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

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DATE: July 10, 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, July 16, 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 **10** 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
July 16, 2026
1:30pm - 3:30pm

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

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A	**Fresno County At-Large BOS Reappointment** • Joyce Fields-Keene *Action: Ratify reappointment*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D Attachment 4.E Attachment 4.F Attachment 4.G Attachment 4.H Attachment 4.I	**Consent Agenda:** • Commission Minutes dated 5/21/26 • Finance Committee Minutes dated 3/19/26 • QIUM Committee Minutes dated 3/19/26 • Public Policy Committee Minutes dated 3/4/26 • Finance Committee Charter • Credentialing Committee Charter • Peer Review Committee Charter • Quality Improvement/Utilization Management Charter • Public Policy Committee Charter *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	
	Action	**A. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Executive Officer Annual Review Per Government Code Section 54957(b)(1)	
	Information	**B. Conference with Legal Counsel - Anticipated Litigation.** Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Section 54956.9 of the California Government Code.	

6 Information	Attachment 6.A	**Review of Fiscal Year End 2026 Goals** • BL 26-012 Review of Fiscal Year End Goals 2026	J. Nkansah, CEO
7 Action	Attachment 7.A	**Goals and Objectives for Fiscal Year 2027** • BL 26-013 Goals and Objectives FY 2027 *Action: Approve Goals for FY 2026*	J. Nkansah, CEO
8 information	Attachment 8.A	**Update on July 1, 2025, Health Net Community Solutions Contract** • BL 26-014 Update on July 1, 2025 Health Net Community Solutions Contract	J. Nkansah, CEO
	Handout will be available at meeting	*PowerPoint Presentation will be used for item 9*	
9 Information	Attachment 9.A	**Care Management** • 2025 Program Evaluation & Executive Summary	P. Marabella, MD, CMO
10 Action		**Standing Reports**	
	Attachment 10.A	**Finance** • Financials as of May 31, 2026	D. Maychen, CFO
	Attachment 10.B	**Compliance** • Compliance Report	M.L. Leone, CCO
	Attachment 10.C Attachment 10.D Attachment 10.E Attachment 10.F Attachment 10.G	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Quarterly Summary Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment 10.H	**Equity** • Health Equity Report	S. Xiong-Lopez, EqO
	Attachment 10.I	**Executive Report** • Executive Dashboard *Action: Accept Standing Reports*	J. Nkansah, CEO
11		**Final Comments from Commission Members and Staff**	
12		**Announcements**	
13		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission*	

	but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.	
14	**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for September 17, 2026 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item 3
Attachment 3.A

Fresno County BOS
Reappointed Commissioner

May 20, 2026

Joyce Fields-Keene
Central California Faculty Medical Group dba Inspire Health Medical Group
2625 E. Divisadero Street
Fresno, CA 93721

Subject: Appointment to Fresno-Kings-Madera Regional Health Authority

Dear Ms. Fields-Keene,

We are pleased to inform you that on May 19, 2026, under Chairman Bredefeld's nomination, you were reappointed by the Board of Supervisors to serve on the **Fresno-Kings-Madera Regional Health Authority** (hereinafter referred to as "authority") for a term expiring on **May 1, 2029**. We thank you for your interest in serving our County.

Certificate of Appointment and Oath of Office: Your oath may be executed before a Deputy Clerk in our office or a Notary Public. **Please note you are not considered a voting member of your authority until your oath is taken.** Your original oath is to be filed with your authority and a copy forwarded to the Clerk of the Board's office at the following address:

Office of the Clerk of the Board of Supervisors
ATTN: Dean Dela Cruz
2281 Tulare Street, Room 301
Fresno, CA 93721

Statement of Economic Interests (Form 700): You are required to file a Form 700 for your appointed position. Please contact your authority's staff at (559) 540-7842 or churley@calvivahealth.org for information and instructions on filing your Form 700.

Brown Act Requirements

Newly elected and appointed members of a "legislative body" who have not yet assumed office must conform to the requirements of the Brown Act as if already in office (California Government Code Section 54952.1). Until you hear otherwise, you should immediately begin to refrain from any discussions of authority business, with a quorum of the authority, outside a formal authority meeting. If you have any questions about the Brown Act or your responsibilities and duties under it, please consult your authority's legal counsel.

State Mandated Ethics Training

California Government Code Section 53235 provides that if a local agency (which includes special districts) provides any type of compensation, salary, or stipend to a member of a legislative body, or provides for reimbursement for actual and necessary expenses incurred by a member of a legislative body in the performance of official duties, then all local agency officials shall receive training in ethics. Such local agency officials must receive **two hours** of ethics training within one year of commencing service with the local agency and once every two years thereafter. Please consult your authority's staff or legal counsel with questions relating to this requirement.

Should you be required to comply with the ethics training requirement, the Fair Political Practices Commission (FPPC) offers **free online training** at http://localethics.fppc.ca.gov/login.aspx. This course requires that you log onto the FPPC's website, review the course content materials, and take periodic tests to assure retention of the information. For those who choose this option, please be aware that the certificate will record how much time an individual spends to complete the online training. You must complete **at least 2 hours** of training time in order to be compliant with the training requirement. If an individual completes the online training in less than two hours, the certificate will reflect this, indicating that the individual has not completed the required amount of training.

When you complete the training, you will receive a Proof of Participation certificate to sign and submit to whoever maintains the training compliance records for your authority (e.g., the clerk or secretary for the authority). You should keep a copy of the certificate for your records. The authority is required to retain the certificates as public records for at least five years.

On behalf of the Fresno County Board of Supervisors, we wish to extend sincere appreciation for the time and effort you are giving in service to your community and Fresno County.

Sincerely,

Bernice E. Seidel
Clerk of the Board

cc: **Fresno-Kings-Madera Regional Health Authority**

Item #4
Attachment 4.A-I

Consent Agenda

A. Commission Minutes dated 5/21/26
B. Finance Committee Minutes dated 3/19/26
C. QI/UM Committee Minutes dated 3/19/26
D. Public Policy Committee Minutes 3/4/26
E. Finance Committee Charter
F. Credentialing Committee Charter
G. Peer Review Committee Charter
H. QIUM Charter
I. Public Policy Committee Charter

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.*

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

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

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

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

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

	• 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:
	  ○ Partner with Kings County Public Health to advance their Community Health Improvement Plan (CHIP) priorities to improve preventive care, access and outcomes.
	  ○ 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.
	  ○ 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*

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

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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<u>Components of the Plan</u> • 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. <u>LTC Dashboard Monitoring</u> • 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. <u>2025 Long Term Care Skilled Nursing Facility Dashboard Q4</u> 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		

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

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

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

	• Staffing Challenges in Central Valley
	  ○ 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
	  ○ 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*

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

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

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

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

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

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

	• 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:
	  ○ Interpersonal
	  ○ Transportation
	  ○ Balance Billing
	  ○ Access to Care
	  ○ Prior Authorization Delay
	  ○ 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,		

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

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

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

March 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 February 19, 2026, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Neves / Rahn)*
#3 Financials – as of January 31, 2026 Action D. Maychen, Chair	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		Motion: *Financials as January 31, 2026, were approved* *6 – 0 – 0 – 1* *(Rogers / Soares)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	Plan is approximately $3.2M above the DHCS standard. 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.		
#4 Fiscal Year 2027 Proposed Budget Action D. Maychen, Chair	The revised basic assumptions for FY 2027 budget were presented to the Committee. One change was made related to revenue assumption. The change relates to incorporating state directed payments into the Plan's main capitation rates that are paid monthly. DHCS has confirmed they will begin incorporating state directed payments into the Plan's main capitation rates on a monthly basis beginning January 2027. Historically and currently, the Plan accounted for the state directed payments as a balance sheet entry as it was viewed as a pass-thru type mechanism. However, since it is being paid in the main capitation rates on a monthly basis and the federal government is pushing for the rates to be at risk to Plans, the payments will be deemed at-risk, therefore if DHCS pays the Plan more or less than what the Plan has to pay to the hospitals and providers, the Plan is at-risk for those amounts. This necessitates a change in the way the Plan accounts for these payments from a balance sheet entry transaction to an income statement transaction, which explains the increase in revenues and corresponding expense. It amounts to approximately $167M for FY 2027. The actual proposed budget for FY 2027, medical revenue is projected to be $1.88B, which is $133.2M less than FY 2026 budgeted revenues primarily due to		Motion: *Approve Budget Timetable and Budget Assumptions* *6 – 0 – 0 – 1* *(Frye / Rahn)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	the decrease in MCO taxes by approximately $376.8M, net of an increase in rates and decrease in membership relative to budgeted FY 2026 enrollment . Admin Service Agreement Fee expense is projected to be approximately $48M which is approximately $4M less than what was budgeted in FY 2026 due to a projected decline in enrollment. Salary, wages, and benefits is projected to be approximately $5.7M which is approximately $285K more than prior year budget due to the projection of hiring additional staff and succession planning for key management roles reaching retirement age. 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 (using CY 2024 net income) and phase two (using CY 2025 net income) during FY 2027 as required by DHCS' Community Reinvestment APL. Insurance expense is projected to be approximately $554K which is approximately $69K more than budgeted in FY 2026 due to accounting for an increase in premiums primarily related to the Plan's cyber security insurance policy. All other expense line items are relatively consistent with budgeted amounts for FY 2026. MCO taxes projected to be approximately $376.8M which is approximately $376.8M less due to MCO taxes projected to end midway through FY 2027 as the current MCO tax structure sunsets on 12/31/2026. Other income is projected to be approximately $504K which is approximately $149K more than budgeted in FY 2026 due to now having full occupancy in the building CalViva owns and operates. Capital expenditures budget is projected to be $500K which is $100K less than budgeted in FY 2026 due to actual FY 2026 tenant improvements being less than previously anticipated in addition to accounting for any building improvements that may be needed during FY 2027. Net income is projected to be approximately $10.6M, which is approximately $1.6M more than budgeted for FY 2026 primarily due to interest income increasing by approximately $1.9M net of a decrease in membership.		
#5 Announcements/Comments	None.		
#6 Adjourn	Meeting was adjourned at 11:47 am		

