Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
May 21, 2026

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

	Commission Members		
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health	✓	**Tim Haydock**, 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 1:32 pm. A quorum was present.		
#2 Roll Call	A roll call was taken for the current Commission Members.		*A roll call was taken.*

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Cheryl Hurley, Clerk to the Commission			
#3 Kings County BOS Appointed Commissioner **Action** Joe Neves, Co-Chairman	The Commission ratified the appointment of Timothy Haydock for the Kings County BOS appointed At-Large Commission seat.		***Motion:*** *The appointment of Timothy Haydock was ratified.* *10 – 0 – 0 – 7* *(Frye / Naz)*
#4 Kings County At-Large Commission Seat **Action** Joe Neves, Co-Chairman	The Commission voted to reappoint Kerry Hydash for an additional three-year term for the Kings County At-Large Commission seat.		***Motion:*** *Commission approved reappointment of Kerry Hydash.* *10 – 0 – 0 – 7* *(Soares / Prado)*
#5 Chair and Co-Chair Nominations for FY 2027 **Action** Joe Neves, Co-Chairman	The Commissioners nominated and subsequently re-elected David Hodge, MD as chair and Supervisor Joe Neves as Co-Chair to serve during Fiscal Year 2027.		***Motion:*** *Chair and Co-Chair nominated and appointed for FY 2027.* *10 – 0 – 0 – 7* *(Naz / Frye)*
#6 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** Joe Neves, Co-Chairman	All consent items were presented and accepted as read.		***Motion:*** *Consent Agenda was approved.* *10 – 0 – 0 – 7* *(Naz / Soares)*

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#7 Closed Session	Jason Epperson reported out of closed session. The Commission discussed in closed session the items agendized in closed session discussion; direction was given to staff. The commission took no other reportable action. Closed session was recessed at 1:58 pm.		***No Motion*** *Jennifer Armendariz arrived at 1:41 pm*
#8 CEO Annual Review **Action** Joe Neves, Co-Chairman	Commission members selected for the CEO Annual Review ad-hoc committee are Dr. Hodge, Paulo Soares, and Mr. John Frye.		***Motion:*** *Ad-hoc committee was selected and approved.* *11 – 0 – 0 – 6* *(Naz / Fields-Keene)*
#9 Sub-Committee Members FY 2027 **Information** Joe Neves, Co-Chairman	No changes in Commission members were made for FY 2027 to the following committees, as described in BL 26-101: • Finance Committee • Quality Improvement/Utilization Management Committee • Credentialing Sub-Committee • Peer Review Sub-Committee • Public Policy Committee		***No Motion*** *Paulo Soares left the meeting at 2:03 pm; no vote after #8.*
10. Community Support & DHCS Reinvestment Program **Action** J. Nkansah, CEO	Jeff Nkansah presented a summary of the 2026-2027 Community Support & DHCS Reinvestment Program and proposed grant recommendations. 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.		***Motion:*** *Review and approve the Community Support & DHCS Reinvestment Program for 2026-2027* *9 – 0 – 0 – 8* *(Haydock / Prado)* *Technical difficulties, no vote from Kerry Hydosh for #10.*
11. Health Equity Program **Action** P. Marabella, CMO	Dr. Marabella presented the 2025 Health Equity Annual Evaluation and the 2026 Health Equity Program Documents.		***Motion:*** *See #13 for motion*

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	Regarding the Health Equity Annual Evaluation, all 2025 workplan activities were completed. Language Assistance Services: Some of the activities completed include: • A member newsletter article on how to access language services was completed and disseminated. • 125 staff completed their bilingual assessment/re-assessment. • MY2024 Geo Access report completed in November. • 26 translation reviews were completed in 2025. • Attended quarterly CAHPS Action Plan meetings and provided feedback for health equity interventions. • 10 health education materials were field tested. Compliance Monitoring Some of the activities completed include: • HEQ reviewed 8 interpreter complaints and 29 grievance cases with 3 interventions identified. • 2024 grievance trending report was completed in Q2. • Launched Findhelp and Cozeva integration in 2025. • Two Findhelp trainings were completed for staff with 245 attendees and 2 provider trainings with 86 attendees. 288 new programs were added to the platform. Communication, Training, and Education Some of the activities completed include: • One A&G training was completed on coding and resolution of grievances. • Two Call Center trainings conducted for 47 new staff. • Providers were updated on cultural practices, LAP services, health literacy, and on-line cultural competency/Office of Minority Health (OMH) training. • Language identification poster for provider offices was remediated and posted in provider library. Health Literacy, Cultural Competency, and Health Equity		

