter improvement in overall quality scores from an average of 4.2 in Q3 2025 to an average of 4.3 in Q4 2025. Fowler Care Center improved .54 points to take the top rank.

Table 3 – Q4 2025 Overall Bottom Performing SNFs in CalViva Health Region based on a weighted 5-point scale using metrics in Summary

Overall Quality Score - Bottom Ranked	
Skilled Nursing Facility	**Quality Score**
Dycora Transitional Health – Community Care	3.58
Sunnyside Convalescent Hospital	3.43
Willow Creek Healthcare Center	3.40
Sierra Vista Healthcare	3.25
Hanford Post Acute	3.24
Coalinga Regional Medical Center D/P	2.89
Kingsburg Center	2.76
Madera Rehabilitation & Nursing Center	2.71
Dycora Transitional Health Memory Care of Fresno	2.69
Oakhurst Healthcare Center	2.56

Source: Publically available data, claims data

Note: Bottom ranked SNFs saw a quarter over quarter improvement in overall quality scores from an average of 3.01 in Q3 2025 to an average of 3.05 in Q4 2025.

Table 4 – SNFs with low rate of preventable Emergency Department visits Q1 Q2 Q3 Q4 2025 comparison

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q3 2025 Unique Mbrs	Q4 2025 Unique Mbrs	Q1 2025 ER Avoid	Q2 2025 ER Avoid	Q3 2025 ER Avoid	Q4 2025 ER Avoid
Centerpointe Care Center	53	53	49	61	1	0	0	4
Brighton Post Acute	45	46	41	43	0	0	0	0
Willow Creek Healthcare	40	38	40	44	1	0	0	2
Kingsburg Center	37	37	37	44	3	0	1	8
Kings Healthcare & Wellness	26	26	26	32	0	0	0	2

Source: claims data

Table 5 – SNFs with high rate of preventable Emergency Department visits Q1 Q2 Q3 Q4 2025 comparison

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q3 2025 Unique Mbrs	Q4 2025 Unique Mbrs	Q1 2025 ER Avoid	Q2 2025 ER Avoid	Q3 2025 ER Avoid	Q4 2025 ER Avoid
Manning Gardens Care Center	52	54	46	49	8	6	6	13

Madera Rehabilitation	73	70	65	64	4	4	3	6
Community Subacute	59	66	58	64	2	4	0	4
Cornerstone Care Center	38	50	34	45	0	4	2	2
Sierra Vista Healthcare	32	33	32	51	2	4	1	6

Source: claims data

Table 6 – SNFs with low rate of preventable Acute Inpatient Admissions Q1 Q2 Q3 Q4 2025 comparison

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q3 2025 Unique Mbrs	Q4 2025 Unique Mbrs	Q1 2025 IP Avoidable	Q2 2025 IP Avoidable	Q3 2025 IP Avoidable	Q4 2025 IP Avoidable
Fresno Post Acute Care	46	46	48	49	0	0	0	4
Palm Village Retirement	33	33	22	33	1	0	0	0
Vineyard Care Center	22	20	19	5	1	0	3	1
Gateway Care Center	21	19	18	17	0	0	0	2
North Point Healthcare	26	27	28	27	1	1	0	0

Source: claims data

Table 7 – SNFs with highest rate of preventable Acute Inpatient Admissions per CalViva Health member Q1 Q2 Q3 2025 comparison

SNF Name	Q1 2025 Unique Mbrs	Q2 2025 Unique Mbrs	Q3 2025 Unique Mbrs	Q4 2025 Unique Mbrs	Q1 2025 IP Avoidable	Q2 2025 IP Avoidable	Q3 2025 IP Avoidable	Q4 2025 IP Avoidable
Community Subacute	59	66	58	64	3	8	3	4
Manning Gardens Care	52	54	46	49	16	8	10	13
Cornerstone Care Center	38	50	34	45	2	5	3	2
Healthcare Center of Fresno	52	60	65	63	5	4	1	4
Oakwood Gardens Care	35	37	26	40	7	4	0	1

Source: claims data

Table 8 – 2024 SNF Workforce Quality Incentive Program (WQIP) Quality Score

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

Source: DHCS Scoring Report – 2025 Quality Scores pending

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

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

Analysis/Findings/Outcomes:

The following 3 SNFs have the highest rates of preventable ED utilization and Acute Inpatient Admissions in Q4 2025, and oversight will continue through the end of 2026:

- Manning Gardens Care Center (managed by Cambridge Health)
- Kingsburg Center (managed by NewGen)
- Community Subacute & Transitional

Manning Gardens Care Center

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

- Hydration Rounds – Daily, starting 9/1/25, dedicated staff will monitor availability and consumption of water
    - Hydration Rounds continue daily, all shifts
- Pharmacy Education – Anti-Psychotic Utilization education held in Q4
    - In-service conducted on November 4 – all shifts
- **Management of Behavioral Health**
    - Psychiatrist-led in-service of all staff held in Q1 2026

Kingsburg Center

Analysis of the publically available data shows this SNF has higher than the State average rates of Falls, development of new wounds/ulcers and UTI. The Health Plan has shared with Kingsburg Center's leadership member-level detail for additional investigation and targeted training. The SNF is implementing the following to improve their quality outcomes:

- Hydration Rounds – Daily, starting 3/1/26, dedicated staff will monitor availability and consumption of water
    - Hydration Rounds continue daily, all shifts
- Repositioning Training and In-Services
    - Hosted during various shifts in March 2026, the Director of Staff Development and the Wound Care nurse provided training and education on repositioning, wound care and techniques to relieve pressure.
    - Arrangements will be made in Q2 for a Wound Care Specialist physician to provide wound care and pressure sore in-service to the licensed and clinical staff at Kingsburg.
- Physical Therapy Team making rounds to ensure all Walkers are properly measured – Starting 03/01/2026
    - Rounds being conducted 2-times per month
    - All new admits are assessed by Physical Therapy within 48 hours of admission

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

- Hydration Rounds – Daily, starting 9/1/25, dedicated staff will monitor availability and consumption of water
    - Hydration Rounds continue daily, all shifts
- Physical Therapy Team to provide staff caregiver training on safe patient repositioning skills - Starting 9/1/25
    - Rounds being conducted 2-times per month
    - All new admits are assessed by Physical Therapy within 48 hours of admission

Barrier Analysis:

- Staffing Challenges in Central Valley
    - Multiple SNFs reporting challenges with recruiting and retention of Certified Nursing Assistants – Immigration enforcement in the community caused fear. Immigrant CNAs stopped showing up for work. Additionally, Fresno Adult School and Pacific Health Education have reported a drop in enrollment in their CNA programs. Nursing Homes and their associations are working to develop strategies to train staff for certified nursing assistant positions.
- Acute hospital psychiatric evaluations
    - Patients showing behavioral health needs/episodes in acute care are not assessed or evaluated by the acute psychiatric physicians.

Actions Taken/Next Steps:

Manning Gardens

- Education on Psychotropic medication use for licensed staff to ensure safe and effective treatment, understanding risks, benefits, proper administration and monitoring of side effects. Training includes obtaining informed consent, establishing clear treatment goals, regular monitoring and review, open communication with families, providers and staff, avoiding abrupt discontinuation and recognizing the need for comprehensive mental health care. In-services hosted on November 4 and March 18.
- Psychiatric in-service hosted on March 3 and follow-up in-service scheduled for Q2.

Kingsburg Center

- Next step includes in-person meeting with NewGen leadership scheduled for May 14.

Community Subacute & Transitional

- Ongoing Hydration Rounds, starting 9/1/25. Hydration programs are essential in nursing homes to prevent serious health consequences like falls and infections. Additionally, hydration programs improve resident well-being, cognitive function and physical independence. Regular, targeted fluid intake is crucial because seniors often experience a reduced sense of thirst and may be at higher risk for dehydration due to factors like immobility, incontinence and certain medications. A good

hydration program involves identifying risk factors, creating personalized care plans with measurable goals and using various interventions, such as providing fluids with meals, offering water-rich foods and placing drinks in convenient locations.

Item #14

Attachment 14.A-B

Financials

A. Financials as of March 31, 2026
B. FY 2027 Proposed Budget

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of March 31, 2026

			Total
1	ASSETS		
2	Current Assets		
3	Bank Accounts		
4	Cash & Cash Equivalents		511,694,539.37
5	Total Bank Accounts	$	**511,694,539.37**
6	Accounts Receivable		
7	Accounts Receivable		207,298,731.26
8	Total Accounts Receivable	$	**207,298,731.26**
9	Other Current Assets		
10	Interest Receivable		1,099,901.47
11	Investments - CDs		0.00
12	Prepaid Expenses		652,334.39
13	Security Deposit		0.00
14	Total Other Current Assets	$	**1,752,235.86**
15	Total Current Assets	$	**720,745,506.49**
16	Fixed Assets		
17	Buildings		5,611,974.33
18	Computers & Software		3,111.09
19	Construction in Progress		0.00
20	Land		3,161,419.10
21	Office Furniture & Equipment		119,745.79
22	Total Fixed Assets	$	**8,896,250.31**
23	Other Assets		
24	Investment -Restricted		304,526.74
25	Lease Receivable		2,615,525.14
26	Total Other Assets	$	**2,920,051.88**
27	TOTAL ASSETS	$	**732,561,808.68**
28	LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY		
29	Liabilities		
30	Current Liabilities		
31	Accounts Payable		
32	Accounts Payable		114,391.79
33	Accrued Admin Service Fee		4,615,644.00
34	Capitation Payable		134,462,515.11
35	Claims Payable		50,489.58
36	Directed Payment Payable		164,493,015.86
37	Total Accounts Payable	$	**303,736,056.34**
38	Other Current Liabilities		
39	Accrued Expenses		1,611,482.33
40	Accrued Payroll		189,817.49
41	Accrued Vacation Pay		513,843.00
42	Amt Due to DHCS		33,295,555.66
43	IBNR		327,903.91
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		188,375,000.00
48	Total Other Current Liabilities	$	**224,639,006.67**
49	Total Current Liabilities	$	**528,375,063.01**
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	$	**528,418,991.30**
55	Deferred Inflow of Resources		2,199,094.23
56	Equity		
57	Retained Earnings		184,108,458.37
58	Net Income		17,835,264.78
59	Total Equity	$	**201,943,723.15**
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$	**732,561,808.68**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2025 - March 2026 Income Statement