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission
Dated: May 21, 2026

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson
Dated: 5/21/26

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
March 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 Foss, 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 Senior Nurse Analyst
		✓	**Norell Naoe,** Medical Management Administrative Coordinator
	Guests/Speakers		
	None were in attendance.		

✓ = in attendance
* = Arrived late/left early
** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D., Chair	The meeting was called to order at 10:10 am. A quorum was not present. *Dr. Ramirez arrived at 10:11 am, and a quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: February 19,	February 19th, 2026, QI/UM minutes were reviewed, and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2026 - Appeals & Grievances Validation Audit Summary (Q3) - Behavioral Health Performance Indicator Report (Q4) - Pharmacy Provider Updates (Q4 2025, Q1 2026) - Performance Improvement Project Updates – Clinical & Non-Clinical - Specialty Referrals Report (Q4) - Standing Referrals Report (Q4) - Evolent (NIA) (Q4) - SPD HRA Outreach (Q4) - Access Committee Update (December 2025, January 2026) - Enhanced Care Management (ECM) & Community Supports (CS) Performance Report (Q4) (Attachments A-K) **Action** Patrick Marabella, M.D., Chair	discussion at the request of any committee member. A link for the Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Waugh) 4-0-0-4
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (January 2026) (Attachments L)	The **Appeals & Grievances Dashboard and Turnaround Time Report** through January 2026 were presented. The Dashboard (or log) identifies each member who submitted a grievance during the reporting period (monthly) with a narrative description of the grievance and the resolution. A total of 209 grievances were received during January 2026. • This month, 158 grievances were categorized as Quality of Service (QOS), most commonly for prior authorization, access other/DMHC, Administrative issues, Balance Billing, and other.	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (January 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	• Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes were consistent with prior months at 171 in January 2026. Balance Billing continues to be one of the higher volume categories, but Transportation Access – Provider no-show has dropped to zero (0) for January. • The total number of Appeals received has increased (55) in January 2026, with 54 resolved. Patterns are consistent with Community Supports/meals and housing, and DME (Durable Medical Equipment), having the highest volumes of cases for the month. o Advanced imaging cases have decreased to nine (9) this month. o Surgery category had eight (8) cases this month with four (4) venous ablations for varicose veins from the same provider noted. Education follow-up will be provided. o The Upholds (44.4%) and Overturn (33.3%) rates have improved. The Partial Overturns (22%) were mentioned due to the member requesting an out-of-network service or DME, which were approved as medically necessary however, an in-network provider/vendor needed to be used. o One (1) Appeal resolution letter was out of compliance with the turnaround time. The translation vendor was experiencing Outlook system issues and was unable to respond to translation requests on 1/22/26. The issues have since been resolved.	
#3 **QI Business** -CVH QIUM Committee Charter 2026 (Attachment M) **Action** Patrick Marabella, M.D., Chair	The **CVH QI/UM Committee Charter 2026** was presented and reviewed. The Long-Term Care Quality Assurance Performance Improvement Annual Plan has been added to the list of Program Documents that require the QI/UM Committee's approval to recommend to the RHA Commission. No other edits were made to the charter.	**Motion:** *Approve* - CVH QIUM Committee Charter 2026 (Cardona/Ramirez) 4-0-0-4
#3 **QI Business** - Lead Screening Quarterly Report (Q3 2025) (Attachment N)	The **Lead Screening Quarterly Report (Q3 2025)** was presented to provide results of practitioner adherence to lead screening guidelines and their compliance rates for providing anticipatory guidance to parents/caregivers to prevent lead exposure. Lead screening compliance reflects adherence to clinical guidelines. 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.	**Motion:** *Approve* - Lead Screening Quarterly Report (Q3 2025)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	• 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. *Discussion:* Dr. Cardona asked what the positive Lead exposure rate was for the County. Dr. Marabella indicated that it is lower than in urban areas with older homes and lead paint exposure. Exposure in this region is primarily environmental and airborne. Amy Schneider indicated that the state gave us a rate a few years ago, but that information isn't consistently communicated to the plans. Dr. Marabella indicated that Lead poisoning is generally more prevalent in the socioeconomic group that doesn't have access to healthcare, so it is difficult to track.	(Cardona/Waugh) 4-0-0-4

#3 QI Business
- Initial Health Appointment (IHA) Quarterly Report
(Q3 2025)
 	
(Attachment O)
 	
Action
Patrick Marabella, M.D., Chair
	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. The Q3 2025 IHA Quarterly Report demonstrates CVH's performance on IHA compliance monitoring from Q4 2024 through Q3 2025.
	The current approach to monitoring has three components:
	• Primary Care Physician Facility Site (FSR) and Medical Record Review (MRR) via onsite (or virtual) provider audits.
	  o Facility Site Review/Medical Records Review results show that 68% of pediatric patients and 55% of adult patients completed their IHAs for the providers audited during Q3 2025. For providers who were found non-compliant during the review period, follow-up occurs via provider notification of IHA requirements and corrective action when indicated.
	• Monitoring includes claims and encounters data.
	  o IHA completed visits within 120 days of enrollment at a rate of 46.44 %, decreased by 2.46 % compared to Q4 2024. IHA completed outside the 120-day window rate of 4.32 % declined by 7.10% compared to Q4 2024.
	• Member outreach utilizes a three-step methodology. Outreach Compliant [three (3) attempts completed, two (2) + phone and one (1) + mail].
	  o The Q3 2025 outreach automated call completion rate 82.66% demonstrates a 2.29 percentage point decrease from Q2 2025. The Q3 2025 outreach attempt completion rate, 48.22%, represents a 7.56 percentage-point decline compared to Q2 2025. Q3 2025
		Motion: *Approve*
		- Initial Health Appointment (IHA) Quarterly Report
		(Q3 2025)
		
		(Cardona/Waugh)
		4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	successful attempts to mail members a welcome packet rate of 90.83%, increased by 11.17 percentage points compared to Q2 2025. *Discussion:* *Dr. Cardona asked if there are additional barriers to compliance other than providers not looking at their list of new members, therefore not conducting an IHA.* *Dr. Marabella indicated that if there were a standardized format and code for the IHA, it would be easier to implement across the state, as when the SHA was implemented years ago. When a physical assessment plus the SHA was completed, we could count it as IHA. Right now, there is too much variation to capture if the IHA was completed and all the criteria were met. An additional barrier is that it is a cumbersome, manual process to capture new member outreach attempts before an appointment is scheduled and the member's information is uploaded to a provider's EMR system.*	
#4 Key Presentations - QI/HE Program Description and Change Summary 2026 (Attachment P) **Action** Patrick Marabella, M.D., Chair	The **2026 Quality Improvement/Health Education Program Description** was presented to the committee for approval. Updates include: • Information Systems and Analysis (p. 5). Removed section since it is redundant to the additional resources - Information Systems section. • Quality Improvement Goals (p. 7). Added bullet item: Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities. • Scope: Services Covered by CVH (p. 10). Removed Health Homes Program (HHP), added Community Supports to meet social needs of all members. • Health Education Programs (p. 13) Added description on Complex Health Needs/Care Management. • Care Management (CM) Program (p. 15). Removed section and added Complex Health Needs/Care Management to the Health Management Programs section. • Operations and Service (p. 16). Provider Performance & Analytics team name updated to Data Strategy & Insights. Removed "Sales" from collaboration efforts. • Health Plan Performance (pgs. 16-17) • The Health Equity Accreditation survey name was updated to Health Outcomes Accreditation (HOA), and Health Equity Accreditation Plus was updated to Community-Focused Care Accreditation (CFCA). • Added MCAS and DMHC Health Equity and Quality measure performance to CVH's monitoring	**Motion**: *Approve* - QI/HE Program Description and Change Summary 2026 (Waugh/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	activities. Specified that member outreach activities are conducted to close care gaps to improve outcomes and performance metrics. • Delegation (p. 19). 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 (p. 20). Replaced Diversity, Equity, and Inclusion training with Cultural Competency Training. • Access and Availability (pgs. 23-24) 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 (p. 24). Revised and rephrased Satisfaction description. Added ECHO/OPMH surveys and description of Program Manager responsibilities. • Health Education Programs (p. 25). Removed the Health Education phone number. Rephrased the "Kick It California" description. • Telehealth Services (pgs. 26-27) Added ConferMed of CA as vendor. Removed and replaced the goals for the Telehealth Program. • Staff Resources and Accountability (p. 35-39). • 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. • QI Program Activities: Projects, Surveys and Audits, Incentive Programs (pgs. 41-42). Added ECHO and OPMH, Revised Member and Provider Incentive Programs. • QI Process (p. 48) Added DMHC Health Equity and Quality measure performance as areas for focused performance improvement. • Other minor edits. *Dr. Marabella left the meeting at 10:38 a.m. and returned at 10:38 a.m.*	
#4 **Key Presentations** - QI/HE & W Work Plan 2026	The **2026 Quality Improvement/Health Education and Wellness Work Plan** was presented for approval. The Work Plan is divided into two (2) sections:	**Motion:** *Approve* - QI/HE Work Plan