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	Some of the activities completed include: • English material review completed for a total of 58 materials. • Conducted Plain Language training to 9 staff. • Implemented Diversity, Equity & Inclusion (DEI) and Transgender, Gender Diverse or Intersex (TGI) trainings for providers to meet All Plan Letter 24-017 and APL 24-018. Cultural competency training extended to be completed by providers by 12/31/2026. • Completed cultural competency education through Culturally and Linguistically Appropriate Services (CLAS) Month. • Supported the completion of quality projects for Well Child Visits (W30-6+) and SUD/MH. • Completed 3 focus groups on perimenopause/menopause. Perimenopause and Menopause Awareness Campaign was completed in October. Regarding the Health Equity 2026 Program Description, the following changes were made: • Updated NCQA Accreditation name • Due to DHCS APL-25-005 updated tagline term to "Notice of Availability of Language Assistance Services and Auxiliary Aids and Services" (NOA). • Removed list of topics from Cultural Competency Training and instead referenced the CalViva Health Policy (CA.CLAS.10). • Included information on training completed by providers, which can be found in the Provider Directory. • Updated health literacy process to include "Content and Layout Review checklist to streamline EMRs". Updated title of section. • Changed the checklist name from Cultural Competency and Plan Language checklist to Content and Layout Review checklist. • Updated Health Equity Interventions to new intervention strategies. • Remove Population Needs Assessment (PNA) from the Health Equity Program Description, as responsibility has moved to the Population Health Management team. • Removed Director of Program and added VP of Quality Management. Regarding the 2026 Health Equity Work Plan, the following key updates include:	*Joe Prado asked if there is an opportunity to think about HEDIS follow-thru stating he would be willing to work with a group to see about offering an option to new mothers*	

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	• Removed Population Needs Assessment (PNA) from workplan as the Health Equity Department now instead contributes to Population Health and the Community Health Assessment which is developed in collaboration with each county. • Added, Attendance at Community Events and meetings to sustain local relationships and partnerships. • Expanded activities associated with Oversight of Provider Training in collaboration with other departments. • Updated the project goal for Phase 2 of the IHI/DHCS Child Equity Sprint Collaborative focusing on improving Well Child Visits for non-Spanish speaking Hispanic children 0-15 months at 3 targeted clinic sites from Clinica Sierra Vista in Fresno County. • Adding three new activities: o Partner with Kings County Public Health to advance their Community Health Improvement Plan (CHIP) priorities to improve preventive care, access and outcomes. o Participate in the Fresno CHIP to develop and administer a provider-facing survey to identify gaps in Developmental Services and Convene a Community Advisory Council by Q3. o Co-lead the Diabetes and Heart Health Workgroup within Madera County Public Health Live Well Madera initiative to improve prevention, early detection, and management of chronic conditions among priority populations.	*prior to discharge for scheduling their first well-child visit.* *Dr. Marabella stated there is an opportunity to discuss potential collaborative activities. There are various projects such as the PIP working with Black Infant Health and Black/African American birthing parents. There can be challenges when working directly in hospitals due to the various health plans involved. . There is outreach to birthing parents and providers are incentivized to report pregnancy which facilitates contact with parents.*	
12. Population Health **Action** P. Marabella, CMO	Dr. Marabella presented the 2026 Population Health Management Strategy Description. Highlights of Changes for 2026: • Population Needs Assessment (PNA): Added reference to rename of Population Needs Assessment to "Local Planning". Added Local Planning requirements including participation in each LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process and data sharing. • Stakeholder Engagement: Removed requirement for PNA report to be available on health plan's website.		***Motion:*** *See #13 for motion*