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	**Interest Income**	7,299,045.31	3,950,000.00	3,349,045.31
3	**Premium/Capitation Income**	1,767,426,487.40	1,524,825,339.00	242,601,148.40
4	**Total Income**	**1,774,725,532.71**	**1,528,775,339.00**	**245,950,193.71**
5	**Cost of Medical Care**			
6	**Capitation - Medical Costs**	1,135,084,791.72	900,170,191.00	234,914,600.72
7	**Medical Claim Costs**	4,054,459.59	4,950,000.00	(895,540.41)
8	**Total Costs of Medical Care**	**1,139,139,251.31**	**905,120,191.00**	**234,019,060.31**
9	**Gross Margin**	**635,586,281.40**	**623,655,148.00**	**11,931,133.40**
10	**Expenses**			
11	**Admin Service Agreement Fees**	42,286,662.00	39,667,518.00	2,619,144.00
12	**Bank Charges**	0.00	5,400.00	(5,400.00)
13	**Computer & IT Services**	150,491.58	203,344.00	(52,852.42)
14	**Consulting & Accreditation Fees**	120,940.07	408,749.00	(287,808.93)
15	**Depreciation Expense**	260,602.70	279,000.00	(18,397.30)
16	**Dues & Subscriptions**	195,947.68	243,000.00	(47,052.32)
17	**Grants (Community Reinvestment)**	3,522,800.62	3,707,546.00	(184,745.38)
18	**Insurance**	296,469.62	364,396.00	(67,926.38)
19	**Labor**	3,531,118.23	4,074,088.00	(542,969.77)
20	**Legal & Professional Fees**	135,451.68	280,876.00	(145,424.32)
21	**License Expense**	965,345.13	1,335,636.00	(370,290.87)
22	**Marketing**	1,237,279.05	1,245,000.00	(7,720.95)
23	**Meals and Entertainment**	18,561.63	25,250.00	(6,688.37)
24	**Office Expenses**	77,991.56	93,749.00	(15,757.44)
25	**Parking**	275.79	1,170.00	(894.21)
26	**Postage & Delivery**	1,386.90	3,690.00	(2,303.10)
27	**Printing & Reproduction**	695.61	4,126.00	(3,430.39)
28	**Recruitment Expense**	46,566.31	129,375.00	(82,808.69)
29	**Rent**	0.00	9,000.00	(9,000.00)
30	**Seminars & Training**	5,587.64	25,600.00	(20,012.36)
31	**Supplies**	10,854.97	11,250.00	(395.03)
32	**Taxes**	565,125,000.00	565,125,000.00	0.00
33	**Telephone & Internet**	15,659.82	36,000.00	(20,340.18)
34	**Travel**	17,954.46	23,200.00	(5,245.54)
35	**Total Expenses**	**618,023,643.05**	**617,301,963.00**	**721,680.05**
36	**Net Operating Income**	**17,562,638.35**	**6,353,185.00**	**11,209,453.35**
37	**Other Income**			
38	**Other Income**	272,626.43	266,617.00	6,009.43
39	**Total Other Income**	**272,626.43**	**266,617.00**	**6,009.43**
40	**Net Other Income**	**272,626.43**	**266,617.00**	**6,009.43**
41	**Net Income**	**17,835,264.78**	**6,619,802.00**	**11,215,462.78**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

July 2025 - March 2026 vs July 2024 - March 2025 Income Statement

		Total	
		July 2025 - March 2026 (Current Year)	July 2024 - March 2025 (Prior Year)
1	Income		
2	Interest Income	7,299,045.31	9,112,944.89
3	Premium/Capitation Income	1,767,426,487.40	1,750,349,987.52
4	Total Income	$ 1,774,725,532.71	$ 1,759,462,932.41
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,135,084,791.72	1,025,653,788.61
7	Medical Claim Costs	4,054,459.59	5,488,711.90
8	Total Costs of Medical Care	$ 1,139,139,251.31	$ 1,031,142,500.51
9	Gross Margin	$ 635,586,281.40	$ 728,320,431.90
10	Expenses		
11	Admin Service Agreement Fees	42,286,662.00	43,068,124.00
12	Computer & IT Services	150,491.58	116,693.36
13	Consulting & Accreditation Fees	120,940.07	44,313.00
14	Depreciation Expense	260,602.70	255,004.66
15	Dues & Subscriptions	195,947.68	180,775.48
16	Grants (Community Reinvestment)	3,522,800.62	3,476,321.77
17	Insurance	296,469.62	264,155.32
18	Labor	3,531,118.23	3,191,841.14
19	Legal & Professional Fees	135,451.68	130,613.09
20	License Expense	965,345.13	1,115,489.04
21	Marketing	1,237,279.05	995,340.14
22	Meals and Entertainment	18,561.63	15,996.48
23	Office Expenses	77,991.56	73,846.42
24	Parking	275.79	252.37
25	Postage & Delivery	1,386.90	1,286.70
26	Printing & Reproduction	695.61	2,309.71
27	Recruitment Expense	46,566.31	-549.00
28	Rent	0.00	0.00
29	Seminars & Training	5,587.64	11,164.69
30	Supplies	10,854.97	8,874.07
31	Taxes	565,125,000.00	660,000,000.00
32	Telephone & Internet	15,659.82	40,717.75
33	Travel	17,954.46	15,908.87
34	Total Expenses	$ 618,023,643.05	$ 713,008,479.06
35	Net Operating Income	$ 17,562,638.35	$ 15,311,952.84
36	Other Income		
37	Other Income	272,626.43	284,657.13
38	Total Other Income	$ 272,626.43	$ 284,657.13
39	Net Other Income	$ 272,626.43	$ 284,657.13
40	Net Income	$ 17,835,264.78	$ 15,596,609.97

Basic assumptions used in FY 2027 budget projections

1. FY 2027 enrollment projected to decline throughout the fiscal year primarily due to:
   a) **1/1/2026**: **Medi-Cal UIS enrollment freeze**
   Medi-Cal enrollment freeze for undocumented adults aged 19 and over. Individuals already enrolled in full-scope Medi-Cal will remain eligible as long as they complete their periodic renewals on time.

   b) **1/1/2027**: **CMS Updated Interpretation on UIS Members**
   Per CMS Guidance Letter to State Medicaid Directors, dated 9/30/2025, CMS issued updated interpretation of section 1903(v) of the Social Security Act ("Act") stating CMS believes "*it is reasonable and prudent to interpret the emergency Medicaid provision under section 1903(v) of the Act to apply only to specific payments made for care and services necessary for the treatment of an emergency medical condition actually furnished (i.e., rendered) to aliens ineligible for full Medicaid benefits. Under this updated interpretation, the section 1903(v) emergency Medicaid provision does <u>NOT apply to Medicaid managed care payments, including risk-based capitation payments</u>, made on behalf of aliens ineligible for full Medicaid benefits"* as capitation payments made to Medi-Cal managed care plans such as CalViva Health are paid prospectively.

   As such, States that are currently making managed care payments on behalf of undocumented members ineligible for full Medicaid benefits in their Medicaid managed care programs (e.g., California) <u>must revise their contracting practices and payment methodologies</u> and must ensure that rate certifications exclude all data and assumptions associated to undocumented individuals ineligible for full Medicaid benefits.

   CMS is highly recommending States provide undocumented emergency services in a fee-for-service ("FFS") delivery system to ensure simplest and clearest documentation of verifiable data.
   Given updated interpretation from CMS and CA State budget deficit currently and foreseeable budget years, it appears more likely than not that DHCS will move undocumented members out of Medi-Cal managed care into a FFS delivery system. This will result in a decrease of approximately 52K CalViva Health members effective 1/1/2027.

   c) **1/1/2027: Work and Community Engagement Requirements**
   Per Section 71119 of H.R.1, States must condition Medicaid eligibility on compliance with work rules for adults ages 19 – 64. This provision applies to the adult expansion enrollees. Individuals must complete one or more of the qualifying activities:

- Have monthly income at least 80 times the federal hourly minimum wage (i.e., $580) or employment of 80 hours/month (Seasonal work will be averaged over the last six months)
- Community service of 80 hours/month
- Enrolled at least half-time in an educational program
- Participation in a work program of 80 hours/month

It is estimated that a total of 233K Medi-Cal members will lose coverage per California State budget projections. For CalViva Health, this represents approximately 7K members that potentially may be disenrolled by the end of FY 2027 and projected to increase in future fiscal years.
NOTE: Hardship Exemption - Living in a county with a high unemployment rate (at or above *the lesser of* 8% or 150% of the national unemployment rate, which as of December 2025 was 4.4% per Federal Reserve data = 6.6%). Currently, all CalViva Health counties would qualify for this exemption as the unemployment rate is currently higher than 6.6% in each county (Fresno County = 8.2%, Kings County 9.1%, Madera County = 7.8% as of December 2025 per CA EDD).

d) **1/1/2027: 6 Month Eligibility Checks**
States must conduct eligibility redeterminations for adult expansion enrollees once every 6 months instead of once every 12 months. This population is also subject to work and community engagement requirements. Per DHCS, estimated total up to 289K Medi-Cal members may lose coverage by 6/30/2027. For CalViva Health, this represents approximately 8.5K members.
Exemptions: Some exemptions include but are not limited to tribal members, individuals that are pregnant or 12 months postpartum.

2. Revenues projected based on enrollment breakdown by aid category, using current aid code category specific rates as a benchmark known at time of budget preparation. Overall, revenues are projected to decrease in comparison to prior year budget primarily due to the following:

   a) Decrease in Managed Care Organization ("MCO") taxes. Per H.R.1, there are stricter rules regarding MCO taxes relating to the requirement that the MCO taxes are broad based and uniform which the current California MCO tax is not as the California MCO tax imposes higher tax rates on Medicaid Managed Care plans relative to commercial plans. CMS allowed California a transition period through the end of CY 2026. Any new MCO taxes must meet these stricter broad based, uniformity requirements noting it appears very difficult for California to create a compliant MCO tax without heavily taxing commercial health care plans. As such, we are projecting MCO taxes, at least in its current structure, to end 12/31/2026.

   b) Decrease in enrollment as indicated by reasons above (see bullet #1 above).

c) Net of overall increase in capitation rates paid by DHCS to CalViva due to higher utilization and member acuity in addition to CalViva including State Directed Payments (SDPs) as revenue during FY 2027 as DHCS has confirmed they will incorporate SDPs (e.g., Private Hospital Directed Payment, Enhanced Payment Program, etc...) in Plans' capitation rates beginning with CY 2027 capitation rates.

3. Administrative Services Fee expense projected at $11 pmpm based on enrollment. Overall, Administrative Services Fee expense projected to decrease due to lower projected enrollment in FY 2027 vs budgeted FY 2026 enrollment.

4. Interest income projected to increase due to additional funds being allocated to the money market fund in addition to higher interest rates than previously projected in FY 2026 budget as the Federal Reserve has been slower than initially projected in cutting rates.

5. Supplemental revenue from DHCS such as Maternity KICK and Ground Emergency Medical Transportation ("GEMT") payments projected based on current historical monthly average as a baseline.

6. Medical Cost Expense projected as Gross Medi-Cal Revenue less MCO taxes, $11 per-member, per-month ("pmpm") Administrative Services fee expense, and retention rate retained by CalViva.

7. We are projecting FY 2027 staffing at 21 full-time employees. Salary, Wages, and Benefits based on current staffing and rates. Projected wage increases of up to 5% based on employee performance at anniversary date, 9% increase in health insurance premiums based on January renewal, current deferral rate and employer contribution/match into the 457b-retirement program. The increase is primarily due to potential succession planning efforts for key management positions near retirement age.

8. Depreciation expense based on current fixed assets useful life.

9. Projected increase in Dues & Subscriptions expense as a result of increase in dues from trade organizations who represent CalViva Health and other Medi-Cal managed care plans. Increase mainly related to Local Heath Plans of California ("LHPC") and their legal review and efforts to ensure DHCS uses Prop 35 MCO tax funds according to the law's intent which was, in large part, to increase provider rates above pre-existing levels.

10. Community Support/Grants expense based on the continuation of the existing Community Support Program and funding categories (e.g., a continuation of providing

grants to community-based organizations, scholarship funding to various local colleges, physician recruitment grants, etc.…) and the DHCS contractual requirement which requires Plans to initiate Community Reinvestment activities. Plans must contribute 5% of annual net income to Community Reinvestment initiatives. In addition, if Plans do not meet certain quality outcome metrics, Plans must contribute an additional 7.5% of their annual net income to community reinvestment initiatives. The Community Support/Grants expense includes the amounts for these applicable DHCS Community Reinvestments which starts with using CY 2024 Plan net income, noting CalViva Health will receive the official funding obligation amount from DHCS by Q2 of 2026, and CalViva Health would be expected to begin funding the Community Reinvestments by the end of 2026. The increase from the prior year is primarily due to CalViva Health capturing/expending a portion of the CY 2025 required funding obligation from DHCS which we expect to receive from DHCS by Q2 2027.

11. Projected increase to Insurance expense to account for increase in insurance premiums, particularly related to cyber insurance.

12. Knox-Keene DMHC License expense projected to be consistent with prior year budgeted amount.

13. Marketing expense incurred directly by the Plan is projected based on marketing plan for the fiscal year. Marketing expense is consistent with prior year.