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment Q) **Action** Patrick Marabella, M.D., Chair	I. ***Work Plan Initiatives:*** *Implement activities to improve performance measures in eight (8) key areas for QI & Health Education Work. Includes program objectives, monitoring, and evaluation for the year. Each section has specific initiatives for a total of fourteen (14).* 1. ***Behavioral Health:*** Improving Behavioral Health (Mental Health and Substance Use) Outcomes MY2024 Results: FUA-30: (100%, 3/3 objectives met) FUM-30: (100%, 3/3 objectives met) New Measure for 2026: (DSF-E) Depression Screening and Follow-up for Adolescents and Adults (must meet MPL in MY26) • MPL met for both measures (FUM &FUA) in Kings County for MY2024. • Statistically significant directional improvement noted in Fresno and Madera Counties, but MPL was not met for either measure in MY2024. • Continue efforts on both FUM/FUA measures in 2026. • Ensure broad and consistent implementation of depression screening by all providers in all 3 counties (DSF-E). • Work with providers to capture depression screening data. 2. ***Chronic Conditions:*** • Maintain achievement of MPL for two measures in 2026: Diabetes (CDC GSD/HBD): CDC >9 – HbA1c to below 9; Heart Health: Control Blood Pressure (CBP) • Asthma Medication Ratio measure retired. • "Follow-up After Acute and Urgent Care Visits for Asthma" is a new measure this year. MCPs are not held to MPL for this measure in MY26. 3. *A.* ***Hospital Quality/Patient Safety:*** Monitoring of hospital-acquired conditions (infections & c-section rates). Goals were not met in MY2024. • MY2026 focus is to increase the number of reporting hospitals. • Reduce infection rates & c-section rates. B. ***Hospital Quality/Patient Safety/Maternal Health:*** In 2026, maintain achievement of MPL with a new priority activity that will focus on the coordination of care. • Implement two (2) new Depression Screening Measures consistently in all three (3) counties, ensuring appropriate follow-up and data capture for MY2026: o PND-E: Prenatal Depression Screening and Follow –up Screening (held to MPL) o PDS-E: Postpartum Depression Screening and Follow-up Screening (held to MPL)	2026 (Waugh/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	4. ***Member Engagement and Experience (IHA):*** New Member completion of Initial Health Appointment (IHA) in under 120 days. IHA does not have a HEDIS benchmark, but it is a DHCS compliance measure. In 2026: • Meet or exceed the goal for timely IHA of 59.40%. • Ensure providers are clear on the minimum requirements for a comprehensive IHA. • Connect new members with medical home and support the timely completion of IHA within 120 days. 5. ***Pediatric/Dental:*** Improvement noted in Children's Domain measures in MY2024, but continued focus needed in MY2026 for: • Well Child Visits (W30) in Fresno County and (WCV & W30) in Kings County. • Topical Fluoride (TFL-CH), Developmental Screening (DEV), and Immunizations (CIS-10) in Kings County. • Maintain achievement in other Children's Domain measures in all counties. 6. ***Preventive Health***: *For 2026:* 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 (AISE Flu). 7. ***Member Engagement and Experience****: For 2026:* A. Continue to obtain directional improvement from prior year on CAHPS Access measures, including Getting Needed Care, Getting Care Quickly, and Care Coordination. 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:*** • After Hours Access met performance goal > 90% on both metrics. • Improvement needed for Appointment Access related to: o Specialist Urgent o Specialist Non-urgent • Interventions will focus on improving member access to appointments with Specialists in 2026. *II.* ***Quality Improvement Tracking System Activities Log.*** *These activities support meeting the program objectives in Section 1. Some of these activities include, but are not limited to, the following:*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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. • 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 devices to self-monitor blood pressure (CBP). • Outreach campaign to support Diabetic Members who may be due for an A1c test to provide "Simple Health Kits", 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. • Produce and distribute Hospital Quality Scorecards. 4. ***Member Experience (IHA):*** • Identify high-volume, low-performing Initial Health Appointment (IHA) providers quarterly 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. • Send IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1-year checkup.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Promote the CDC's Milestone Tracker App in future newsletters, website locations, add to Health Education Provider Resource (QR Codes), promote it to CVH's Pregnancy and First Year of Life programs, etc. 6. ***Preventive Health:*** • 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:*** Revise the CAHPS Provider Playbook Best Practices into one (1) resource for providers to utilize and improve CAHPS measures. 8. ***Member Experience:*** • 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. *Discussion:* *Dr. Cardona commented that the PCP's ability to refer to an MH provider was removed, and now patients need to self-refer. It is ultimately up to the patient, so the Plan should provide them with access numbers.* *Amy Schneider indicated that a tool is in development and will be helpful to get the conversations started. Patients are more likely to follow through with seeing a MH provider after a conversation with their PCP.* *Dr. Marabella agreed that the tool in development must contain a QR code or a link to the most up-to-date resources and how to get plugged into the system of care, which can be overwhelming and stigmatizing.*	
#4 **Key Presentations** - UM Program Description and Change Summary 2026	The **2026 Utilization Management Program Description & Change Summary** was presented, and changes for this year include, but are not limited to: • Page 10. Removed Managed Risk Medical Insurance Board. • Page 11-12. Updated decisions about following the required medical necessity review. Also	**Motion:** *Approve* - UM Program Description and Change Summary