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	• Population Stratification: Updated definitions and descriptions including Population Stratification and PHM Risk Stratification, Segmentation and Tiering (RSST) methodology. Updated the PHM model. Added Adverse Childhood Experiences (ACEs) screening to ways in which SDoH needs are identified. • Basic Population Health Management (BPHM): Added information on First Year of Life program. Added statement on Care Management availability to members at any time and any age to support with physical health, behavioral health, or SDoH needs. • Transitional Care Services: Changed "Conducting an initial outreach call within 72 hours of inpatient referral" to "successfully connecting with the member within 7 days of discharge to complete an inpatient discharge risk assessment". Removed "A minimum of 2 follow up calls are made to the Member within 15 days of discharge". • PHM Programs and Services: o Updated age eligibility criteria and program goals. Added program services and updated verbiage. Added program eligibility criteria. o Updated eligibility criteria for Pregnant Members at risk for adverse maternal and neonatal outcomes using the new Pregnancy Prioritization logic. Updated Program services to include Trimester Based Assessment, Edinburgh Postnatal Depression Scale and Patient Health Questionnaire-9. o Added Enhanced Care Management (ECM) to supplemental support for Members. o Updated details of the Diabetes Management Program goal to explain that a lower rate indicates better performance for GSD. Removed value of directional improvement of 1-5% from program goal. • PHM Programs and Services: o Updated program name and eligibility criteria throughout. o Updated Program goal for Tobacco Cessation. o Updated eligibility criteria for BCS Screening to 40-74 years. Added high-risk breast cancer screening e-project for appropriate member outreach, scheduling, and follow-up to program services.		

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	○ Added phobia, anxiety and additional self-harm diagnoses to the denominator in the event/diagnoses for Severe and Persistent Mental Illness and Follow-Up Care after Mental Health Emergency Department Visits (SPMI & FUM). • External Partnerships: Within Local Health Departments, removed COVID-19 information and added community-based vaccination events. • Data and information sharing with Practitioners: As Behavioral Health Quality Improvement Program (BHQIP) ended added information on developing new partnerships and data exchange options to facilitate bidirectional data exchange with organizations across California through the MOU process		
13. Long Term Care **Action** P. Marabella, CMO	Dr. Marabella presented the 2026 Long-Term Care Quality Assurance & Performance Improvement Plan. <u>Responsibility for Quality of LTC</u> With responsibility for contracting with providers and authorizing members to receive LTC services, health plans are required to establish a system for monitoring and overseeing the quality of services provided to their members. The goal is for continuous, data-driven improvement across the full long-term-care continuum, and the scope is all three service counties in and out of network for skilled nursing facilities (SNF). <u>LTC Quality Plan</u> • Ongoing, comprehensive program covering clinical care, quality of life & resident autonomy. • Multi-source data integration: ○ Claims Data ○ Data from DHCS ○ CDPH Survey Data (Publicly available) ○ Critical Incident Data (Never events) ○ Appeal & Grievance Data ○ Satisfaction Data • Benchmark against Title 22/42, LTC MCAS measures, CMS quality metrics, others as indicated. • Oversight: QI/UM Committee & RHA Commission		***Motion:** Approve the Health Equity Program documents, the Population Health Program Strategy Description, and Long Term Care documents.* *10 – 0 – 0 – 7* *(Naz / Frye)* *Kerry Hydash reconnected; vote included.*