14. Projected increase to Office expense to account for increase in office related expenses such as security patrol services, paper shredding services, repairs to printer/workstations, computer program subscriptions, etc.…

15. Recruitment expense projected to be consistent with prior year budgeted amount.

16. MCO tax expense calculated per CMS approved MCO tax structure for FY 2027, noting MCO taxes in its current form will expire 12/31/2026. At this point, it appears unlikely DHCS will be able to develop a new compliant MCO tax per revised CMS guidelines. MCO tax is projected to be budget neutral (i.e., no gain or loss).

17. Projecting a decrease to Capital Expenditures as tenant improvements to previously vacant office space has been completed. Remaining Capital Expenditure amount is allocated for potential building improvements (e.g., roof improvements, replace older HVAC units, etc.…).

Fresno Kings Madera Regional Health Authority dba CalViva Health

FY 2027 PROPOSED BUDGET

		<A>	<B>	<C> = <B> - <A>	<D> = <C>/<A>
		FY 2026 Approved Budget	**Proposed FY 2027 Budget**	**Proposed FY 2027 vs FY 2026 Approved Budget Difference**	**% Change from Proposed FY 2027 Budget vs FY 2026 Approved Budget**
1	Medical Revenue	2,014,010,594	**1,880,848,973**	(133,161,621)	-6.61%
2	Interest Income	5,000,000	**6,875,000**	1,875,000	37.5%
3	**Total Revenues**	2,019,010,594	**1,887,723,973**	(131,286,621)	-6.5%
4	**Medical Cost Expense**	1,188,835,211	**1,434,833,584**	245,998,373	20.7%
5	**Gross Margin**	830,175,383	**452,890,389**	(377,284,993)	-45.4%
	Expenses				
6	Administrative Services Fee	52,078,224	**48,035,605**	(4,042,619)	-7.8%
7	Salary,Wages & Benefits	5,438,873	**5,724,327**	285,455	5.2%
8	Bank Charges	7,200	**7,200**	0	0.0%
9	Consulting & Accreditation	545,000	**545,000**	0	0.0%
10	Computer & IT	271,126	**291,500**	20,374	7.5%
11	Depreciation	372,000	**372,000**	0	0.0%
12	Dues & Subscriptions	324,000	**360,000**	36,000	11.1%
13	Grants (Community Reinvestment)	4,378,000	**6,000,000**	1,622,000	37.0%
14	Insurance	485,863	**554,432**	68,569	14.1%
15	Legal & Professional	374,500	**374,500**	-	0.0%
16	License	1,780,848	**1,780,848**	-	0.0%
17	Marketing	1,500,000	**1,500,000**	0	0.0%
18	Meals	31,250	**33,450**	2,200	7.0%
19	Office	125,000	**135,000**	10,000	8.0%
20	Parking	1,560	**1,560**	0	0.0%
21	Postage & Delivery	4,920	**4,920**	0	0.0%
22	Printing & Reproduction	5,500	**5,500**	0	0.0%
23	Recruitment	172,500	**172,500**	-	0.0%
24	Rent	12,000	**12,000**	0	0.0%
25	Seminars & Training	33,600	**33,600**	0	0.0%
26	Supplies	15,000	**16,200**	1,200	8.0%
27	Telephone/Internet	48,000	**48,000**	0	0.0%
28	Travel	30,100	**33,400**	3,300	11.0%
29	**Total Expenses**	68,035,063	**66,041,542**	(1,993,521)	-2.9%
30	**Income before Taxes**	762,140,320	**386,848,847**	(375,291,472)	-49.2%
31	**Taxes-MCO**	753,500,000	**376,750,000**	(376,750,000)	-50.0%
32	**Excess Revenue (Expenses)**	8,640,320	**10,098,847**	1,458,528	16.9%
33	**Other Income**	355,488	**504,000**	148,512	41.8%
34	**Net Income/(Loss)**	8,995,808	**10,602,847**	1,607,040	17.9%
35	**Capital Expenditure Budget**	600,000	**500,000**	(100,000)	-16.7%

	Fresno Kings Madera Regional Health Authority dba CalViva Health													
	Combined Fresno -Kings - Madera Counties													
	FY 2027 Budget Projections													
		2026	2026	2026	2026	2026	2026	2027	2027	2027	2027	2027	2027	FY 2027
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Budget Total
1	**Enrollment**													
2	Enrollment	408,214	406,214	404,214	402,214	400,214	398,214	337,056	332,073	327,090	322,107	317,124	312,141	**4,366,873**
3	**Total Enrollment**	408,214	406,214	404,214	402,214	400,214	398,214	337,056	332,073	327,090	322,107	317,124	312,141	**4,366,873**
4	**Revenue**													
5	Medical Revenue	196,984,132	196,365,354	195,746,576	195,127,798	194,509,020	193,890,242	121,220,880	119,947,585	118,674,290	117,400,994	116,127,699	114,854,403	**1,880,848,973**
6	Interest Income	650,000	560,000	650,000	465,000	450,000	600,000	600,000	600,000	575,000	575,000	575,000	575,000	**6,875,000**
7	**Total Revenues**	**197,634,132**	**196,925,354**	**196,396,576**	**195,592,798**	**194,959,020**	**194,490,242**	**121,820,880**	**120,547,585**	**119,249,290**	**117,975,994**	**116,702,699**	**115,429,403**	**1,887,723,973**
8	Medical Cost Expense	127,590,724	127,003,228	126,415,732	125,828,235	125,240,739	124,653,242	116,015,405	114,816,022	113,616,639	112,417,256	111,217,873	110,018,490	**1,434,833,584**
9	**Total Medical Cost Expense**	**127,590,724**	**127,003,228**	**126,415,732**	**125,828,235**	**125,240,739**	**124,653,242**	**116,015,405**	**114,816,022**	**113,616,639**	**112,417,256**	**111,217,873**	**110,018,490**	**1,434,833,584**
10	**Gross Margin**	70,043,408	69,922,126	69,980,844	69,764,563	69,718,281	69,836,999	5,805,476	5,731,563	5,632,651	5,558,739	5,484,826	5,410,914	**452,890,389**
11	**Expenses**													
12	Administrative Services Fee	4,490,354	4,468,354	4,446,354	4,424,354	4,402,354	4,380,354	3,707,613	3,652,800	3,597,987	3,543,174	3,488,361	3,433,548	**48,035,605**
13	Salary,Wages & Benefits	456,073	495,687	509,322	439,322	439,322	539,322	448,415	454,392	524,392	449,361	449,361	519,361	**5,724,327**
14	Bank Charges	600	600	600	600	600	600	600	600	600	600	600	600	**7,200**
15	Consulting & Accreditation	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	**545,000**
16	Computer and IT Expenses	24,292	24,292	24,292	24,292	24,292	24,292	24,292	24,292	24,292	24,292	24,292	24,292	**291,500**
17	Depreciation Expense	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	**372,000**
18	Dues & Subscriptions	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	**360,000**
19	Grants (Community Reinvestment)	1,650,000	395,455	395,455	395,455	395,455	395,455	395,455	395,455	395,455	395,455	395,455	395,450	**6,000,000**
20	Insurance Expense	46,203	46,203	46,203	46,203	46,203	46,203	46,203	46,203	46,203	46,203	46,203	46,203	**554,432**
21	Legal & Professional	31,208	31,208	31,208	31,208	31,208	31,208	31,208	31,208	31,208	31,208	31,208	31,208	**374,500**
22	License Expense	148,404	148,404	148,404	148,404	148,404	148,404	148,404	148,404	148,404	148,404	148,404	148,404	**1,780,848**
23	Marketing Expense	125,000	125,000	125,000	125,000	125,000	125,000	125,000	125,000	125,000	125,000	125,000	125,000	**1,500,000**
24	Meals	2,000	2,000	5,500	2,500	1,650	6,000	2,300	2,300	2,300	2,300	2,300	2,300	**33,450**
25	Office Expense	11,250	11,250	11,250	11,250	11,250	11,250	11,250	11,250	11,250	11,250	11,250	11,250	**135,000**
26	Parking	130	130	130	130	130	130	130	130	130	130	130	130	**1,560**
27	Postage & Delivery	410	410	410	410	410	410	410	410	410	410	410	410	**4,920**
28	Printing & Reproduction	458	458	458	458	458	458	458	458	458	458	458	458	**5,500**
29	Recruitment	14,375	14,375	14,375	14,375	14,375	14,375	14,375	14,375	14,375	14,375	14,375	14,375	**172,500**
30	Rent	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**12,000**
31	Seminars & Training	2,600	4,000	3,000	2,400	2,200	2,400	3,000	3,000	3,000	3,000	3,000	2,000	**33,600**
32	Supplies	1,350	1,350	1,350	1,350	1,350	1,350	1,350	1,350	1,350	1,350	1,350	1,350	**16,200**
33	Telephone/Internet	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	**48,000**
34	Travel	2,600	2,600	2,600	4,800	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	**33,400**
35	**Total Expenses**	7,118,724	5,883,192	5,877,327	5,783,927	5,758,677	5,841,227	5,074,480	5,025,643	5,040,830	4,910,986	4,856,173	4,870,355	**66,041,542**
36	**Income before Taxes**	62,924,684	64,038,934	64,103,517	63,980,635	63,959,604	63,995,772	730,996	705,921	591,821	647,752	628,653	540,559	**386,848,847**
37	**Taxes-MCO**	62,791,667	62,791,667	62,791,667	62,791,667	62,791,667	62,791,667	0	0	0	0	0	0	**376,750,000**
38	**Operating Income (Loss)**	133,017	1,247,267	1,311,850	1,188,969	1,167,937	1,204,105	730,996	705,921	591,821	647,752	628,653	540,559	**10,098,847**
39	**Other Income**	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	**504,000**
40	**Net Income (Loss)**	175,017	1,289,267	1,353,850	1,230,969	1,209,937	1,246,105	772,996	747,921	633,821	689,752	670,653	582,559	**10,602,847**
41	**Capital Expenditures**													**500,000**