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment R) **Action** Patrick Marabella, M.D., Chair	added services related to the California Prenatal Screening Program (CPSP). • Page 18. Behavioral health utilization management decisions follow Centene Clinical Policy and evidence-based guidelines from recognized professional organizations. To ensure consistent application of these criteria, all BH Utilization Review Clinicians complete annual Inter-Rater Reliability testing. • Page 26. Updated the most recent locations for mental health and substance abuse. • Page 38. Added referral of Members to CalAIM Community Supports. • Page 48. Updated the Vice President of Population Health and Clinical Operations.	2026 (Cardona/Ramirez) 4-0-0-4
#4 Key Presentations - UM/CM Work Plan 2026 (Attachment S) **Action** Patrick Marabella, M.D., Chair	**The 2026 Utilization Management/Care Management Work Plan** was presented. UM/CM Work Plan for 2026 includes: • Expanding the integration of BH into utilization activities was a key enhancement this year. • The addition of a separate section for Enhanced Care Management (ECM) was also a priority. • Five Areas of focus remain the same for the 2026 Work Plan, with minor changes, including but not limited to: ***1. Compliance with Regulatory & Accreditation Requirements*** o Annual Review of UM Clinical Criteria (1.7) ▪ 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. ***2. Monitoring the UM Process*** o The number of authorizations for services requested (2.1) ▪ Clarified objectives to track both PH and BH authorizations monthly. o Timeliness of processing authorization requests (2.2) ▪ Monitor turnaround times for both PH and BH authorizations. o Annual Interrater Reliability (IRR) testing of healthcare professionals (2.3) ▪ Clarified IRR testing applies to both PH and BH. ▪ Clarified two (2) remediation opportunities offered for scores below 90%. o Number of Appeals of UM Decisions Received (2.4) ▪ Clarified tracking for PH and BH. ▪ Expanded planned interventions when TATs aren't met. ***3. Monitoring Utilization Metrics*** o Improve Shared Risk & Fee for Service UM Acute Inpatient Performance (3.1)	**Motion:** *Approve* - UM/CM Work Plan 2026 (Cardona/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Updated Planned Interventions to emphasize support of discharge to various Post-Acute care destinations. ▪ Goals for Key Metrics (admits, ALOS, Bed Days, etc.) under review, to be established by the end of Q1. ***4. Monitoring Coordination with Other Programs and Vendor Oversight*** o Care Management (4.1) ▪ Removed ECM enrollment and graduation rates. o Disease/Chronic Condition Management (4.4) ▪ New program implemented last year. ▪ Added new annual report to monitor Member outcomes. o Behavioral Health Care Coordination (4.6) ▪ Added measures related to screening for referral to county programs, other referral data, referrals to CM, and appointment access data. ▪ Added demonstrate 12-month growth in % of members receiving ECM. ▪ Added Members not meeting criteria are referred to alternative programs or CM. o Added new section for **Enhanced Care Management** (ECM) to monitor: (4.8) ▪ Demonstrate 12-month growth in percentage of members receiving ECM ▪ Members not meeting ECM criteria will be referred to alternative programs or care management ▪ Notice of Action Letters (NOA) are distributed to members being disenrolled from ECM ***5. Monitoring Activities for Special Populations*** o *No changes.* *There were no questions or recommendations from the Committee.*	
#4 **Key Presentations** - Population Segmentation Report 2026 (Attachment T) **Action** Patrick Marabella, M.D., Chair	The **Population Segmentation Report 2026** was presented and reviewed to understand the portions of the population targeted by each Population Health Management program in accordance with NCQA Accreditation standards. The following programs were reviewed along with their eligible population, and the number of eligible members ranged from 231 to 423,525/0.05%-100%: • Improve Preventive Health: Flu Vaccinations 92.46%, Breast Cancer Screening 14.37% • Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care	**Motion**: *Approve* - Population Segmentation Report 2026 (Waugh/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	after Mental Health Emergency Department Visits – Data unavailable until mid-2026; Depression Screening and Follow-Up Care 59.81% • CVH Pregnancy Program 0.05% (per month) • Care Management 8.45% • Transitional Care Services 0.56% (per month) • Chronic Condition Disease Management (Asthma, COPD, Diabetes, Cardiovascular Conditions, and Sickle Cell Disease) 28.82% • Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program 3.33% • Tobacco Cessation – Kick It California 71.64% • Diabetes Prevention Program 5.77% • Diabetes Management Program 6.54% • Cardiac + Diabetes 21.14% • Health Information Form 100% • Initial Health Appointment 100% • Teladoc Mental Health Digital Platform 71.64% • Behavioral Health Care Management 100% • Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma) 6.28% • Emergency Room Diversion Program 0.05% • Chronic Condition: Oncology 1.69% • Telemedicine 100% *There were no questions or recommendations from the Committee.* *Morgan Simpson left the meeting at 11:05 a.m. and returned at 11:09 a.m.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (January 2026) (Attachments U)	The **Key Indicator Report & Turnaround Time Report** through January 2026 were presented. • Numbers remain similar from the Year-end report presented in February. • Membership has decreased slightly. • Utilization for Acute Admits, Acute Length of Stay, and ER visits (adjusted PTMPY) have remained roughly the same. • Utilization for Bed Days and for Readmissions (all adjusted PTMPY) for TANF, MCE, and SPDs	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (January 2026)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	shows a decline in January. The Readmission rates remain low as well. • Behavioral Health, Perinatal, Physical Health, Transitional Care Services (TCS), and First Year of Life Care Management referrals and member engagement rates have demonstrated random and seasonal variation throughout calendar year 2025 and demonstrate positive trends in January 2026. Timely Pre-service Urgent letters requiring language translation were delayed due to a technological issue that has since been resolved. In another instance, increased urgent inventory volumes contributed to assignment delays, alongside manual process-driven routing to the transplant review team.	(Cardona/Ramirez) 4-0-0-4
#5 **UM/CM Business** - Care Management & CCM Report (Q4 2025) (Attachment V) **Action** Patrick Marabella, M.D., Chair	The **Care Management and CCM Report Q4 2025** was presented to provide an overview of Physical Health Care Management (PH CM), Transitional Care Services (TCS), Behavioral Health Care Management (BH CM), Perinatal (PCM), and First Year of Life (FYoL) activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness. • From Q3 to Q4 2025, the referral volume for PH CM decreased by 16%, TCS referrals decreased by 3%, and BH CM referral volume increased by 22%. Referrals decreased for PCM 9% and for FYoL programs 3% in Q4. Managed cases decreased across all programs in Q4, except for BH, which had an increase. Year to date (YTD) 2025 compared to YTD 2024, all programs had significant increases in referrals. • PH CM referral numbers decreased 16% in Q4 and demonstrated a seasonal trend. • TCS referrals, engagement, and cases managed decreased from Q3 to Q4, however total volumes for 2025 are significantly higher compared to 2024. • PCP Visits within 7, 14, and 30 days of referral remained consistent. • BH CM referrals increased in Q4, but the engagement rate and total cases managed decreased. • PCM's total numbers are up compared to last year, with a notable increase in engagement. Key metrics show improved post-enrollment outcomes, such as reduced readmissions, fewer emergency department visits, improved timeliness of prenatal visits, fewer preterm births, and an increase in postpartum visit rates. • Seventy-five (75) members completed a Member Satisfaction Survey, with 92% being satisfied with the CM program, though respondents were less satisfied with their specific Care Manager. Going forward, the team will review satisfaction survey results with staff to identify opportunities to improve results.	Motion: *Approve* - Care Management & CCM Report (Q4 2025) (Ramirez/Cardona) 4-0-0-4
#5 **UM/CM Business**	**InterQual® Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2025** were	Motion: *Approve*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2025 (Attachment W) **Action** Patrick Marabella, M.D., Chair	presented to demonstrate UM staff consistency in applying InterQual® Clinical Decision Support Criteria, along with other evidence-based medical policies, clinical support guidelines, training, and technical assessment tools approved by the Medical Advisory Council to ensure consistent and standardized medical criteria review across all cases. To reinforce competency in applying InterQual criteria, Physician and Non-Physician clinical staff completed InterQual® IRR preparatory training in Q3 2025. In Q3 & Q4 2025, InterQual® IRR testing was administered, requiring a minimum passing score of 90% to demonstrate proficiency. Average initial test scores for non-physicians and physicians were 93.5% and 92.0%, respectively. • 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. • Concurrent review nurses also demonstrated strong competency overall, with the majority meeting or exceeding 90% across their testing. • Acute Pediatrics was a consistent strength area, with a high proportion of results at or above 90%. o Durable Medical Equipment (DME) was the clearest opportunity area, with the lowest overall average performance and the highest concentration of lower scores compared with other domains. o Home Care and Subacute and Skilled Nursing showed higher variability than other domains, with a greater share of results below 80%, indicating an opportunity to improve consistency through targeted reinforcement. • Focused training in DME, Home Care, and Subacute and Skilled Nursing is likely to produce measurable improvement, given the strong pattern of score increases following remediation.	- Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2025 (Ramirez/Cardona) 4-0-0-4
#5 **UM/CM Business** - NCQA UM Information Integrity Appeals & Denials Oversight Report (Attachment X) **Action** Patrick Marabella, M.D., Chair	The **NCQA UM Information Integrity Appeals & Denials Oversight Report** was presented to demonstrate CVH's oversight of utilization management information and security standard compliance by HN. Per NCQA standards, the report describes how UM Appeals & Denials information is received, stored, reviewed, tracked, and dated. CVH monitors compliance with its UM denial and appeal controls by tracking: 1. What primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.	Motion: *Approve* - NCQA UM Information Integrity Appeals & Denials Oversight Report (Cardona/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	4. Annual training, to ensure incidents of data integrity are reported. 5. The security controls in place to protect the information from unauthorized modification. 6. How the organization monitors its compliance with the policies and procedures. 7. Initiate a Corrective Action Plan (CAP) for findings. 8. Assess CAP findings to ensure validity of corrections/actions. Audit results regarding monitoring for compliance with established UM System Controls were provided. Results were provided for *Appeals* (January to December 2025) and for *Denials & Partial Approvals* (January to December 2025). The UM Data Integrity Reports for calendar year 2025 included only CVH members. Appropriate samples per NCQA requirements of 31 appeals and 50 denials were reviewed. Total Universe Volumes: • Appeals – January 1 to December 31, 2025 - total CVH Appeals = 605 (modified & non-modified) • Denials – January 1 to December 31, 2025 - total CVH Denials & Partial Approvals = 15,882 (modified & non-modified) • All 81 cases were audited for compliance with system controls. No (0) incidents of non-compliance were identified; therefore, no (0) corrective actions are indicated at this time. Zaman Jennaty left the meeting at 11:25 a.m. and returned at 11:31 a.m.	
#5 **UM/CM Business** - PA Member Letter Monitoring Report (Q4 2025) (Attachment Y) **Action** Patrick Marabella, M.D., Chair	The **PA Member Letter Monitoring Report Q4 2025** provides a summary of the daily audits of acknowledgment and resolution letters to ensure: • Use clear and concise denial language in decision letters. • Use clinical criteria or guidelines for decision letters. • To provide correct anticipated decision date for deferral letters. • Use clear and concise language in deferral letters. • Appropriate member letter translation for deferral letters. These metrics show improvement, with a few minor issues that are being corrected. All errors identified by the A & G team in Table 1 were corrected prior to mailing. Future versions of this report will include monitoring of compliance with EPSDT criteria for members under 21 as a result of the CAP issued by DHCS. The clinical team will continue to monitor and track acknowledgment and resolution letters.	Motion: *Approve* - PA Member Letter Monitoring Report (Q4 2025) (Waugh/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q4 2025) - Pharmacy Operations Metrics (Q4 2025) - Pharmacy Top 25 Prior Authorizations (Q4 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2025) - Pharmacy Quality Assurance Results 2025 (Attachments Z-DD) **Action** Patrick Marabella, M.D., Chair	The **Pharmacy Executive Summary Q4 2025** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q4 2025. o Overall, TAT for Q4 2025 was 99.8%. o PA volume was lower in Q4 2025 compared to Q3 2025 and there were some drug-specific differences. October had a higher volume compared to all other months in Q4 2025. The **Pharmacy Operations Metrics Q4 2025** provides key indicators measuring the performance of the PA Department in service to CVH members. The turnaround time (TAT) expectation is 100%, with a threshold for action of 95%. • The average turnaround time met the standard with 99.8%. The **Pharmacy Top 25 Prior Authorizations Q4 2025** identifies the most requested medications to the Medical Benefit PA team for CVH members and assesses potential barriers to accessing medications through the PA process. The top 25 PA requests in Q4 2025 were mostly consistent with the top 25 drugs reviewed in Q3 2025, with a few placement variations. Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products. The **Quality Assurance Reliability Results (IRR) for Pharmacy Q4 2025** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten (10) prior authorizations [four (4) approvals and six (6) denials] from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas, with a threshold for action of 90%. • The 90% threshold was met. The 95% goal was not met. The overall score was 95%. • Three sample cases had potential criteria application or documentation issues after plan review. The **Quality Assurance Reliability Results for Pharmacy 2025** reviews the prior authorizations performed on the medical benefit drugs to evaluate the consistency and accuracy with which the MedPharm Pharmacy staff involved in utilization management (UM) review and apply prior	Motion: *Approve* - Pharmacy Executive Summary (Q4 2025) - Pharmacy Operations Metrics (Q4 2025) - Pharmacy Top 25 Prior Authorizations (Q4 2025) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2025) - Pharmacy Quality Assurance Results 2025 (Cardona/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	authorization criteria in decision-making, and communicate the decisions made to providers and patients. • The Quality Assurance (QA) results for all quarters in 2025 show that the Overall (cumulative) threshold was met for the random request reviews in each quarter of 2025 with an average score of 94%. However, the 95% goal was not met. Criteria Application and Clarity of Response seemed to be the largest contributing factors to the overall score meeting the threshold but not meeting the goal. After each quarterly review, QA results are provided to the Pharmacy Services MedPharm Management for review to discuss opportunities for improvement based on deficiencies in the individual categories and specific cases. The Plan provides ongoing feedback and guidance on all cases reviewed.	
#7 Policy & Procedure Business - Annual Pharmacy Policy & Procedure Review 2026 (Attachment EE) Action Patrick Marabella, M.D., Chair	The **Annual Pharmacy Policy & Procedure Review 2026** was presented to the committee. The following policies were presented for annual review with **no changes made:** RX-002 Program Metrics Review RX-003 Pharmacy Program RX-006 Specialty Pharmacy Program RX-008 Mental Health Parity RX-120 Drug Utilization Review **The following policies were presented for annual review and were approved with the following changes:** RX-001 Medication Prior Authorization: Minor clarifications made regarding Pharmacy oversight of prior authorization processes. RX-005 Pharmacy Prior Authorization and Medical Necessity Criteria: Policy updated to clarify PAC oversight of prior authorization criteria development and approval. Updated to align with DHCS APL 25-013 regarding Medi-Cal Rx pharmacy benefit administration and MCP responsibilities. Minor edit to update Continuity of Care (COC) language to be consistent with APL 14-021. Full policy attached. RX-007 Injectable Medication Review: Policy updated to align with DHCS APL 25-013 requirements regarding Medi-Cal Rx pharmacy benefit oversight, including coverage distinctions between pharmacy-dispensed medications and provider-administered drugs.	Motion: *Approve* - Annual Pharmacy Policy & Procedure Review 2026 (Cardona/Waugh) 4-0-0-4
#7 Policy & Procedure Business - UM Policy Review and New ABA Clinical Policy Review	The **UM Policy Review and New ABA Clinical Policy Review** were presented to the committee. **The following policies were presented for annual review and were approved with the following changes:**	Motion: *Approve* - UM Policy Review and New ABA