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	Components of the Plan • Main monitoring tool is a Quarterly QAPI Dashboard Report. • CalViva LTSS Liaison maintains dashboard, leads SNF & stakeholder engagement, and ensures transparency. • A cross-functional team (LTSS, UM, Transitional Care, Contracting, Quality/Data Analytics, etc.) updates the dashboard on a quarterly basis by gathering and compiling data from the various sources. • QI/UM Committee reviews the Dashboard Report to identify trends and opportunities. • CVH Collaborates with SNFs, LTC Ombudsman, CBOs for root-cause analysis & technical assistance. LTC Dashboard Monitoring • Integrated monitoring: claims analytics, public survey metrics, MCAS LTC measures per SNF/county. • Track ED visits, preventable admissions/readmissions, HAIs, infection control, staffing, abuse/neglect. • PQI system for reporting & investigating potential quality issues / critical incidents. Tied to Appeal & Grievance Data. • Adverse events: root-cause analysis, corrective action plans for prevention of recurrence (ensure CDPH has completed). • Active feedback loops with staff, residents, families incorporated into improvement cycle. Satisfaction/complaints. 2025 Long Term Care Skilled Nursing Facility Dashboard Q4 The Dashboard will capture data from the following sources: • Claims Data – ED and inpatient • DHCS Supplied WQIP Data –scoring system that uses a combination of metrics across workforce, clinical quality and equity domains to determine incentive payments for skilled nursing facilities. • Publicly Available Data- CMS & CDPH data including survey and complaint data and critical incident (never events) • MCAS/HEDIS Long Term Care measures		

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	The Dashboard will monitor for: • Preventable ED visits • Preventable admissions/readmissions • Healthcare acquired infections • Facility Staffing Issues • Abuse/neglect • Potential Quality Issues • Adverse events • Member Satisfaction/complaints SNF Dashboard 2025 Member Utilization + SNF Performance: • There are 36 licensed SNFs in the CalViva Health designated service area. • In the last 12 months, CalViva Health Members were admitted to 90 different nursing homes statewide. • As of October 2025, there were approximately 1,100 members. • The top ten facilities with the most members are: o Madera Rehabilitation o Community Subacute o Healthcare Centre of Fresno o Centerpointe Cre Center o Hanford Post Acute o Sunnyside Convalescent Hospital o Sierra Vista Healthcare o Fresno Post Acute Care o Manning Gardens Care Center o Cornerstone Care Center SNF Dashboard 2025 Quality Categories: There is a weighted 5-point scale used for the metrics in the Quality Categories as indicators of overall quality of care and outcomes for the skilled nursing facilities in CalViva Counties to assign an overall score for each facility. Metrics used to identify and trend the quality of providers include the following Quality Categories:	*Sara Bosse stated it would be good to know how these top 10 SNFs rate as having approaches where the plan intensively work with the facilities that have the higher volumes would be great.* *Dr. Marabella stated they are tracked quarter to quarter to monitor rates. We can modify our analysis when indicated.* *Dr. Naz asked in reference to the medical problems, what kind of medical trackers do we have? Do we credential them or do they credential them? Do we check on them? This is a big concern. Who makes rounds in those facilities?*	

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	• 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 SNF Dashboard 2025-Q4 Top Performing SNF Weighted 5-Point Scale • The number one SNF is Fowler Care Center. • Top ranked SNFs saw quarter over quarter improvement in overall quality scores from an average of 4.2 in Q3 2025 to 4.3 in Q4 2025. • Fowler Care Center improved 0.54 points to take the top rank. SNF Dashboard 2025-Q4 Bottom Performing SNF Weighted 5-Point Scale • The lowest ranked SNF is Oakhurst Healthcare Center. • 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. 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 SNF Dashboard Barrier Analysis	*Dr. Marabella responded it's not specified in the summary report but the spreadsheet includes monitoring staffing (WQIP). This is monitored closely by the state to ensure adequate staffing, which includes qualified medical staff.* *John Frye asked if Community Subacute is the only subacute?* *Dr. Marabella responded, in town, yes.* *John Frye asked if that gives a different patient population that skews any of the numbers?* *Dr. Marabella responded yes, their acuity may be higher, however we want to include them in our monitoring*	