Item #14
Attachment 14.C

Medical Management

- Appeals and Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2026

Current as of End of the Month: March
Revised Date: 04/22/2026

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	15	19	41	0	0	0	0	0	0	0	0	0	0	0	0	41	111
Standard Grievances Received	200	191	222	613	0	0	0	0	0	0	0	0	0	0	0	0	613	2295
Total Grievances Received	**207**	**206**	**241**	**654**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**654**	**2406**
Grievance Ack Letters Sent Noncompliant	1	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	8
Grievance Ack Letter Compliance Rate	**99.5%**	**99.5%**	**99.5%**	**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%**	**99.51%**	**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	14	19	40	0	0	0	0	0	0	0	0	0	0	0	0	40	110
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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	182	200	545	0	0	0	0	0	0	0	0	0	0	0	0	545	2292
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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**	**196**	**219**	**585**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**585**	**2403**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**158**	**186**	**211**	**555**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**555**	**2259**
Access - Other - DMHC	29	30	36	95	0	0	0	0	0	0	0	0	0	0	0	0	95	431
Access - PCP - DHCS	4	9	13	26	0	0	0	0	0	0	0	0	0	0	0	0	26	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	6	4	11	0	0	0	0	0	0	0	0	0	0	0	0	11	73
Administrative	31	36	29	96	0	0	0	0	0	0	0	0	0	0	0	0	96	438
Balance Billing	19	26	42	87	0	0	0	0	0	0	0	0	0	0	0	0	87	313
Community Supports	6	8	4	18	0	0	0	0	0	0	0	0	0	0	0	0	18	58
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	19	17	27	63	0	0	0	0	0	0	0	0	0	0	0	0	63	213
Behavioral Health	6	2	2	10	0	0	0	0	0	0	0	0	0	0	0	0	10	1
Other	14	14	11	39	0	0	0	0	0	0	0	0	0	0	0	0	39	178
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
SNF-Long Term Care	2	2	1	5	0	0	0	0	0	0	0	0	0	0	0	0	5	15
Transportation - Access	6	11	12	29	0	0	0	0	0	0	0	0	0	0	0	0	29	126
Transportation - Behavior	1	6	7	14	0	0	0	0	0	0	0	0	0	0	0	0	14	49
Transportation - Other	20	19	22	61	0	0	0	0	0	0	0	0	0	0	0	0	61	209
Quality Of Care Grievances	**12**	**10**	**8**	**30**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Other	3	2	2	7	0	0	0	0	0	0	0	0	0	0	0	0	7	26
PCP Care	8	4	2	14	0	0	0	0	0	0	0	0	0	0	0	0	14	58
PCP Delay	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	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	3	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Exempt Grievances Received	**171**	**154**	**154**	**479**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**479**	**1798**
Access - Avail of Appt w/ PCP	3	5	2	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	**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	1	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**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	2	7	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**9**	**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	1	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**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	7	3	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	**15**
Attitude/Service - Provider	9	4	11	**24**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**24**	**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	3	2	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	**36**
Attitude/Service - Health Plan	3	2	1	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**6**	**8**
Authorization - Authorization Related	2	2	1	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	**17**
Eligibility Issue - Member not eligible per Health Plan	1	1	2	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	**40**
Eligibility Issue - Member not eligible per Provider	10	9	14	**33**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**33**	**100**
Health Plan Materials - ID Cards-Not Received	36	25	20	**81**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**81**	**238**
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**10**
Health Plan Materials - Other	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**7**
Behavioral Health Related	2	3	1	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**6**	**16**
PCP Assignment/Transfer - Health Plan Assignment - Change Request	42	36	36	**114**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**114**	**533**
PCP Assignment/Transfer - HCO Assignment - Change Request	13	9	5	**27**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**27**	**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	3	2	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	**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	2	2	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	**4**
Transportation - Access - Provider Late	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	**3**
Transportation - Behaviour	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	**5**
Transportation - Other	14	9	14	**37**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**37**	**85**
OTHER - Other	4	3	3	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	**27**
Claims Complaint - Balance Billing from Provider	18	26	23	**67**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**67**	**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	1	3	8	0	0	0	0	0	0	0	0	0	0	0	0	8	49
Standard Appeals Received	51	63	75	189	0	0	0	0	0	0	0	0	0	0	0	0	189	564
Total Appeals Received	55	64	78	197	0	0	0	0	0	0	0	0	0	0	0	0	197	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%	100.0%	100.0%	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	1	3	7	0	0	0	0	0	0	0	0	0	0	0	0	7	49
Expedited Appeals Compliance Rate	66.7%	100.0%	100.0%	85.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	87.5%	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	49	68	167	0	0	0	0	0	0	0	0	0	0	0	0	167	562
Standard Appeals Compliance Rate	100.0%	100.0%	100.0%	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	50	71	175	0	0	0	0	0	0	0	0	0	0	0	0	175	611
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	54	48	69	171	0	0	0	0	0	0	0	0	0	0	0	0	171	602
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	2	1	5	8	0	0	0	0	0	0	0	0	0	0	0	0	8	16
Community Supports	13	16	15	44	0	0	0	0	0	0	0	0	0	0	0	0	44	95
DME	12	9	13	34	0	0	0	0	0	0	0	0	0	0	0	0	34	111
Experimental/Investigational	1	4	3	8	0	0	0	0	0	0	0	0	0	0	0	0	8	34
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Advanced Imaging	9	7	13	29	0	0	0	0	0	0	0	0	0	0	0	0	29	127
Other	2	4	9	15	0	0	0	0	0	0	0	0	0	0	0	0	15	75
Pharmacy/RX Medical Benefit	7	3	6	16	0	0	0	0	0	0	0	0	0	0	0	0	16	61
Surgery	8	3	5	16	0	0	0	0	0	0	0	0	0	0	0	0	16	58
SNF-Long Term Care	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	19
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Post Service Appeals	0	2	2	4	0	0	0	0	0	0	0	0	0	0	0	0	4	9
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	2	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	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	25	26	75	0	0	0	0	0	0	0	0	0	0	0	0	75	272
Uphold Rate	44.4%	50.0%	36.6%	42.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	42.9%	44.5%
Overturns - Full	18	14	25	57	0	0	0	0	0	0	0	0	0	0	0	0	57	272
Overturn Rate - Full	33.3%	28.0%	35.2%	32.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	32.6%	44.5%
Overturns - Partials	12	6	12	30	0	0	0	0	0	0	0	0	0	0	0	0	30	42
Overturn Rate - Partial	22.2%	12.0%	16.9%	17.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	17.1%	6.9%
Withdrawal	0	5	8	13	0	0	0	0	0	0	0	0	0	0	0	0	13	25
Withdrawal Rate	0.0%	10.0%	11.3%	7.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%	4.1%
Membership	420,475	418,423	416,089		-	-	-		0	0	0		0	0	0			
Appeals - PTMPM	0.13	0.12	0.17	0.42	-	-	-	-	-	-	-	-	-	-	-	-	0.42	0.24
Grievances - PTMPM	0.40	0.47	0.53	1.40	-	-	-	-	-	-	-	-	-	-	-	-	1.40	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	13	16	**35**	0	0	0	0	0	0	0	0	0	0	0	0	**35**	87
Standard Grievances Received	171	158	185	**514**	0	0	0	0	0	0	0	0	0	0	0	0	**514**	1870
Total Grievances Received	**177**	**171**	**201**	**549**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**549**	**1957**
Grievance Ack Letters Sent Noncompliant	1	1	1	**3**	0	0	0	0	0	0	0	0	0	0	0	0	**3**	7
Grievance Ack Letter Compliance Rate	**99.4%**	**99.4%**	**99.5%**	**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	12	17	35	0	0	0	0	0	0	0	0	0	0	0	0	**35**	87
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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	154	167	455	0	0	0	0	0	0	0	0	0	0	0	0	**455**	1864
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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**	**166**	**184**	**490**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**490**	**1951**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**129**	**157**	**177**	**463**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**463**	**1832**
Access - Other - DMHC	25	26	30	81	0	0	0	0	0	0	0	0	0	0	0	0	**81**	358
Access - PCP - DHCS	4	7	10	21	0	0	0	0	0	0	0	0	0	0	0	0	**21**	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	4	4	9	0	0	0	0	0	0	0	0	0	0	0	0	**9**	54
Administrative	25	34	26	85	0	0	0	0	0	0	0	0	0	0	0	0	**85**	353
Balance Billing	14	20	39	73	0	0	0	0	0	0	0	0	0	0	0	0	**73**	251
Community Supports	4	6	4	14	0	0	0	0	0	0	0	0	0	0	0	0	**14**	50
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Interpersonal	16	15	23	54	0	0	0	0	0	0	0	0	0	0	0	0	**54**	173
Behavioral Health	5	2	1	8	0	0	0	0	0	0	0	0	0	0	0	0	**8**	1
Other	12	12	8	32	0	0	0	0	0	0	0	0	0	0	0	0	**32**	152
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	0
SNF-Long Term Care	2	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	15
Transportation - Access	4	10	10	24	0	0	0	0	0	0	0	0	0	0	0	0	**24**	104
Transportation - Behaviour	1	4	6	11	0	0	0	0	0	0	0	0	0	0	0	0	**11**	37
Transportation - Other	16	15	15	46	0	0	0	0	0	0	0	0	0	0	0	0	**46**	159
Quality Of Care Grievances	**11**	**9**	**7**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	2
Other	3	2	2	7	0	0	0	0	0	0	0	0	0	0	0	0	**7**	20
PCP Care	7	3	2	12	0	0	0	0	0	0	0	0	0	0	0	0	**12**	46
PCP Delay	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	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	3	1	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**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	1	2	6	0	0	0	0	0	0	0	0	0	0	0	0	6	36
Standard Appeals Received	39	49	55	143	0	0	0	0	0	0	0	0	0	0	0	0	143	444
Total Appeals Received	**42**	**50**	**57**	**149**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**149**	**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%**	**100.0%**	**100.0%**	**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	1	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	36
Expedited Appeals Compliance Rate	**50.0%**	**100.0%**	**100.0%**	**80.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**80.0%**	**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	36	52	127	0	0	0	0	0	0	0	0	0	0	0	0	127	444
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**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**	**37**	**54**	**133**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**133**	**480**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**36**	**53**	**131**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**131**	**472**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	2	1	5	8	0	0	0	0	0	0	0	0	0	0	0	0	8	14
Community Supports	11	13	11	35	0	0	0	0	0	0	0	0	0	0	0	0	35	73
DME	11	8	11	30	0	0	0	0	0	0	0	0	0	0	0	0	30	91
Experimental/Investigational	1	3	2	6	0	0	0	0	0	0	0	0	0	0	0	0	6	27
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Advanced Imaging	5	5	9	19	0	0	0	0	0	0	0	0	0	0	0	0	19	105
Other	2	1	7	10	0	0	0	0	0	0	0	0	0	0	0	0	10	50
Pharmacy/RX Medical Benefit	7	3	5	15	0	0	0	0	0	0	0	0	0	0	0	0	15	52
Surgery	3	2	3	8	0	0	0	0	0	0	0	0	0	0	0	0	8	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**	**1**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**8**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Supports	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	20	18	54	0	0	0	0	0	0	0	0	0	0	0	0	54	204
Uphold Rate	**38.1%**	**54.1%**	**33.3%**	**40.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.6%**	**42.5%**
Overturns - Full	16	10	21	47	0	0	0	0	0	0	0	0	0	0	0	0	47	223
Overturn Rate - Full	**38.1%**	**27.0%**	**38.9%**	**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%**	**46.5%**
Overturns - Partials	10	4	10	24	0	0	0	0	0	0	0	0	0	0	0	0	24	33
Overturn Rate - Partial	**23.8%**	**10.8%**	**18.5%**	**18.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**18.0%**	**6.9%**
Withdrawal	0	3	5	8	0	0	0	0	0	0	0	0	0	0	0	0	8	20
Withdrawal Rate	**0.0%**	**8.1%**	**9.3%**	**6.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.0%**	**4.2%**
Membership	332,462	330,913	329,090															