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment FF) Action Patrick Marabella, M.D., Chair	UM-040 UM Information Integrity and System Control: Updated annual training requirement and other edits to align with NCQA. Full policy attached. ABA Criteria Clinical Policy: Applied Behavior Analysis: New clinical criteria for approval. Full clinical policy attached.	Clinical Policy Review (Cardona/Waugh) 4-0-0-4
#8 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q1 2026) (Attachment GG) Action Patrick Marabella, M.D., Chair	The **Credentialing Sub-Committee Quarterly Report Q1 2026** was presented. The Credentialing Sub-Committee met on February 19, 2026. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q3 2025 were reviewed for delegated entities, and Q4 2025 for HN and HN Behavioral Health (BH). A summary of Q3 2025 data was presented. • The **Adverse Events Q4 2025** report was presented. o There was one (1) case identified in Q4 2025 that met the criteria for reporting, in which an adverse outcome was associated with a contracted practitioner. o Zero (0) cases involved behavioral health o There were no (0) reconsiderations or fair hearings during Q4 2025. o 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. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2025. o There were zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q4 2025. o Reviews completed in September, October, November, and December did not identify any practitioners requiring removal from the Plan's network. o Zero (0) cases required reporting for 805 in Q4 2025. • The **Access & Availability Substantial Harm Report Q4 2025** was presented and reviewed. This report identifies incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked by severity level. o 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	Motion: *Approve* - Credentialing Subcommittee Report (Q1 2026) (Ramirez/Cardona) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	defined in Civil Code section 3428(b)(1). • The **Credentialing Adverse Actions** report for Q4 2025 for CVH from the HN Credentialing Committee was presented. o There was one (1) case presented for discussion for Q4 2025 for CVH. The Medical Board of California issued a Cease Practice Order against a practitioner's medical license. 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 with no changes made to the Charter this year. • The **Credentialing Policies & Procedures Annual Review** was presented to the committee. Most policies were presented with minor or no changes made. Two (2) 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.	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q1 2026 (Attachment HH) Action Patrick Marabella, M.D., Chair	The **Peer Review Sub-Committee Quarterly Report Q1 2026** was presented. The Peer Review Sub-Committee met on February 19, 2026. • The county-specific **Peer Review Sub-Committee Summary Reports for Q4 2025** were reviewed for approval. No (0) significant cases to report. • The **Q4 2025 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o Seven (7) cases were identified in Q4 2025 that met the criteria for reporting. Three (3) of these cases involved practitioners, and four (4) cases involved organizational providers (facilities). ▪ Of the seven (7) cases, one (1) was tabled, one (1) was closed to track and trend with a letter of concern, and five (5) were closed to track and trend. ▪ Six (6) cases were quality of care grievances, one (1) was a potential quality issue, zero (0) were lower-level cases, and zero (0) were identified through track and trend.	Motion: Approve - Peer Review Subcommittee Report Q1 2026 (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Three (3) cases involved Seniors and Persons with Disabilities (SPDs) ▪ None (0) involved Behavioral Health. o There were no (0) incidents involving appointment availability resulting in substantial harm to a member or members in Q4. o 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) o Zero (0) cases were placed on corrective action in the fourth quarter of 2025. o Zero (0) cases were 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. o Thirteen (13) cases were identified and required further outreach. Outreach can include, but is not limited to, an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. o 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. o Zero (0) cases required reporting for 805.01 in Q4 2025. • The **Access & Availability Substantial Harm Report for Q4 2025** was also presented. This report aims to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances, Quality of Care (QOC), and Potential Quality Issues (PQIs) related to identified appointment availability issues, and they are ranked by severity level. o Sixteen (16) cases were submitted to the Peer Review Committee in Q4 2025. There were two (2) incidents found involving appointment availability issues *without significant harm* to a member. Five (5) cases were determined to be related to significant harm to a member, but *without appointment availability issues*. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2025. • The **2026 Peer Review Sub-Committee Charter** was presented and approved by the committee with no changes made to the Charter this year.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The **2026 Peer Review Policy & Procedure Annual Review** was presented. All Peer Review policies were approved with minor or no changes. • The **Q3 2024 Peer Count Report** was presented and discussed with the committee. There was a total of sixteen (16) cases reviewed. Eleven (11) cases were closed and cleared. Two (2) cases were tabled for further information, two (2) were closed with CAP outstanding/continued monitoring, and one (1) case was pending closure for CAP compliance. • The **Peer Review Sub-Committee** reports for Q4 2025 were reviewed for outcomes of Peer Review cases for Fresno, Kings, and Madera Counties. There were zero (0) cases reported in Q4 2025.	
#8 **Credentialing & Peer Review Subcommittee Business** - NCQA Information Integrity Credentialing Oversight Report (Q1 2026) (Attachment II) Action Patrick Marabella, M.D., Chair	The **NCQA Information Integrity Credentialing Oversight Report Q1 2026** was presented and reviewed. This report aims to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe: 1. How primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. 4. Annual training, to ensure incidents of data integrity are reported. 5. The security controls in place to protect the information from unauthorized modification. 6. How the organization monitors its compliance with the policies and procedures. 7. Initiate a Corrective Action Plan (CAP) for findings. 8. Assess CAP findings to ensure validity of corrections/actions. Quarterly audits were performed of a 5% sampling methodology (50 cases, 25 credentialing, and 25 recredentialing). Three (3) cases met threshold criteria. There was a total of 159 cases completed for CVH provider records in 2025, and all of these were considered. All files with modifications (3) were included in this review. The audit results provided to CVH reflect 100% compliance with audit criteria. There were no incidents of non-compliance with policies in the 3-case universe.	Motion: *Approve* - NCQA Information Integrity Credentialing Oversight Report (Q1 2026) (Cardona/Ramirez) 4-0-0-4
#9 **Compliance Update** -Compliance Regulatory Report	Mary Lourdes Leone presented the **Compliance Report.** **CVH Oversight Activities: HN:** CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group	-Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment JJ)	meetings, and discuss any issues or questions during the monthly oversight meetings with HN. CVH and HN also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access and availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits:** The following annual audits are in progress: UM/CM, Call Center, Claims/PDR, and Provider Network. No audits have been completed since the last Commission report. **Fraud, Waste, and Abuse:** Since the 2/19/26 Compliance Report, there have been five (5) new MC609 filings with the DHCS. **DMHC/DHCA 2026 Joint Medical Audit Survey:** 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. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** DHCS issued its final audit report and Corrective Action Plan (CAP) citing deficiencies related to delegated oversight of Health Net, including: 1) application of EPSDT criteria for members under age 21; 2) provision of all required ECM core service components; 3) timely notification of ECM benefit discontinuation; and 4) inclusion of required elements in member-facing ECM materials. The Plan submitted its monthly CAP update on 2/27/2026 and will continue to send updates until the CAP is closed. **Public Policy Committee (PPC):** The Public Policy Committee met on March 4, 2026. The next PPC meeting will be held on June 3, 2026, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is on May 21st, 2026.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 11:47 a.m.	