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	• Staffing Challenges in Central Valley o SNFs report 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 o Patients showing behavioral health needs/episodes in acute care are not assessed or evaluated by the acute psychiatric physicians.		
14. Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of March 31, 2026</u> As of March 2026, total current assets were approximately $720.7M; total current liabilities were approximately $528.4M. Current ratio is approximately 1.36. TNE as of the end of March 2026 was approximately $201.9M which is approximately 678% above the minimum DMHC required TNE amount. For the DHCS standard, the minimum required TNE is approximately $196.4M, which the Plan is approximately $5.6M above the DHCS standard. Interest income actual recorded was approximately $7.3M which is approximately $3.3M more than budgeted due to interest rates staying higher than projected. Premium capitation income actual recorded was approximately $1.77B which is approximately $242.6M more than budgeted primarily due to rates and enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $1.14B which is approximately $234M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $42.3M which is approximately $2.6M more than budgeted due to enrollment being higher than projected. Labor expense actual recorded was approximately $3.5M which is approximately $543K less than projected mainly due to open positions during the current fiscal year. DMHC license expense actual recorded was approximately $965K, which is approximately $370K less than budgeted due to the assessment		***Motion:*** *Commission approved standing reports* *9 – 0 – 0 – 8* *(Frye / Prado)* *Joyce Fields-Keene left meeting at 3:31 pm, no vote for #14*

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	being less than projected. All other expenses are in line or below budgeted amounts. Total net income through March 2026 was approximately $17.8M, which is approximately $11.2M more than budgeted primarily due to interest income being approximately $3.3M more than projected and enrollment and rates being higher than projected. In addition, in March 2026, the Plan assessed a $1.2M performance penalty to Health Net due to repeated regulatory audit findings not corrected. <u>FY 2027 Proposed budget</u> On March 19, 2026, the FY 2027 budget was reviewed and approved by the Finance committee to move to the Commission for recommendation of full review and approval. With regard to budget assumptions, enrollment is projected to decline in fiscal year 2027, primarily due to a number of factors, one being the 1/1/2026 freeze on the UIS undocumented enrollment for those age 19 and over. The effects of that flowing through into fiscal year 2027, specifically the first six months of FY 2027, July 2026 through December 2026. Secondly, the Plan is anticipating the undocumented members will move out of Medi-Cal managed care into a fee for service (FFS) delivery system. That is due to a letter from CMS, that was sent out to state Medicaid directors in September of 2025, which communicated their revised interpretation of federal law, which states that States can no longer cover undocumented members in a Medi-Cal managed care environment. For CalViva, that equates to approximately 52,000 CalViva members being disenrolled effective 1/1/2027. Statewide, that amounts to approximately 2 million undocumented members moving from Medi-Cal managed care into a FFS delivery system. The state May revised budget was released the week of May 11th, and it was confirmed that the state will move forward with the policy in terms of moving the undocumented members out of Medi-Cal managed care into a FFS delivery system. For the members moving into FFS, they will still have the full scope Medi-		

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	Cal benefits, with the exception of Community Supports and Enhanced Care Management ("ECM"). Additionally, another impact to enrollment relates to the One Big Beautiful Bill or H.R. 1, which requires work or community engagement requirements for Medicaid members for able-bodied adults age 19 and over. This requires able-bodied adults to be engaged in either work or community service or an educational program of at least 80 hours a month, effective 1/1/2027. Initially, the State expected approximately 233,000 Medi-Cal members statewide to disenroll from Medi-Cal; for CalViva, that equates to approximately 7,000 members the Plan would lose during FY 2027. Built into the H.R. 1 work requirement is a hardship exemption, which states that if you live in a county with a high unemployment rate, which they define as the lesser of 8% or 150% of the national unemployment rate, Medi-Cal beneficiaries would be exempt from the requirements. To be conservative, the Plan budgeted approximately 7,000 members leaving CVH. In the State May 2026-2027 revised budget, the State revised their projected disenrollment related to the work requirements from 233,000 to approximately 43,000 as they have identified that most of the Medi-Cal members that would be subject to the work requirements would meet various exemptions such as due to medical frailty or also being enrolled in CalFresh, the California food benefit program. Additional membership impact is related to the redetermination for the adult expansion population from once a year to two times a year, effective 1/1/2027. Initially, the State projected approximately 289,000 Medi-Cal members statewide would lose coverage due to the redetermination moving to two times a year. For CVH, that equates to approximately 8,500 members the Plan would potentially lose. As part of the May revised budget, the State has changed their projection from 289,000 members leaving Medi-Cal statewide to zero because of updated federal guidance which essentially would make this change effective 7/1/2027 (i.e., FY 2028). The next budget assumption highlighted was revenues. Overall, the Plan is projecting revenues to decline relative to FY 2026, primarily due to MCO taxes. As part of the H.R. 1, there are stricter requirements on any provider MCO taxes, essentially requiring these MCO taxes to be broad-based and uniform, which the		