Appeals - PTMPM	0.13	0.11	0.16	0.40	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.10	0.29
Grievances - PTMPM	0.42	0.50	0.56	1.48	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.37	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	2	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	11
Standard Grievances Received	16	11	13	40	0	0	0	0	0	0	0	0	0	0	0	0	40	196
Total Grievances Received	**17**	**13**	**15**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**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%**	**100.0%**	**100.0%**	**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	2	1	4	0	0	0	0	0	0	0	0	0	0	0	0	4	11
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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	14	12	41	0	0	0	0	0	0	0	0	0	0	0	0	41	196
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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**	**16**	**13**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**207**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**16**	**12**	**43**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**	**197**
Access - Other - DMHC	2	2	1	5	0	0	0	0	0	0	0	0	0	0	0	0	5	32
Access - PCP - DHCS	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	1	1	6	0	0	0	0	0	0	0	0	0	0	0	0	6	35
Balance Billing	2	4	1	7	0	0	0	0	0	0	0	0	0	0	0	0	7	26
Community Supports	1	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	4
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	1	2	4	0	0	0	0	0	0	0	0	0	0	0	0	4	24
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Transportation - Access	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	8
Transportation - Behaviour	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	7
Transportation - Other	4	3	3	10	0	0	0	0	0	0	0	0	0	0	0	0	10	26
Quality Of Care Grievances	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	3	3	5	11	0	0	0	0	0	0	0	0	0	0	0	0	11	36
Total Appeals Received	**3**	**3**	**5**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	11	**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%**	**100.0%**	**100.0%**	**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	3	4	7	0	0	0	0	0	0	0	0	0	0	0	0	7	37
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**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 Appeals Resolved	**0**	**3**	**4**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**44**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**3**	**3**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**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	1	2	3	0	0	0	0	0	0	0	0	0	0	0	0	3	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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Other	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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**	**1**	1	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	2	3	**5**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	5	23
Uphold Rate	**0.0%**	**66.7%**	**75.0%**	**71.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**71.4%**	**52.3%**
Overturns - Full	0	1	1	**2**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	2	13
Overturn Rate - Full	**0.0%**	**33.3%**	**25.0%**	**28.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**28.6%**	**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**	**38,072**	**37,909**													**0**		
Appeals - PTMPM	-	0.08	0.11	**0.06**	-	-	-	**0.00**	-	-	-	**0.00**	-	0	-	0.00	**0.02**	**0.16**
Grievances - PTMPM	0.42	0.42	0.34	**0.39**	-	-	-	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	13
Standard Grievances Received	13	22	24	59	0	0	0	0	0	0	0	0	0	0	0	0	59	229
Total Grievances Received	**13**	**22**	**25**	**60**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**60**	**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%**	**100.0%**	**100.0%**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	13
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**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	14	14	21	49	0	0	0	0	0	0	0	0	0	0	0	0	49	232
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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**	**14**	**22**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**50**	**245**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**13**	**22**	**49**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**49**	**230**
Access - Other - DMHC	2	2	5	9	0	0	0	0	0	0	0	0	0	0	0	0	9	41
Access - PCP - DHCS	0	1	3	4	0	0	0	0	0	0	0	0	0	0	0	0	4	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	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	11
Administrative	2	1	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	50
Balance Billing	3	2	2	7	0	0	0	0	0	0	0	0	0	0	0	0	7	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	1	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	16
Behavioral Health	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Other	1	1	3	5	0	0	0	0	0	0	0	0	0	0	0	0	5	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	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	14
Transportation - Behaviour	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Transportation - Other	0	1	4	5	0	0	0	0	0	0	0	0	0	0	0	0	5	24
Quality Of Care Grievances	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Standard Appeals Received	9	11	15	35	0	0	0	0	0	0	0	0	0	0	0	0	35	59
Total Appeals Received	**10**	**11**	**16**	**37**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	37	**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%**	**100.0%**	**100.0%**	**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	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**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	10	12	33	0	0	0	0	0	0	0	0	0	0	0	**0**	33	63
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**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**	**10**	**13**	**35**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**	**87**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**12**	**9**	**13**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**	**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	2	2	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	1	1	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Experimental/Investigational	0	1	1	2	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	2	3	9	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other	0	2	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	5	1	2	8	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**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	3	5	**16**	0	0	0	0	0	0	0	0	0	0	0	**0**	**16**	**45**
Uphold Rate	**66.7%**	**30.0%**	**38.5%**	**45.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**45.7%**	**51.7%**
Overturns - Full	2	3	3	**8**	0	0	0	0	0	0	0	0	0	0	0	**0**	**8**	36
Overturn Rate - Full	**16.7%**	**30.0%**	**23.1%**	**22.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**22.9%**	**41.4%**
Overturns - Partials	2	2	2	**6**	0	0	0	0	0	0	0	0	0	0	0	**0**	**6**	2
Overturn Rate - Partial	**16.7%**	**20.0%**	**15.4%**	**17.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**17.1%**	**2.3%**
Withdrawal	0	2	3	**5**	0	0	0	0	0	0	0	0	0	0	0	**0**	**5**	4
Withdrawal Rate	**0.0%**	**20.0%**	**23.1%**	**14.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**14.3%**	**4.6%**
Membership	49,776	49,438	49,090													**-**		
Appeals - PTMPM	0.24	0.20	0.26	**0.71**	-	-	-	**0.00**	-	-	-	0.00	-	0	-	0.00	**0.18**	**0.38**
Grievances - PTMPM	0.28	0.28	0.45	**1.01**	-	-	-	**0.00**	-	-	-	0.00	-	0	-	0.00	**0.25**	**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	4	4	11	0	0	0	0	0	0	0	0	0	0	0	0	11	31
Standard Grievances Received	26	21	78	125	0	0	0	0	0	0	0	0	0	0	0	0	125	658
Total Grievances Received	**29**	**25**	**82**	136	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**136**	**689**
Grievance Ack Letters Sent Noncompliant	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**98.7%**	**99.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.2%**	**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	5	4	12	0	0	0	0	0	0	0	0	0	0	0	0	12	34
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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	59	51	160	0	0	0	0	0	0	0	0	0	0	0	0	160	718
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**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**	**64**	**55**	**172**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**172**	**752**
Grievance Descriptions - Resolved Cases	**53**	**64**	**55**	**172**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**172**	**752**
Access to primary care	1	1	2	4	0	0	0	0	0	0	0	0	0	0	0	0	4	43
Access to specialists	0	4	1	5	0	0	0	0	0	0	0	0	0	0	0	0	5	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	17	13	47	0	0	0	0	0	0	0	0	0	0	0	0	47	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	5	3	10	0	0	0	0	0	0	0	0	0	0	0	0	10	29
QOS Non Access	30	37	36	103	0	0	0	0	0	0	0	0	0	0	0	0	103	428
Exempt Grievances Received	**22**	**24**	**25**	**71**	0	0	0	**0**	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**71**	**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	3	2	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	1
Attitude/Service - Provider	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	19
Attitude/Service - Health Plan	2	0	1	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	0
Authorization - Authorization Related	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	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	2	1	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	6	15
Health Plan Materials - ID Cards-Not Received	10	2	4	**16**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	16	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	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	3
Behavioral Health	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	2	4	3	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	9	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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	9
Transportation - Other	3	6	8	**17**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	17	34
OTHER - Other	1	1	1	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	7
Claims Complaint - Balance Billing from Provider	0	3	3	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	6	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	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	16
Standard Appeals Received	9	9	21	39	0	0	0	0	0	0	0	0	0	0	0	0	39	159
Total Appeals Received	**9**	**9**	**23**	**41**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	41	**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%**	**100.0%**	**100.0%**	**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	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	17
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**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 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	24	20	61	0	0	0	0	0	0	0	0	0	0	0	**0**	61	164
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**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**	**24**	**22**	**63**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**63**	**181**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**17**	**24**	**22**	**63**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**63**	**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	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Community Supports	6	12	4	22	0	0	0	0	0	0	0	0	0	0	0	0	22	34
DME	4	6	6	16	0	0	0	0	0	0	0	0	0	0	0	0	16	40
Experimental/Investigational	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	2	1	3	6	0	0	0	0	0	0	0	0	0	0	0	0	6	25
Other	0	2	6	8	0	0	0	0	0	0	0	0	0	0	0	0	8	20
Pharmacy/RX Medical Benefit	2	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	17	9	**34**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**34**	85
Uphold Rate	**47.1%**	**70.8%**	**40.9%**	**54.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**54.0%**	**47.0%**
Overturns - Full	6	5	5	**16**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**16**	70
Overturn Rate - Full	**35.3%**	**20.8%**	**22.7%**	**25.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**25.4%**	**38.67%**
Overturns - Partials	3	0	4	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**7**	15
Overturn Rate - Partial	**17.6%**	**0.0%**	**18.2%**	**11.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**11.1%**	**8.3%**
Withdrawal	0	2	4	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**6**	11
Withdrawal Rate	**0.0%**	**8.3%**	**18.2%**	**9.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**9.5%**	**6.1%**
Membership	43,916	43,978	43,870															
Appeals - PTMPM	0.39	0.55	0.50	**1.43**	-	-	-	**0.00**	-	-	-	**0.00**	0	-	-	0.00	**0.36**	**0.79**
Grievances - PTMPM	1.21	1.46	1.25	**3.92**	-	-	-	**0.00**	-	-	-	**0.00**	0	-	-	0.00	**0.98**	**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 #14