NEXT MEETING: May 21st, 2026

Submitted this Day: May 21, 2026

Submitted by: Amy Schneider, RN

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, MD, Committee Chair

Public Policy Committee
Meeting Minutes
March 4, 2026

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

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

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:32 am. Roll call was taken to establish a quorum.		
#2 Meeting Minutes from December 3, 2025 **Action** Joe Neves, Chair	The December 3, 2025, meeting minutes were reviewed and approved.		**Motion:** Approve September 3, 2025, Minutes 8-0-0-1 (M. Garcia / R. Rodiguez)

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
			J. Garner not included in vote; arrived late
#3 Enrollment Dashboard **Information** Maria McDivitt	Maria Sanchez presented the enrollment dashboard through December 2025. Membership as of December 31, 2025, was 427,533. CalViva Health maintains a 66.89% market share.		**No Motion**
#4 Annual Report **Information** Courtney Shapiro	This is a mandated report by DHCS and is for the benefit of stakeholders, community partners, and elected officials, and is posted on the CVH website for public viewing. Courtney Shapiro gave a brief summary of the report and each PPC member was provided with a hard copy of the annual report.		**No Motion**
#5 Committee Membership Update **Information** Courtney Shapiro	Public Policy Committee membership has been updated as follows: Renewals: Kristi Hernandez, Fresno County, renewed for a 3-year term through March 2029. Norma Mendoza, Madera County, renewed for a 3-year term through March 2029.		**No Motion**
#6 Appeals, Grievances and Complaints **Information** Maria McDivitt	For Q4 2025 there were 385 Coverage Disputes (Appeals), 100 Disputes Involving Medical Necessity (Appeals), 42 Quality of Care, 199 Access to Care, and 366 Quality of Service, for a total of 745 appeals and grievances for Q4. The majority of which are from Fresno County. There were 101 appeal cases for Fresno County, 10 for Kings County, and 27 for Madera County, for a total of 138 for Q4 2025. There were 487 grievances cases in Fresno County, 51 for Kings County, and 69 for Madera County for a total of 607 for Q4 2025. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for all categories. There was a total of 344 Exempt Grievances received in Q4 2025.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Of the total grievances and appeals received in Q4, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 131 • Appeals: 36 • Exempt: 47 The majority of appeals and grievances are from members in Fresno County, which has the largest CalViva Health enrollment. The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Other, Administrative, and Balance Billing. The majority of quality of care (QOC) cases resolved were categorized as PCP Delay, PCP Care, and Specialist Care. The top categories of appeal cases resolved were related to Advanced Imaging, Other, and DME. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received. Dr. Marabella provided additional clarification/information on end of the year Appeals & Grievances.		
#7 DHCS Community Reinvestment **Information** Courtney Shapiro Jeff Nkansah	Courtney Shapiro provided a recap of the DHCS Community Reinvestment program and how it is a new way of how the Plan will fund the community. This is a standing agenda item for the Public Policy Committee. The PPC was polled to see if there are any non-profits that the committee would like for the Plan to meet with, and if there are any issues within their communities that they think need to be addressed. No suggestions by the PPC were made. All PPC members were encouraged to contact Courtney with any recommendations.	*Miguel Rodriguez requested a summary of categories.* *Courtney Shapiro will email the information to Miguel.*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#8 Regulatory Audit Status: • 2023 DHCS Focused Audit CAP • 2025 DMHC Follow-Up Audit • 2026 DMHC Audit • 2026 DHCS Audit **Information** M.L. Leone, CCO	• 2023 DHCS Focused Audit CAP: The Plan submitted all corrective actions for the findings early last summer 2025. Pending final close out letter from DHCS. • 2025 DMHC Follow-Up Audit: There were two outstanding issues; one of which the Plan has corrected. DMHC determined the Plan did not correct the second issue having to do with post stabilization care. Because this is a repeated issue, the DMHC is sending this to their office of enforcement, and the Plan could possibly get a fine for not having corrected the issue. • 2026 DMHC Audit: this is ongoing. The Plan just sent in a large volume of documents for their review. DMHC will be onsite at CVH in June to conduct the audit interviews. • 2026 DHCS Audit: DHCS will also be joining the DMHC onsite during their June onsite visit to conduct their audit interviews.		**No Motion**
#9 Health Education **Information** Steven Si	Member Incentive Programs Q3-Q4 2025: • Program Participation 7,805 CalViva Health members participated across five programs: o Well Care Visit (WCV) o Breast Cancer Screening (BCS) o Cervical Cancer Screening (CCS) o Childhood Immunization Status (CIS-10) o W30–6+ Postpartum Incentive Program (PIP) • Member Distribution o 94% Fresno County o 5% Madera County o 1% Kings County • Program Impact o 55% increase in total incentive awards (Q3–Q4 2025) o $195,125 in gift cards distributed to members Challenges and Opportunities: • Barriers - Quality Edge: o For Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Childhood Immunization Status (CIS-10), and Well Care Visits (WCV), no barriers were identified for Quarters 3-4, 2025.		**No Motion** *R. Garcia left at 12:26 pm*