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	current MCO tax in California is not. For context, California charges or assesses a $274 per member month fee to Medicaid plans, in comparison to the $2.25 per member month tax on commercial plans. That is because the Medicaid plans can get paid back the fees that are assessed. For commercial plans, it's an actual tax. As part of H.R. 1, that was essentially disallowed. Technically the State's current MCO tax is not in compliance with H.R. 1 rules, however, CMS provided the State of California a transition period up to the end of calendar year 2026 to be compliant with the new MCO tax rules. When the budget was created, the Plan was unsure of how the State was going to come up with a new MCO tax that was compliant with the new federal and State rules. As such, the Plan did not budget anything for MCO taxes because of the complexity surrounding the new MCO rules. For example, under Prop 35, which passed in 2024, it limits the amount of tax to non-Medicaid plans to $36M in total. For context, the current MCO tax is approximately $7B, noting that any new MCO tax compliant with Prop 35 would amount to a substantially lower MCO tax. As part of the State May revise budget, the Plan did get insight into the new MCO tax the State is looking to propose. They're looking to submit a first proposal that is compliant with Prop 35, being under $36 million for non-Medicaid plans. However, it will not be compliant with H.R. 1 because it will not be uniform. The State fully anticipates that the initial MCO tax proposal will be rejected at the federal level, but they're going to submit a second proposal, which is compliant with H.R. 1 but not compliant with Prop 35. That is the State's way of getting around Prop 35 which would allow the State to divert MCO tax funds back to general fund vs reinvesting MCO tax funds back into Medi-Cal as Prop 35 intended. They are going to assess approximately $8.85 per member month to Medicaid plans and non-Medicaid plans. For CalViva for FY 2027, that would equate to approximately $20M in MCO taxes when for calendar year 2026, the total MCO tax for CalViva was approximately $750M. The recommendation is for CalViva to move forward with this budget as proposed without any changes. Once the MCO taxes are finalized, the Plan will decide if it wants to bring a revised budget to the Commission at that time. The second reason for revenues decreasing is the decrease in enrollment due to the reasons previously mentioned. The projected overall net decrease in revenue is net of an increase in capitation rates paid by DHCS to CalViva and also net of state directed payments, and how CalViva is going to account for them in FY 2027. State directed payments are supplemental payments the State pays Plans, noting that Plans are		

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	then directed to pay to various providers, primarily hospitals. The most material state directed payment program is the private hospital directed payment program. This provides up to $7.2 billion in additional funds to hospitals that serve Medicaid beneficiaries. The change in how the State will pay Plans is because of a CMS final rule which affects how States pay directed payments. Currently and historically, the State would pay Plans the state directed payments retroactively. Beginning 1/1/2027, DHCS is looking to change this payment method and pay state directed payments to Plans monthly (i.e., prospectively). For FY 2027, CalViva budgeted a change in accounting for state directed payments from a balance sheet transaction to an income statement transaction, hence the increase in revenues. There is some discussion between Plans, hospitals, and DHCS about delaying this state directed payment change until 1/1/2028. If DHCS grants this delay, CalViva may bring a revised budget to the Commission for review and approval. Medical revenue is projected to be approximately $1.88B, which is approximately $133.2M less than what the Plan budgeted in FY 2026, primarily due to the MCO taxes ending midway through fiscal year 2027, net of an increase in rates paid by DHCS and the state directed payments being incorporated into the income statement. Interest income is projected to be approximately $6.9M, which is approximately $1.9M more than the Plan budgeted in FY 2026 due to the Federal Reserve being slower to cut rates, and the Plan predicts rates might stay higher for a little longer than what was projected in FY 2026. Medical cost expense is projected to be $1.43B, which is approximately $246M more than the Plan had budgeted in FY 2026 primarily due to the capitation rates increasing and also the inclusion of the state directed payments in revenue and medical cost expense for fiscal year 2027. Admin service agreement fees expense is projected to be $48M, which is approximately $4M less than what we had budgeted in FY 2026, primarily due to the projected decline in enrollment.		