Attachment 14.D

Medical Management

- Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 3/1/2026 to 3/31/2026

Report created 4/24/2026

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:

Read Me
Main Report CalVIVA
CalVIVA Commission
CalVIVA Fresno
CalVIVA Kings
CalVIVA Madera
Glossary

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.cor
Authorization Metrics	John Gonzalez

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 3/1/2026 to 3/31/2026
Report created 4/24/2026

ER utilization based on Claims data	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2025-Trend	2026-01	2026-02	2026-03	2026-Trend	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Qtr Trend	CY- 2025	YTD-2026	YTD-Trend
				MEMBERSHIP														Quarterly Averages					Annual Averages	
Expansion Mbr Months	122,118	122,345	123,026	123,322	123,901	122,392	121,296	121,003	120,883	120,655		119,264	118,394	117,406		121,576	122,898	122,530	120,847	118,355		121,963	118,355	
Adult/Family/O TLIC Mbr Mos	262,053	261,911	262,247	262,070	262,013	260,399	258,290	257,463	257,291	257,397		255,067	253,880	252,988		261,819	262,076	260,234	257,384	253,978		260,378	253,978	
Aged/Disabled Mbr Mos	47,808	47,837	48,038	48,242	48,532	48,562	48,579	48,705	48,603	48,463		47,702	47,574	46,195		47,683	48,039	48,558	48,590	47,157		48,218	47,157	
				COUNTS																				
Admits - Count	2,073	2,041	2,058	2,093	2,122	2,149	2,027	2,156	2,100	2,183		2,134	2,001	2,082		2,129	2,064	2,099	2,146	2,072		2,110	2,267	
Expansion	731	729	756	781	787	809	743	838	755	749		786	725	741		774	755	780	781	751		772	824	
Adult/Family/O TLIC	892	850	874	849	894	884	864	900	902	968		894	877	929		900	858	881	923	900		890	983	
Aged/Disabled	450	462	428	463	441	456	420	418	443	466		454	399	412		455	451	439	442	422		447	461	
Admits Acute - Count	1,365	1,405	1,331	1,371	1,339	1,379	1,238	1,331	1,340	1,367		1,426	1,336	1,408		1,410	1,362	1,367	1,369	1,347		1,361	1,522	
Expansion	581	591	603	633	603	638	577	668	603	595		641	580	628		613	609	606	622	616		613	674	
Adult/Family/O TLIC	434	440	396	393	402	389	357	353	403	406		425	447	443		446	410	383	387	438		406	482	
Aged/Disabled	350	374	332	345	334	352	304	310	334	366		360	309	337		351	350	330	337	335		342	367	
Readmit 30 Day - Count	231	255	234	244	234	222	228	248	233	200		124	174	76		231	244	228	227	125		233	125	
Expansion	107	117	108	119	102	113	108	138	112	100		62	79	39		105	115	108	117	60		111	60	
Adult/Family/O TLIC	31	37	28	41	41	44	41	38	41	17		21	28	10		36	35	42	32	20		36	20	
Aged/Disabled	93	101	98	84	91	65	79	72	80	83		41	67	27		90	94	78	78	45		85	45	
**ER Visits - Count	17,401	16,884	17,746	16,254	15,983	16,648	17,249	16,679	16,217	17,174		17,045	15,431	5,821		17,020	16,961	16,627	16,690	12,766		16,825	12,766	
Expansion	5,017	5,012	5,382	5,217	5,384	5,455	5,473	5,112	4,881	5,196		5,179	4,421	1,808		4,856	5,204	5,437	5,063	3,803		5,140	3,803	
Adult/Family/O TLIC	10,297	9,801	10,194	8,901	8,412	8,994	9,737	9,413	9,269	9,842		9,812	9,173	3,401		10,148	9,632	9,048	9,508	7,462		9,584	7,462	
Aged/Disabled	2,087	2,071	2,170	2,136	2,187	2,199	2,039	2,154	2,067	2,136		2,054	1,837	612		2,016	2,126	2,142	2,119	1,501		2,101	1,501	
				PER/K																				
Admits Acute - PTMPY	37.9	39.0	36.9	37.9	37.0	38.4	34.7	37.4	37.7	38.5		40.5	38.2	40.6		39.3	37.7	38.0	38.5	38.5		37.9	43.5	
Expansion	57.1	58.0	58.8	61.6	58.4	62.6	57.1	66.2	59.9	59.2		64.5	58.8	64.2		60.5	59.5	59.3	61.8	62.5		60.3	68.3	
Adult/Family/O TLIC	19.9	20.2	18.1	18.0	18.4	17.9	16.6	16.5	18.8	18.9		20.0	21.1	21.0		20.4	18.8	17.6	18.1	20.7		18.7	22.8	
Aged/Disabled	87.9	93.8	82.9	85.8	82.6	87.0	75.1	76.4	82.5	90.6		90.6	77.9	87.5		88.3	87.5	81.6	83.1	85.3		85.1	93.3	
Bed Days Acute - PTMPY	205.1	210.2	169.9	184.7	166.7	174.6	170.9	172.5	189.6	197.0		198.2	183.4	223.4		204.2	188.2	170.7	186.4	201.6		187.4	218.4	
Expansion	347.8	301.9	290.2	306.6	267.4	298.9	293.6	321.3	312.9	324.8		315.5	303.1	373.5		348.5	299.6	286.6	319.7	330.5		313.5	359.5	
Adult/Family/O TLIC	74.3	100.5	61.0	65.2	71.3	66.4	64.0	59.0	65.5	73.1		74.3	73.1	92.2		75.0	75.5	67.2	65.9	79.8		70.9	88.2	
Aged/Disabled	557.7	576.2	456.6	522.1	425.0	441.3	432.8	402.8	539.7	536.8		566.8	474.0	560.6		545.2	518.2	433.1	493.0	533.5		497.1	565.3	
ALOS Acute	5.4	5.4	4.6	4.9	4.5	4.6	4.9	4.6	5.0	5.1		4.9	4.8	5.5		5.2	5.0	4.5	4.8	5.2		4.9	5.0	
Expansion	6.1	5.2	4.9	5.0	4.6	4.8	5.1	4.9	5.2	5.5		4.9	5.2	5.8		5.8	5.0	4.8	5.2	5.3		5.2	5.3	
Adult/Family/O TLIC	3.7	5.0	3.4	3.6	3.9	3.7	3.9	3.6	3.5	3.9		3.7	3.5	4.4		3.7	4.0	3.8	3.6	3.9		3.8	3.9	
Aged/Disabled	6.3	6.1	5.5	6.1	5.1	5.1	5.8	5.3	6.5	5.9		6.3	6.1	6.4		6.2	5.9	5.3	5.9	6.3		5.8	6.1	
Readmit % 30 Day	11.1%	12.5%	11.4%	11.7%	11.0%	10.3%	11.2%	11.5%	11.1%	9.2%		5.8%	8.7%	3.7%		10.9%	11.8%	10.9%	10.6%	6.0%		11.0%	5.5%	
Expansion	14.6%	16.0%	14.3%	15.2%	13.0%	14.0%	14.5%	16.5%	14.8%	13.4%		7.9%	10.9%	5.3%		13.6%	15.2%	13.8%	14.9%	8.0%		14.4%	7.3%	
Adult/Family/O TLIC	3.5%	4.4%	3.2%	4.8%	4.6%	5.0%	4.7%	4.2%	4.5%	1.8%		2.3%	3.2%	1.1%		4.0%	4.1%	4.8%	3.5%	2.2%		4.1%	2.0%	
Aged/Disabled	20.7%	21.9%	22.9%	18.1%	20.6%	14.3%	18.8%	17.2%	18.1%	17.8%		9.0%	16.8%	6.6%		19.8%	20.9%	17.8%	17.7%	10.7%		19.1%	9.8%	
**ER Visits - PTMPY	483.4	468.9	491.5	449.8	441.5	463.1	483.4	468.5	456.0	483.2		484.7	441.0	167.7		473.8	470.0	462.6	469.2	365.2		468.9	365.2	
Expansion	493.0	491.6	525.0	507.6	521.4	534.8	541.5	507.0	484.5	516.8		521.1	448.1	184.8		479.3	508.1	532.5	502.8	385.6		505.7	385.6	
Adult/Family/O TLIC	471.5	449.1	466.5	407.6	385.3	414.5	452.4	438.7	432.3	458.8		461.6	433.6	161.3		465.1	441.0	417.2	443.3	352.6		441.7	352.6	
Aged/Disabled	523.8	519.5	542.1	531.3	540.8	543.4	503.7	530.7	510.3	528.9		516.7	463.4	159.0		507.4	531.0	529.3	523.3	382.0		522.8	382.0	

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-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%	96%	100%	98%	100%	98%	100%	100%	100%	100%		100%	100%	100%		100%	98%	98%	97%		100%		NA	NA	
Routine Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	98%	74%	66%	68%	86%	93%	100%	100%	100%	100%		100%	100%	100%		97%	69%	96%	100%		100%		NA	NA	
Expedited Pre-Service Authorization TAT (non-BH)	100%	100%	100%	100%	80%	94%	94%	100%	100%	94%		96%	98%	100%		100%	100%	89%	98%		98.46%		NA	NA	
Expedited Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	75%	80%	100%	NA	NA	100%	NA	100%	100%	100%		NA	100%	100%		88%	83%	100%	100%		100%		NA	NA	
Post-Service Authorization TAT (non-BH)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%		100%	100%	100%	100%		100%		NA	NA	
Concurrent Authorization TAT (non-BH)	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%		100%	100%	100%		100%	100%	98%	100%		100%		NA	NA	
	CCS ID rate															CCS ID rate							CCS ID rate		
CCS %	8.42	8.34	8.43	8.36	8.35	8.47	8.39	8.48	8.49	8.51		8.48	8.50	8.48		8.47	8.38	8.40	8.49		8.49		8.44	8.49	

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-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	317	366	320	221	274	204	272	236	216	233		222	241	343		777	907	750	685		806		3,119	806	
Pending	-	-	-	-	-	-	-	1	-	13		-	-	5		-	-	-	14		5		14	5	
Ineligible	17	18	22	13	19	12	13	6	7	8		19	7	9		50	53	44	21		35		168	35	
Total Outreached	300	348	298	208	255	192	259	229	209	212		203	234	329		727	854	706	650		766		2,937	766	
Engaged	187	225	197	122	162	127	182	164	141	157		154	151	218		441	544	471	462		523		1,918	523	
Engagement Rate	62%	65%	66%	59%	64%	66%	70%	72%	67%	74%		76%	65%	66%		61%	64%	67%	71%		68%		65%	68%	
Total Screened and Declined	6	5	6	3	3	1	6	4	2	12		3	2	4		9	14	10	18		9		51	9	
Unable to Reach	107	118	95	83	90	64	71	61	66	43		46	81	107		277	296	225	170		234		968	234	
Total Cases Managed	342	374	389	361	363	359	385	372	364	359		321	295	303		477	494	530	448		429		1,089	429	
Total Cases Closed	50	62	74	85	81	61	61	63	58	69		71	55	56		185	221	203	190		182		799	182	
Cases Remained Open	277	297	310	270	266	289	311	303	289	284		225	169	131		277	270	311	284		131		284	131	
					Physical Health Case Management											Physical Health Case Management							Physical Health Case		
Total Number Of Referrals	401	544	516	385	334	403	397	337	267	351		481	579	535		771	1,445	1,134	955		1,595		4,305	1,595	
Pending	-	-	-	-	-	1	3	2	3	55		2	3	51		-	-	4	60		56		64	56	
Ineligible	4	28	16	10	18	15	18	6	16	10		35	20	5		10	54	51	32		60		147	60	
Total Outreached	397	516	500	375	316	387	376	329	248	286		444	556	479		761	1,391	1,079	863		1,479		4,094	1,479	
Engaged	180	292	273	215	175	227	226	206	136	182		266	339	302		413	780	628	524		907		2,345	907	
Engagement Rate	45%	57%	55%	57%	55%	59%	60%	63%	55%	64%		60%	61%	63%		54%	56%	58%	61%		61%		57%	61%	
Total Screened and Refused/Decline	72	33	57	32	28	30	18	17	18	19		24	34	43		87	122	76	54		101		339	101	
Unable to Reach	145	191	170	128	113	130	132	106	94	85		154	183	134		261	489	375	285		471		1,410	471	
Total Cases Closed	100	104	81	88	104	90	95	96	74	112		118	129	108		240	273	289	282		355		1,084	355	
Cases Remained Open	277	253	287	308	297	295	314	345	355	329		342	345	407		277	308	314	329		407		329	407	
Total Cases Managed	388	384	388	418	419	401	440	464	437	458		500	526	541		528	572	634	558		788		1,430	788	
Complex Case	35	29	28	37	38	49	59	76	73	78		92	95	95		48	42	70	81		128		148	128	
Non-Complex Case	353	355	360	381	381	352	381	388	364	380		408	431	446		480	530	564	477		660		1,282	660	
					Transitional Care Services											Transitional Care Services							Transitional Care Services		
Total Number Of Referrals	511	514	623	502	660	640	710	801	591	563		719	714	623		1,590	1,639	2,010	1,955		2,056		7,194	2,056	
Pending	-	-	-	-	-	-	-	2	-	15		-	-	4		-	-	-	17		4		17	4	
Ineligible	2	3	2	2	4	4	5	3	14	6		48	21	2		10	7	13	23		71		53	71	
Total Outreached	509	511	621	500	656	636	705	796	577	542		671	693	617		1,580	1,632	1,997	1,915		1,981		7,124	1,981	
Engaged	462	466	558	442	581	519	602	637	462	470		604	625	558		1,437	1,466	1,702	1,569		1,787		6,174	1,787	
Engagement Rate	91%	91%	90%	88%	89%	82%	85%	80%	80%	87%		90%	90%	90%		91%	90%	85%	82%		90%		87%	90%	
Total Screened and Refused/Decline	10	6	6	-	6	8	6	18	9	6		4	9	7		21	12	20	33		20		86	20	
Unable to Reach	37	39	57	58	69	109	97	141	106	66		63	59	52		122	154	275	313		174		864	174	
Total Cases Closed	283	285	253	303	321	323	348	399	340	387		327	281	431		837	841	992	1,126		1,039		3,796	1,039	
Cases Remained Open	324	301	367	364	395	418	445	478	450	386		392	488	436		324	364	445	386		436		386	436	
Total Cases Managed	653	639	679	721	778	793	850	938	840	789		781	837	932		1,207	1,227	1,493	1,164		1,540		4,198	1,540	