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Barriers - DHCS W30-6+ Clinical Performance Improvement Project (PIP): o Tracking Gaps: Lack of real-time visibility into gift card inventory and distribution. o Supply Constraints: Inventory shortages impacted consistent delivery to prenatal/postpartum members. o Data Delays: Inconsistent distribution counts delayed ordering and planning. o Structural Changes: Management shifts at Black Infant Health (BIH) affected local distribution. • Action Taken: o Inventory Stabilized: CalViva supplied additional cards to BIH to resolve shortages. o Flexible Fulfillment: Substituted gift cards with gift baskets and provided direct distribution support. o Increased Oversight: CalViva took a more direct role in the distribution process to ensure eligible members received incentives in a timely manner. o Process Improved: Adjusted tracking and coordination to ensure continuity. Next Steps: • Diabetes Prevention Program (DPP): o 2026 Outreach: Multi-channel campaign including mailers, email, and social media. o Provider Engagement: Live Q1 webinar to increase referral volume. o SMS Campaign: Submission to DHCS for "file and use". • Child and Adolescent Well Care Visits (WCV), Childhood Immunization Status (CIS-10), Cervical Cancer Screening (CCS), and Breast Cancer Screening (BCS) update: o Point-of-Care: Incentives will continue to be distributed directly via provider collaboration • Quality EDGE Program: o Implementation: Program is fully live.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	○ Monitoring: Continuous collaboration with providers to track action plan timelines. • W30-6+ PIP: ○ Program Status: Formally concluded on December 31, 2025. ○ Future Focus: Evaluating ways to sustain Black Infant Health support in Fresno County. ○ Reporting: Final End-of-Program Evaluation to be submitted to DHCS in Q1 2026.		
#10 2025 Annual Compliance Report **Information** Morgan Simpson	Key Compliance Program Activities for 2025: • Achieving National Committee for Quality Assurance (NCQA) Health Equity Accreditation (June 4, 2025); • Achieving Annual Network Certification and Sub-Network Certification for MY 2024; • Developing and implementing the Diversity, Equity, and Inclusion (DEI) training curriculum; • Responding to the 2023 Department of Health Care Services ("DHCS") Focused Audit Corrective Action Plan (CAP), the 2024 DHCS Audit CAP; and the 2025 DHCS Audit CAP; • Preparing for the 2025 DMHC Follow-Up Audit and overseeing the CAPs CalViva issued to Health Net related to post-stabilization care; • Preparing the MY2024/RY2025 DMHC Timely Access Report (TAR) and Annual Network Report (ANR); • Successfully completing the 2025 Health Services Advisory Group (HSAG) Network Validation Audit; • Completing the Plan's California Advancing and Innovating Medi-Cal (CalAim) Model of Care for Transitional Rent. 2025 CVH Member Service Call Center: • Calls Received (includes calls that were not handled by Member Services and routed out to another department and abandoned calls): 149,941; for Mental Health 3,474. • Calls Answered: 148, 562; for Mental Health 3,457 • Abandonment Rate % (Goal 5% or less): 0.8%; for Mental Health 0.5% • Average Speed of Answer (Goal 30 secs or less): 11; for Mental Health 11		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Service Level (goal 80% in 30 seconds): 94%; for Mental Health 97% Provider Communications: • 322 Provider Updates • 18 Informational Letters • 22 Forms Member Communications: • 73 Member Informing • 12 Provider Directories • 1 Newsletter • 1 2025 EOC Delegation Oversight Audits of Health Net include: Appeals & Grievances, Claims, FWA, Credentialing, Provider Disputes, Member Rights, Health Education, Utilization Management, Provider Network, Access & Availabiilty, Emergency Services Quality Improvement, Behavioral Health, Marketing, Health Equity, and Member Rights. Regulatory Audits and Corrective Action Plans (CAPS): Department of Health Care Services (DHCS): • 2023 DHCS Focused Audit - On August 4, 2025, the Plan submitted its final CAP update reflecting responses to the behavioral health and transportation deficiencies. The Plan is awaiting DHCS approval and closure of the CAP. • 2025 DMHC Follow-Up Audit - The DMHC conducted the "18-Month Follow-Up Audit" on May 5, 2025. The Plan received DMHC's Final Audit Report on December 23, 225 in which they determined the following: 1) The Plan had corrected the deficiency related to not identifying potential quality issues (PQIs) in exempt grievances; and 2) the Plan had not corrected the deficiency related to inappropriately denying post-stabilization care. The post-stabilization deficiency was being referred to DMHC's Office of Enforcement.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• 2025 DHCS Audit– The 2025 DHCS Audit was conducted during June 2, 2025 – June 13, 2025. DHCS issued a CAP to the Plan on November 5, 2025. There were four deficiencies: 1) The Plan did not ensure the delegate applied ESPDT criteria in medical necessity denial decisions for members under 21 years of age; 2) The Plan did not ensure the delegate notified members of the discrimination of ECM benefits through the NOA process; 3) The Plan did not ensure the delegate provided members with all ECM core service components; and 4) the Plan did not ensure the delegate included all required information in ECM member-facing written materials. The Plan submitted its first response on December 5, 2025, and will continue to submit monthly responses until CAP approval and closure. • DHCS 2024-2025 External Quality Review (EQR) Performance Evaluation–On July 7, 2025, the Plan received DHCS' annual EQR report and associated recommendations. There were three recommendations that focused on the following: 1) Working to resolve the findings from the DHCS' 2024 compliance review scoring process related to the Coverage and Authorization of Services Code of Federal Regulations (CFR) standard to ensure the Plan meets all CFR standard requirements; 2) improving MY2023 HEDIS measures; and 3) Working with DHCS to identify and clarify methodologies used by DHCS for calculation of network adequacy indicators, to ensure the Plan's efforts are meeting DHCS' expectations. The Plan submitted its response to how it would address the recommendations on August 4, 2025. • DHCS 2025 Encounter Data Validation Study– The 2025 EDV study was completed on May 13, 2025. The Plan is waiting the Final Report. • DHCS RY2024 Subnetwork Certification (SNC)- The Plan submitted RY SNC on January 2, 2025. On March 24, 2025, DHCS requested that the Plan submit quarterly updates on the status of all CAPs the Plan previously issued to PPGs for not meeting time & distance standards in their networks. The Plan's last quarterly submission was made on September 25, 2025, and approved by DHCS in February 2026.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• DHCS 2024-2025 External Quality Review (EQR) Performance Evaluation–The Plan submitted the 2024 ANC on March 14, 2025. DHCS approved the submission on 12/18/2025. • 2025 Network Adequacy Validation (NAV) Audit– The NAV audit was conducted on August 21, 2025, by DHCS' external review organization Health Services Advisory Group (HSAG). The Plan met all requirements, and the audit was closed on November 17, 2025. Department of Managed Health Care (DMHC): • Measurement Year MY 2023/RY 2024 Timely Access Report (TAR)- On April 18, 2025, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access to PCPs and Hospitals, and Provider Data Accuracy. The Plan submitted a formal response to the findings on July 17, 2025 and is awaiting a final response from the DMHC. • Measurement Year MY 2024/RY 2025 Timely Access Report (TAR) – On May 1, 2025, the Plan submitted its Annual TAR filing to DMHC. The Plan is awaiting a response from DMHC. • 2025 DMHC Routine Finance Exam- On March 19, 2025 the DMHC closed the audit with no findings. New or Expanded DHCS and New Coverage Requirements: • Enhanced Care Management (ECM) - Transitional Rent is a new Community Support service under CalAIM designed to provide up to six months of rental assistance to Medi-Cal members who are experiencing or at risk of homelessness and meet specific clinical and situational eligibility criteria. Coverage of Transitional Rent was optional for Medi-Cal managed care health plans beginning on January 1, 2025, and required for plans by January 1, 2026. Implementation Activities for 2025 DHCS Contract Requirements: • Transgender, Diverse, or Intersex (TGI) Training • Transitional Rent • Received NCQA Health Equity Accreditation		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Submitted updated fully executed MOUs with third-party entities Key Focus Areas for 2026: • Medi-Cal Enrollment Freeze - Effective January 1, 2026, due to federal budget constraints, California made a state policy decision to implement a temporary Medi-Cal enrollment freeze for undocumented adults aged 19 and older, updated asset limits to qualify for Medi-Cal, and Medi-Cal dental coverage for the undocumented; • HR.1 ("The One Big Beautiful Bill") - Begin proactively preparing for the anticipated operational and compliance impacts associated with HR-1; • The DMHC APL 25-019 and DHCS APL 25-006 - Timely Access Requirements; • CMS Interoperability and Prior Authorization Final Rule (CMS-0057-f). This final rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records and improve prior authorization to help ensure that patients remain at the center of their own care; • ECM and Community Supports (CS) - Continue optimization of provider elections/capacity for ECM and CS services; • 2026 Regulatory Audits - The Plan will be audited by both DMHC and DHCS.		
#11 2026 CalViva Health member Handbook/Evidence of Coverage **Information** Morgan Simpson	The 2026 CalViva Health member Handbook/Evidence of Coverage has been distributed and posted on the CVH website.		**No Motion**
#12 Annual Public Policy Committee Charter Review **Action** Joe Neves, Chair	The PPC reviewed the changes to the Charter and approved to move forward to Commission for approval with stated revisions.		**Motion:** Approve PPC Charter to move forward to Commission for final approval. 7-0-0-2 (M. Garcia / N. Mendoza)

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
			R. Garcia not included in vote; left early.
#13 Announcements / Final Comments from Committee Members and Staff	Courtney Shapiro shared a nursing simulation lab sponsored by CVH was just finished at Fresno Pacific. Maria Arreola shared activities for March 2026. Norma Mendoza share events for the first quarter of 2026. Martha Miranda shared the community food pantry is up and running and servicing their community. Miguel Rodriguez shared UHC opened their 40th health center in central Fresno, with other developments under way. Steven Si announced the CVH website added an FAQ section.		
#14 Public Comment	None.		
#15 Adjourn	Meeting adjourned at 12:59 pm.		