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	Salary, wages, and benefits expense is projected to be $5.7M, which is approximately $285K more than the Plan had budgeted in FY 2026, as the Plan is potentially looking to hire additional staff in FY 2027. Grants, community reinvestment expense is projected to be $6M, which is approximately $1.6M more than what the Plan had budgeted in FY 2026, primarily due to the Plan looking to begin the first phase of community reinvestment in FY 2027 and also the second phase, which is based off of the calendar 2025 net income in FY 2027 as well. Insurance expense is projected to be approximately $554K, which is approximately $69K more than what the Plan budgeted in FY 2026, primarily due to increase in premiums, specifically related to the Plan's cyber insurance policy. MCO taxes, as previously mentioned, are projected to be $376.7M, which is $376.7M less than the Plan had budgeted in FY 2026 due to the current MCO tax ending midway through FY 2027 on 12/31/26. Capital expenditure budget is projected to be $500K, which is $100K less than what the Plan budgeted in FY 2026 due to tenant improvements that were made for a vacant office space which ending up being less than what we initially projected. The Plan will allocate some funds for capital expenditures for any improvements to the building in FY 2027. Net income is projected to be $10.6M for FY 2027, which is approximately $1.6M more than what the Plan budgeted in FY 2026, mainly due to an increase in interest income, net of a decrease in membership.		
• **Medical Management** P. Marabella, MD, CMO	**Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievance Data Analysis CAHPS Report for Q1 2026.		

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	• Year-over-year comparison show appeals have increased in Fresno and Madera counties. • Year over year comparison shows grievances have increased in Fresno and Kings counties. • Top drivers for year over year increases in grievances are: o Interpersonal o Transportation o Balance Billing o Access to Care o Prior Authorization Delay o Provider • Year over year, and quarter over quarter, the top drivers for Not Medically Necessary appeals were DME and Diagnostic Testing. For Community Supports, the top drivers for year over year, and quarter over quarter were Meals/Medically Tailored Meals, and Housing Deposits. Summary for Appeals: • 175 total appeals in Q1 2026 • 68% (119) driven by Not Medically Necessary • 37% concentrated in 4 drivers Summary for Grievances: • 585 total grievances in Q1 2026 • 28.7% (168) categorized under Access to Care • 38.6% concentrated in 5 drivers <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through Q1 2026. • For MCE, Acute admissions and utilization remained consistent through Q1, with figures closely aligning to 2025 averages and showing no significant variance. • With regard to the TANF population, stability persisted with only minimal increase in admissions and utilization in Q1 compared to 2025 levels.	*Joe Prado asked if the plan would be digging deeper into the data to validate the assumption that case management, with help from the ECM and Community Support programs, are keeping members out of the hospital.* *Dr. Marabella stated it would be difficult to track*	

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	• With regard to the SPD population, Q1 remained consistent with minor fluctuations. • ALOS remains within acceptable ranges across all populations, with slight increases that align with observed acuity trends. • Readmissions rates have declined for MCE, remained stable for TANF, and significantly improved for SPDs. • TAT times were met at 100% for all categories with the exception of Expedited Pre-Service Authorization TAT at 98%. <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q1 2026. In Quarter 1, two QI/UM Committee meetings were held on February 19th and on March 19th. Documents reviewed and approved included Program Documents, Oversight Audit Results, and General Documents. The following Quality Improvement Reports were reviewed: Appeal and Grievance Dashboard & Quarterly Reports; Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Reporting, Behavioral Health Performance Indicator Report, Lead Screening in Children Report, The Initial Health Appointment Report, and additional QI Reports for Q1. The Access Related Reporting for Q1 included Access Workgroup Report for December 2025/January 2026, and the Access Work Group minutes from September 30, 2025, and December 2, 2025. The Utilization Management & Case Management reports reviewed were the Key Indicator Report, the Inter-rater Reliability Results for Physicians and Non-physicians, Enhanced Care Management and Community Supports Report for Q4 2025, and additional UMCM reports.	*and the ability to do this is not readily available.* *Jennifer Armendariz added it would be great if there was a way to validate the data.* *Dr. Marabella stated he would relay the information to the UM and Case Management team so see if they could provide the requested information.*	