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-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	154	158	132	133	114	120	129	241	95	106		130	161	154		387	423	363	442		445		1,615	445	
Pending	-	-	-	-	-	-	1	-	-	15		-	-	4		-	-	1	15		4		16	4	
Ineligible	1	6	4	1	-	2	4	-	1	1		11	4	1		7	11	6	2		16		26	16	
Total Outreached	153	152	128	132	114	118	124	241	94	90		119	157	149		380	412	356	425		425		1,573	425	
Engaged	112	114	94	100	79	74	86	152	65	65		82	109	109		267	308	239	282		300		1,096	300	
Engagement Rate	73%	75%	73%	76%	69%	63%	69%	63%	69%	72%		69%	69%	73%		70%	75%	67%	66%		71%		70%	71%	
Total Screened and Refused/Decline	-	-	1	-	-	-	2	2	3	1		4	-	1		2	1	2	6		5		11	5	
Unable to Reach	41	38	33	32	35	44	36	87	26	24		33	48	39		111	103	115	137		120		466	120	
Total Cases Closed	57	90	65	54	29	29	27	42	28	25		37	36	37		159	209	85	95		110		548	110	
Cases Remained Open	169	124	101	70	86	97	110	88	93	104		114	136	158		169	70	110	104		158		104	158	
Total Cases Managed	236	232	174	140	125	132	149	139	127	135		163	187	214		338	282	209	168		287		658	287	
Complex Case	17	16	9	9	9	10	11	10	10	11		15	18	19		22	16	15	12		24		39	24	
Non-Complex Case	219	216	165	131	116	122	138	129	117	124		148	169	195		316	266	194	156		263		619	263	
	First Year of Life Care Management															First Year of Life Care Management							First Year of Life Care		
Total Number Of Referrals	50	55	47	47	62	40	45	55	40	47		51	37	61		124	149	147	142		149		562	149	
Pending	-	1	1	-	3	2	-	-	-	2		-	1	8		1	2	5	2		9		10	9	
Ineligible	1	-	-	1	1	-	1	2	1	4		7	2	-		1	1	2	7		9		11	9	
Total Outreached	49	54	46	46	58	38	44	53	39	41		44	34	53		122	146	140	133		131		541	131	
Engaged	44	54	46	46	51	37	41	51	39	40		43	30	51		117	146	129	130		124		522	124	
Engagement Rate	90%	100%	100%	100%	88%	97%	93%	96%	100%	98%		98%	88%	96%		96%	100%	92%	98%		95%		96%	95%	
Total Screened and Refused/Decline	-	-	-	-	-	-	1	-	-	1		-	-	-		-	-	1	1		-		2	-	
Unable to Reach	5	-	-	-	7	1	2	2	-	-		1	4	2		5	-	10	2		7		17	7	
Total Cases Closed	23	34	24	29	46	28	27	20	23	33		29	41	49		78	87	101	76		119		342	119	
Cases Remained Open	327	357	375	395	396	400	405	432	450	449		452	441	435		327	395	405	449		435		449	435	
Total Cases Managed	369	393	405	427	442	428	437	455	474	483		489	482	490		424	479	510	503		560		792	560	

Item #14

Attachment 14.E

Medical Management

- Quarterly Summary Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: May 21st ,2026

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 1 2026 (May 2026)

Purpose of Activity:

This report is to provide the RHA Commission with an update on the CalViva Health **Quality Improvement, Utilization Management, Case Management**, and **Population Health Management** performance, programs and regulatory activities in Quarter 1 of 2026.

I. Meetings

The RHA Commission has delegated the authority and responsibility for development and implementation of the programs identified in the purpose above to the CalViva Health Quality Improvement Utilization Management Committee (QI/UM). The CalViva QI/UM Committee meets seven times per year to direct and oversee these programs and receive routine reports on progress towards goals and completion of planned activities.
In Quarter 1, two QI/UM Committee meetings were held on **February 19th** and on **March 19th**. At the February and March QI/UM Committees the following **guiding documents** were approved:

The **Program Documents** approved were:

1. QI/UM Committee Charter 2026
2. 2025 Quality Improvement/Health Education End of Year Evaluation
3. 2026 Quality Improvement/Health Education Program Description
4. 2026 Quality Improvement/Health Education Work Plan
5. 2025 Utilization Management/Care Management End of Year Evaluation
6. 2026 Utilization Management Program Description
7. 2026 Care Management Program Description
8. 2026 Utilization Management/Care Management Work Plan
9. 2026 Population Segmentation Report
10. NCQA Non-Behavioral Health Member Experience Report
11. NCQA Behavioral Health Member Experience Report

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

1. 2025 Continuity of Care Oversight Audit
2. 2025 Pharmacy Oversight Audit

Other **General Documents** approved were:

1. Pharmacy Provider Updates
2. Medical Policies

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

1. The **Appeal and Grievance Dashboard & Quarterly Reports (8)** provide a summary of all grievances to track volumes, turn-around times, inter-rater reliability, case classifications, and other regulatory compliance parameters. A year-to-year comparison was presented at the February meeting to evaluate 2025 volumes, case types, and turn-around times compared with 2024.
   - **a.** Overall, grievances continue to increase year-over-year, with Access to Care services remaining the most frequently cited category, most commonly related to issues such as prior authorization delays, network adequacy, and missed transportation appointments.
   - **b.** Exempt Grievance volume decreased in Q4 2025 compared to Q4 2024. Administrative, Balance billing and Transportation related grievances continue to be the most common, but with some declines and variation noted within these categories.
   - **c.** The total number of appeals received in 2025 decreased compared to 2024. Appeal types were in a variety of categories including self-injectable medications, outpatient procedures, inpatient admissions, DME, medically tailored meals and housing related benefits.
   - **d.** **A & G Validation Audit Report** for Q3 2025 indicates a high performing process with 95% of cases meeting documentation standards on receipt. All cases are fully reconciled prior to closure.

2. **Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Reporting** provides a summary of the quarterly evaluation of cases/issues that may result in substantial harm to a member. The number of member generated PQI cases reported in Q4 2025 increased compared to recent quarters. Behavioral Health PQIs are now included in this report, however, all cases this quarter fell under physical health. Non-member cases were reported as three (3) and there were sixteen (16) Peer Review cases, consistent with the previous quarters.
   There were three (3) **PPC cases** reviewed in Q4. Two (2) of the three (3) cases met reporting criteria and were reported to DHCS.

3. **Behavioral Health Performance Indicator Report** was presented for Q3 2025. All five (5) metrics included in this report met or exceeded their targets.
   - The Q3 2025 BH utilization rate, as reflected in unique members/k, remained steady over the first half of 2025 at 283.7.
   - Appointment availability met the target at 100%, with zero (0) life threatening emergent cases, two (2) Non-life-threatening emergent cases and there was one (1) Urgent case.
   - Authorization timeliness is reported at 100% for non-ABAs (122) and 95.1% for ABAs (2,706) for Q3 2025.

     Note: Potential Quality Issues (PQIs), provider disputes, network availability and adequacy metrics are now integrated into other existing reports.

4. **Lead Screening in Children Report** for Quarter 3 2025 was presented and discussed with committee members. This report provides results of practitioner adherence to lead screening guidelines and their compliance rates for providing anticipatory guidance to parents/caregivers to prevent lead exposure. The Q3 2025 report provides CVH's performance for Q1 2025 to Q3 2025 for data captured through Facility Site Medical Record Review and Claims and Encounters.
   - The Facility Site Reviews (sample) show in Q3 2025, 76% of member records were compliant for both lead screening and anticipatory guidance, with 50% of the PCP sites in compliance.
   - CVH has issued a Corrective Action Plan (CAP) to HN for the continued poor performance with documentation of anticipatory guidance.
   - A special study is currently in progress to better understand barriers to compliance.

5. **The Initial Health Appointment Report** for Quarter 3 2025 was presented. The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an **Initial Health Appointment** (IHA) completed within the first 120 days of enrollment. This report demonstrates CalViva Health's performance on IHA compliance monitoring from Q4 2024 through Q3 2025.
   The current approach to monitoring has three components:
   a. Primary Care Physician Facility Site (FSR) and Medical Record Review (MRR) via onsite (or virtual) provider audits.
   b. Monitoring of claims and encounters data.
   c. Member outreach utilizes a three-step methodology: Two phone calls and one mailer.

   The IHA workgroup is collaborating with Provider Engagement to identify barriers with high volume low performing providers on a quarterly cadence. Provider training is ongoing.

Additional Quality Improvement Reports were presented including Member Incentive Report, County Relations, Skilled Nursing Facility QAPI Quarterly Report, Performance Improvement Project (PIP) Updates, and others scheduled for presentation at the QI/UM Committee during Q1.

III. Access Related Reporting for Quarter 1 included:

1. **Access Workgroup Report for December 2025/January 2026.**
2. **Access Work Group minutes from 09/30/2025 & 12/02/2025.**

Other Access-related reporting included the Standing Referrals Report, Specialty Referrals Report, and Provider Office Wait Time Report.

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

1. **The Key Indicator Report (KIR) and Concurrent Review Report** provided data for Q4 2025 and January 2026. A quarterly comparison was reviewed for 2025 with the following results:
   a. **Acute Admits** (adjusted PTMPY), remained stable with a downward trend noted for SPDs.
   b. **Acute Length of Stay and Readmissions** (all adjusted PTMPY) shorter hospital stays noted for MCE, TANF and SPDs without an increase in readmissions. This suggests improved discharge planning and more efficient inpatient care.
   c. **Care Management:** Behavioral Health, Perinatal, Physical Health, Transitional Care Services (TCS), and First Year of Life demonstrated improvements in referrals, member engagement, and cases managed in 2025.
   d. **Turn-around Times:** Routine Deferral letters missed the goal in Q1 to Q3, but compliance met (100%) in Q4. Some variation noted for other TAT metrics therefore, Health Net TAT CAP remains open.

2. **Inter-rater Reliability Results for Physicians and Non-physicians** is an annual evaluation of UM physicians and staff to ensure InterQual® Clinical Decision Support Criteria along with other evidence-based policies and guidelines are used consistently during clinical reviews for medical necessity.
   All UM staff and physicians undergo InterQual training upon hire with annual updates and retesting. In Q3 & Q4 2025, InterQual® IRR testing was administered, requiring a minimum passing score of 90% to demonstrate proficiency. Results included:
   a. Average initial test scores for non-physicians and physicians were 93.5% and 92.0%, respectively.
   b. Individuals in leadership roles, including supervisors, managers, and directors, demonstrated consistently high performance, with nearly all meeting or exceeding the 90% threshold across their assigned tests.
   c. Acute Pediatrics was a consistent strength area, with a high proportion of results at or above 90%.
   d. Focused training in DME, Home Care, Subacute and Skilled Nursing is likely to produce measurable improvement, given the strong pattern of score increases following remediation.

3. **Enhanced Care Management and Community Supports Report (Q4 2025)** summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system with program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services.
   - For ECM, of 21,041 members who were assigned in the three (3) CVH counties, 3,854 were successfully enrolled, accounting for an 18.3% enrollment rate. This an improvement compared to 2024.
   - The average assignment to enrollment percentage for each county is: Fresno (19.1%), Madera (22.4%), and Kings County (10.5%).
   - Highest top five ECM providers claims unit submissions were from RH Builders (30%), followed by Universal Healthcare (16%), MedZed (9%), Pair Team (8%), and Central CA Asthma Collaborative (5%), accounting for 68% of all ECM claims submissions.
   - For Community Supports (CS) services, a total of 28,490 authorizations were submitted through December 2025, with 673,677 total claims count. Services most commonly utilized were related to Medically Tailored Meals/Food (36%), Housing Services (24%), Recuperative care (16%) Short-Term Post-Hospitalization Housing (8%), Personal Care Homemaker Services (7.5%) Respite services (2%) and 1% for Asthma Remediation, Day Habilitation and other remaining services.
   - DHCS has identified specific monitoring goals for ECM and CS services, including the key priorities needed to achieve that goal.
   - Key priorities include expanding provider networks to deliver ECM and CS, increasing access to and uptake of ECM and CS, and improving delivery of ECM and CS services.

Additional UMCM Reports including the CCS report, CCR Inter-rater Reliability Report, Care Management & CCM, PA Member Letter Monitoring, SPD Health Risk Assessment, TurningPoint, Evolent (NIA), UM Information Integrity for Appeals and Denials, and others scheduled for presentation at the QI/UM Committee during Q1.

V. **Pharmacy quarterly reports** include **Pharmacy Operations Metrics**, **Top Medication Prior Authorization (PA) Requests**, **Inter-rater Reliability Review Report** and **Quality Assurance Results** which were all reviewed for Quarter 4. All metrics are expected to be within 5% of the standard or goal.

All metrics were within 5% of the goal this quarter with an average **turn-around time rate of 99.8%.** Prior authorization volumes were lower in Q4 compared to Q3 with some drug-specific differences. October had a higher volume than other months in the quarter.