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	The quarterly Pharmacy reports reviewed were Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, Inter-rater Reliability Review Report, and Quality Assurance Results. The Q1 HEDIS® Activities 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; and 4) initial reports are in review for compliance with MCAS measures for MY2025. Quality Improvement Activities included two Performance Improvement Projects, Improve Infant Well-Child Visits (WCV) in the Black/African American(B/AA) Population in Fresno County, and Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue. And also, Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative Phase 2. DHCS County Projects included Fresno County, Transformational Equity Improvement Project; for Kings County, Comprehensive Equity Improvement Project; and for Madera County, Lean Equity Improvement Project. Two areas of non-compliance that were identified through routine monitoring during Quarter 3 2025 continue with open corrective action plans through Quarter 1 2026: • Utilization Management Turnaround Times for Prior Authorization Deferrals. • 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.		

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• **Equity Report** S. Xiong-Lopez, EqO	**Equity** <u>Equity Report</u> Current updated activities for Health Equity include the following: • Madera Live Well: CVH continues to collaborate with Madera County's Public Health team on Community Health Improvement Plan (CHIP) initiatives. • Kings County CHIP: CVH is actively participating and collaborating with Kings County Public Health team and their Community Health Improvement Plan and participating in three out of the five initiatives. • FCHIP HOPE HUB: CVH 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. • Diversity, Equity and Inclusion Survey and training: While NCQA has removed the DEI survey requirement, CVH 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: DHCS has provided a verbal update indicating a potential shift away from requiring NCQA accreditation for MCPs,		

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	with key elements expected to be integrated into future contractual requirements. Although no formal guidance has been released to date, CVH 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.		
• **Executive Report** J. Nkansah, CEO	**Executive Report** <u>Executive Dashboard</u> Enrollment as of March 2026 is 419,209. Enrollment for Anthem is approximately 193,264, and the enrollment for Kaiser is approximately 14,249. Market Share is currently approximately 66.89%. There were no significant issues or concerns as it relates to IT Communications & Systems, the Member Call Center, Provider Network & Engagement, Claims Processing & Provider Disputes. With regard to the hospital count, Madera Community Hospital is still considered a contracted provider for the Plan. Health Net continues to be in dispute with MCH and continues to exchange confidential settlement correspondence under applicable confidentiality protections. Claims are being paid in accordance with the contract that is in existence between Health Net and the hospital. During a previous commission meeting the board discussed being responsive to impacts or disruptions that might be occurring from a state and federal level. The board agreed to appropriate funding for that and the Plan recently learned of an impact in passing when speaking with an organization in Kings County. Through those conversations, the Plan became aware of an issue related to the Emergency Food and Shelter Program that was affecting various organizations in Fresno, Kings, and Madera Counties. That program is usually through a grant initiative, a federal grant through the Federal Emergency Medical Assistance Program. That particular grant has been disrupted as the administration put it under a manual review when the new administration came in. In addition, there were various		

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	shutdowns and it is impacting close to two fiscal years. The Plan has come in with one time, emergency funding from some of those organizations to stabilize them. The Plan's funding will focus on food assistance and shelter. The following organizations received funding from the Plan: Central California Food Bank, Catholic Charities, Poverello House, West Care, Fresno Mission, Marjaree Mason, Foundation for Central Schools, Salvation Army, KCAO, Soup Kitchen, and St. Bridgid's, Madera Rescue Mission, Madera Community Food Bank, Holy Family Table, and Madera Coalition for Community. The total funding was $803,100.		
11. Final Comments from Commission Members & Staff	None.		
12. Announcements	None.		
13. Public Comment	None.		
14. Adjourn	The meeting adjourned at 3:32 pm. The next Commission meeting is scheduled for July 16, 2026, in Fresno County.		

Submitted this Day: 7.16.26

Submitted by: Cheryl Hurley

Cheryl Hurley
Clerk to the Commission