Inter rater Reliability & Quality Assurance reports demonstrated that the 95% goal was **not met for Q4 or for the year, but the 90% threshold for action was consistently met** with an average of **94%** for the year. An analysis of the data revealed that *Criteria Application* and *Clarity of the Response* were the largest contributing factors to not meeting the goal. Results are shared with Prior Authorization management to discuss opportunities for improvement with individual staff. The Plan provides ongoing feedback and guidance on all cases reviewed.

VI. HEDIS® Activity

In Q1, HEDIS® related activities focused on data capture for measurement year 2025 (MY25). Managed Care Medi-Cal health plans had eighteen (18) quality measures they were evaluated on for MY2025, and the Minimum Performance Level (MPL) continued to be the 50th percentile. Activities included:

1. Finalized and submitted the MY2025 HEDIS® Roadmap on January 23, 2026.
2. MY2025 HEDIS® data gathering from clinics and providers in progress throughout the three-county area with final submission to DHCS and HSAG by June 15th, 2026.
3. Completed Annual HEDIS® Audit on March 3rd, 2026.
4. Initial reports are in review for compliance with MCAS measures for MY2025.

VII. Quality Improvement Activities

A. Two Performance Improvement Projects (PIPs):

1. **Clinical Disparity PIP** - Improve Infant Well-Child Visits in the Black/African American(B/AA) Population in Fresno County. Project with Black Infant Health (BIH).
   - Received feedback from HSAG/DHCS on annual submission. Received score of High Confidence 100% for Methodology and Moderate confidence 33% for achieved significant improvement due to second indicator tested did not show significant improvement.
   - Intervention period concluded 12/31/2025. Continuing collaboration with BIH but project ended.
   - Continuing to gather data. Final submission due **August 6th, 2026**.
2. **Non-Clinical PIP** - Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue.
   - Received feedback from HSAG/DHCS on annual submission. Received score of High Confidence 100% for Methodology and High confidence 100% for achieved statistical significance.
   - Continuing to gather data. Final submission due **August 6th, 2026**.

B. Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative Phase 2 *August 2025 to September 2026.* Continuing collaborative effort with **Clinica Sierra Vista** (CSV) and IHI to improve **WCV for *Hispanic Children 0-15 months*** in Fresno County through testing of four targeted interventions related to:

- **Intervention #1 Expanding Appointment Access & Scheduling -**in progress
- **Intervention #2 Optimize Workflows** -Newborn Gateway- in progress
- **Intervention #3 Connect Members to Resources –** Community Baby Showers w/CPSP- in progress
- **Intervention #4 Connect Families to Navigation Services –** Establish routine referral process for eligible families to WIC and imbed in EMR.

VIII. Findings/Outcomes

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

Two areas of non-compliance that were identified through routine monitoring during Quarter 3 2025 continue with open corrective action plans through Quarter 1 2026:

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.

Item #14

Attachment 14.F

Equity

- Health 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. UPDATE 05/2026- CalViva Health continues to collaborate with the HOPE HUB and the Central Valley Developmental Services Program (CVDSP) Taskforce. As part of this work, CVH is leading a provider-focused service and equity assessment among organizations serving individuals with developmental disabilities to identify health gaps impacting the families they support. Findings from this assessment will inform a follow-up survey distributed to families to gather more in-depth insights. CVH and HOPE HUB are working closely to ensure the survey is translated into requested languages and to leverage Community Health Workers (CHWs) to support families who may prefer to complete the survey by phone. Planning and implementation details are currently in development.

Health Equity Annual Activities	Status
Diversity, Equity and Inclusion Survey and training	1/2026 Health Outcome Survey Distributed – Pending. UPDATE 05/2026-While NCQA has removed the DEI survey requirement, CalViva Health remains committed to advancing internal equity and inclusion efforts. To support continuous improvement, an internal staff feedback survey was distributed at the end of April to evaluate the impact of recent engagement activities and to guide future initiatives that strengthen workplace culture and belonging.
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. UPDATE 05/2026- DHCS has provided a verbal update indicating a potential shift away from requiring NCQA accreditation for MCPs, with key elements expected to be integrated into future contractual requirements. Although no formal guidance has been released to date, CalViva Health will continue to pursue NCQA Health Equity Accreditation and associated activities to ensure compliance readiness, maintain alignment with industry best practices, and mitigate potential regulatory risk during this transition period.
Health Equity Annual Oversight Audit- HN	Oversight Audit Schedule to start- April 2026

Health Equity Community Activities/ Updates	Who	Activity

Item #14

Attachment 14.G

Executive Report

- Executive Dashboard

	2025	2025	2025	2025	2025	2025	2025	2025	2025	2025	2026	2026	2026
Month	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
CVH Members													
Fresno	344,009	343,946	344,786	345,260	345,340	342,450	340,709	339,554	339,029	338,291	334,955	332,883	331,574
Kings	38,595	38,593	38,656	38,654	38,730	38,789	38,783	38,729	38,689	38,719	38,543	38,391	38,329
Madera	50,015	50,185	50,466	50,725	50,974	50,958	50,850	50,648	50,627	50,523	50,017	49,650	49,306
Total	432,619	432,724	433,908	434,639	435,044	432,197	430,342	428,931	428,345	427,533	423,515	420,924	419,209
SPD	47,614	47,581	47,873	48,033	48,339	48,274	48,274	48,382	48,315	48,254	47,340	47,218	46,990
CVH Mrkt Share	66.75%	66.77%	66.79%	66.79%	66.78%	66.81%	66.79%	66.83%	66.84%	66.89%	66.83%	66.85%	66.89%
ABC Members													
Fresno	152,377	151,970	151,951	151,925	151,700	149,921	148,987	147,973	147,293	146,465	144,988	143,482	142,360
Kings	25,007	24,942	25,042	25,020	25,119	25,190	25,146	25,108	25,166	25,184	25,211	25,126	25,016
Madera	27,723	27,650	27,553	27,607	27,669	27,375	27,240	27,076	26,930	26,742	26,472	26,186	25,888
Total	205,107	204,562	204,546	204,552	204,488	202,486	201,373	200,157	199,389	198,391	196,671	194,794	193,264
Kaiser													
Fresno	8,737	9,020	9,356	9,681	10,001	10,252	10,551	10,714	10,976	11,117	11,321	11,662	11,971
Kings	206	209	206	209	215	231	239	246	259	259	269	270	265
Madera	1,485	1,565	1,608	1,656	1,700	1,741	1,775	1,811	1,843	1,864	1,923	1,986	2,013
Total	10,428	10,794	11,170	11,546	11,916	12,224	12,565	12,771	13,078	13,240	13,513	13,918	14,249
Default													
Fresno	61.18%	62.07%	60.31%	61.10%	61.03%	58.94%	61.52%	59.59%	60.44%	63.29%	64.73%		
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	64.88%	62.72%	61.33%	60.48%	61.50%	59.30%	61.73%	60.40%	60.85%	61.54%	59.09%		
Kings	61.16%	58.03%		52.59%	54.22%	55.81%	56.51%		55.43%	56.30%	53.62%		
Madera	64.47%	71.61%	63.59%	65.45%	64.90%	65.07%	61.08%	63.92%	65.14%	57.46%	55.67%		

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.
	# of Devices in IT Environment with low space	**0**	Description: These devices are at higher risk for slow performance, failed updates, or application issues
	# of Devices in IT Environment which have been deemed End-of-Life	**0**	Description: Devices running operating systems that are no longer supported or approaching the end of support.
	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	**3.0 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.		

		Year	2024	2025	2025	2025	2025	2026
		Quarter	Q4	Q1	Q2	Q3	Q4	Q1
Member Call Center CalViva Health Website	(Main) Member Call Center	# of Calls Received	33,900	41,923	40,133	42,619	37,637	43,343
		# of Calls Answered	33,610	41,609	39,766	42,295	37,365	42,983
		Abandonment Level (Goal < 5%)	0.90%	0.70%	0.90%	0.80%	0.70%	0.80%
		Service Level (Goal 80%)	93%	92%	94%	96%	95%	89%
	Behavioral Health Member Call Center	# of Calls Received	827	1,008	917	963	847	938
		# of Calls Answered	816	1,004	909	959	843	933
		Abandonment Level (Goal < 5%)	1.30%	0.40%	0.90%	0.40%	0.50%	0.50%
		Service Level (Goal 80%)	88%	95%	96%	98%	98%	98%
	Transportation Call Center	# of Calls Received	14,123	14,958	15,899	18,401	21,331	22,357
		# of Calls Answered	14,010	14,868	15,819	18,327	21,246	22,267
		Abandonment Level (Goal < 5%)	0.60%	0.40%	0.20%	0.20%	0.30%	0.20%
		Service Level (Goal 80%)	82%	86%	85%	84%	91%	91%
	CalViva Health Website	# of Users	69,000	79,000	34,000	54,000	52,000	53,000
		Top Page	Main Page	Main Page	Main Page	Main Page	Main Page	Do You Qualify
		Top Device	Mobile (73%)	Mobile (70%)	Mobile (63%)	Mobile (62%)	Mobile (63%)	Mobile (70%)
		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 5,120 members have registered and created a member portal account.							

CalViva Health
Executive Dashboard

Provider Network & Engagement Activities							
Year	2025	2025	2025	2025	2026	2026	2026
Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospitals	11	11	11	11	11	11	11
Clinics	166	166	167	168	169	169	170
PCP	448	446	453	457	447	440	438
PCP Extender	522	509	504	511	515	506	514
Specialist	1693	1622	1629	1633	1553	1528	1549
Ancillary	334	336	338	341	341	344	343

Year	2024	2024	2025	2025	2025	2025	2026
Quarter	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Behavioral Health	658	558	545	562	486	295	460
Vision	113	114	112	104	106	35	41
Urgent Care	16	17	17	16	16	12	15
Acupuncture	3	2	3	3	3	7	8

Year	2024	2024	2024	2025	2025	2025	2025
Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% of PCPs Accepting New Patients - Goal (85%)	94%	94%	91%	89%	89%	92%	92%
% Of Specialists Accepting New Patients - Goal (85%)	98%	97%	96%	96%	96%	97%	92%
% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	97%	98%	99%	99%	99%	95%	94%

Year	2025	2025	2025	2025	2026	2026	2026
Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Providers Interactions by Provider Relations	446	363	326	445	375	623	564
Reported Issues Handled by Provider Relations	39	23	17	23	55	69	46
Documented Quality Performance Improvement Action Plans by Provider Relations	3	13	9	0	3	23	22
Interventions Deployed for PCP Quality Performance Improvement	3	13	9	0	3	23	22

Message From the CEO

Management is continuing to work with the Plan's Administrator on monitoring counts of the network data which is being represented in the Plan's provider directories.

CalViva Health
Executive Dashboard

	Year	2024	2024	2024	2025	2025	2025	2025
	Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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	94% / 98% N/A	96% / 98% N/A	99% / 99% 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	N/A	99% / 100% NO	100% / 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 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	88% / 99% YES	80% / 100% YES	79% / 95% YES	91% / 100% YES	84% / 99% YES	83% / 99% YES	84% / 100% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	94% / 97% NO	96% / 100% YES	93% / 100% YES	92% / 100% NO	92% / 100% YES	83% / 100% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	95% / 100% NO	97% / 100% YES	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	95% / 100% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	98% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	99% / 100% NO	97% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	79% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 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	Q4 2025 numbers are available. Management is monitoring the performance of PPG 2 and PPG 3							

CalViva Health
Executive Dashboard

Provider Disputes	**Year**	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**	**2025**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	99%	100%	99%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	99%	99%	100%
	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 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	78%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	93%	99%	96%	99%	95%	99%	99%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	99%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	97%	98%	100%	100%	99%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	99%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	99%	100%	100%	99%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	100%	100%	100%	100%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	98%	100%	100%	100%	100%
Message from the CEO	Q4 2025 numbers are available. Management is working with PPG 2 on performance. All other areas met goal.							