NEXT MEETING June 3, 2026, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: June 3, 2026

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

Approval Date: June 3, 2026

Approved By: _____
Joe Neves, Chairman

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
FINANCE COMMITTEE

I. Purpose

A. The purpose of the Finance Committee is to provide a committee structure to monitor and evaluate the financial status of the Fresno-Kings-Madera Regional Health Authority (RHA) from a regulatory compliance and general operating standpoint and to advise RHA on matters which are within the purview of the Finance Committee.

II. Authority

A. The Finance Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority (RHA) Commission in an advisory capacity.

III. Definitions

A. Fresno-Kings-Madera Regional Health Authority (RHA) Commission -
The Fresno-Kings-Madera Regional Health Authority (referred to as the RHA), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Responsibilities

A. The Commission's Finance Committee will discuss, advise and make recommendations to the Commission on the following areas:
   1. Compliance with all financial statutory, regulatory, and industry standard requirements
   2. Medi-Cal managed care rate and impact to the Regional Health Authority
   3. Budgets prior to submission to the Commission
   4. Unaudited financial statements prepared by staff
   5. Compensation and benefit levels for staff
   6. Selection of an independent auditing firm.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Finance Committee shall consist of at least three (3) Commission members, the Chief Executive Officer, and the Chief Financial Officer.
      2.1. Chairperson: Chief Financial Officer.
      2.2. The Committee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership

1. Commissioner Committee members' terms will be established by the RHA Commission Chairperson on an annual basis at the start of each fiscal year.

C. Vacancies
1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
1. All members of the Committee shall have one vote each
2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings

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

B. Minutes
1. Minutes will be kept at every Finance Meeting by a designated staff member. Signed, dated, summary minutes are kept. Minutes are available for review by regulatory entities.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review.

C. Structure

The meeting agenda will consist of:
1. Approval of minutes
2. Standing Items
3. Activity Reports
4. Data Information Reports
5. Ad-hoc Items

VII. Committee Support

A. The Chief Financial Officer/staff will provide Committee support, coordinate activities and perform the following as needed:
1. Regularly attend meetings
2. Assist Chairperson with preparation of agenda and meeting documents
3. Perform or coordinate other meeting preparation arrangements
4. Prepare minutes

APPROVAL:

RHA Commission Chairperson _____ **Date:** July ~~17, 2025~~16, 2026

David Hodge, MD
Commission Chairperson

Fresno-Kings-Madera Regional Health Authority
Credentialing Subcommittee Charter

I. Purpose:

A. The purpose of the Credentialing Subcommittee is to give input on the credentialing and re-credentialing policies used by CalViva Health ("CalViva" or the "Plan") and its Operating Administrator (Health Net) and monitor delegated credentialing/recredentialing activities. Delegated entities performance and compliance with credentialing standards will be monitored and evaluated on an ongoing basis by CalViva's Chief Medical Officer ("CMO"), the Chief Compliance Officer ("CCO"), and CalViva's Credentialing Subcommittee.

II. Authority:

A. The Credentialing Subcommittee serves as a Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Credentialing Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding credentialing and recredentialing, policies, processes, and standards.
B. Has final decision-making responsibility to monitor, sanction, suspend, terminate or deny practitioners or organizational providers.
C. Provide oversight of delegated credentialing and recredentialing functions.
D. Report sanctions for quality of care issues to the appropriate licensing authority including 805 reporting requirements.
E. Provide quarterly summary reports of Credentialing activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's credentialing and recredentialing criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
    1. The RHA Commission shall appoint the members of the Subcommittee.

2. The Subcommittee is chaired by the CalViva CMO.
3. Subcommittee size is determined by the Commission with the advice of the CMO.
4. The Subcommittee is composed of participating physicians including external participating practitioners who are also serving as members of the QI/UM Committee.
   a. Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
   b. Membership shall consist of primary care providers and specialists to reflect our provider network.
   d. The Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the Subcommittee meetings will be at least quarterly.
   2. The Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the Subcommittee members.
   2. Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide Subcommittee support, coordinate activities, and perform the following as needed:

A. Regularly attend Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157
4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)
5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Fresno-Kings-Madera Regional Health Authority
Peer Review Subcommittee Charter

I. Purpose:

A. The Subcommittee processes and activities have been established to achieve an effective mechanism for the Plan's continuous review and evaluation of the quality of care delivered to its enrollees, including monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies by the development of corrective action plans, and initiating remedial actions and follow-up monitoring where necessary and appropriate. Through the Plan's peer review protected activities, the Plan aims to assure its enrollees receive acceptable standards of care and service.

B. To provide a peer review committee structure for the consideration of patterns of medically related grievances that the Chief Medical Officer (CMO) determines require investigation of specific participating providers and to provide peer review of practitioners or organizational providers experiencing problematic credentialing issues, performance issues or other special circumstances.

II. Authority:

A. The Peer Review Subcommittee serves as a Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Peer Review Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding peer review policies, processes, and standards.
B. Reviews potential quality incidents referred by the QI/UM Committee that might involve the conduct or performance of specific practitioners or organizational providers and should be further investigated.
C. Report sanctions for quality-of-care issues to the appropriate licensing authority including 805 reporting requirements.
D. Establish and maintain a process for provider appeal of provider sanctions including a process of conducting fair hearings for providers who are sanctioned for issues related to quality of care.

E. Provide quarterly summary reports of Peer Review activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's peer review criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
   1. The RHA Commission shall appoint the members of the Subcommittee.
   2. The Subcommittee is chaired by the CalViva CMO.
   3. Subcommittee size is determined by the Commission with the advice of the CMO.
   4. The Subcommittee is composed of participating physicians including external participating providers who are also serving as members of the QI/UM Committee.
      a. Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      b. Membership shall consist of primary care providers and specialists to reflect our provider network.
      c. Participating Practitioners from other specialty areas shall be retained as necessary to provide peer review input.
      d. The Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the Subcommittee meetings will be at least quarterly.
   2. The Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the Subcommittee members.
   2. Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide Subcommittee support, coordinate activities and perform the following as needed:

A. Regularly attend Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157
4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)

5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Fresno-Kings-Madera Regional Health Authority
Quality Improvement/Utilization Management Committee Charter

I. Purpose:

A. The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, Health Equity, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.
B. The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of delegated, nondelegated, and collaborative QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

II. Authority:

A. The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Responsibilities:

The QI/UM Committee's responsibilities include but are not limited to the following activities.

A. Review and recommend approval to the RHA Commission of the program documents listed below:
   1. Annual QI and Health Education Program Description
   2. Annual QI and Health Education Work Plan
   3. Annual QI and Health Education Program Evaluation
   4. Annual UM Program Description
   5. Annual CM Program Description
   6. Annual CM Program Evaluation
   7. Annual UM/CM Work Plan
   8. Annual UM/CM Program Evaluation
   9. Annual Health Equity ("HE") Program Description
   10. Annual Health Equity Work Plan
   11. Annual Health Equity Program Evaluation
   12. Population Health Management Strategy Program Description

13. Population Health Management Assessment Report
14. Population Health Management Segmentation Report
15. Population Health Management Effectiveness Analysis Report
16. Quality Improvement Health Equity Transformation Plan
17. Long Term Care Quality Assurance Performance Improvement Plan

B. Reviews quarterly reports of Work Plan progress for the programs listed above;
C. Monitors key clinical and service performance indicators for QI, UM, HE and Credentialing/Recredentialing activities (e.g., access & availability, over and under utilization, key UM and case management indicators, behavioral health, population health, appeals and grievances, HEDIS® and CAHPS® measure results, provider satisfaction surveys, disease management and public health programs activities, timeliness standards etc.);
D. Analyze and evaluate the results of QI and Health Equity activities;
E. Monitor effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social drivers of health (SDoH), and community needs and makes ongoing recommendations;
F. Provide oversight and review reports of delegated UM and Credentialing/ Recredentialing functions and collaborative QI functions;
G. Reviews summarized grievance reports for medically related issues and administrative quality concerns;
H. Reviews analysis of potential quality incident reports (developed from grievances/complaints, utilization management, utilization reports suggesting over or under utilization);
I. Oversees and monitors CalViva's participation in the Department of Health Care Services ("DHCS") required Performance Improvement Projects ("PIPs");
J. Approve and oversee conduct of special QI studies as warranted;

I. Brings general medically-related concerns to the attention of the Plan's Operating Administrator (Health Net);
J. Analyze and evaluate the results of the QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Public Policy Committee and Community Advisory Groups.
K. Advises on the conduct of provider and member satisfaction surveys and submits its review to the Commission;
L. Reviews the results of clinical outcome studies, identifies gaps and reports findings to the Commission;
M. Forwards to the Credentialing Sub-Committee and Peer Review Sub-Committee potential quality incidents that might involve the conduct of specific providers and should be further investigated;
N. Receives reports from the Credentialing Sub-Committee and Peer Review Sub-Committee;
O. Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission.
P. Ensure that the Plan follows state, federal, contractual and NCQA requirements for QI, UM, HE and Credentialing.
Q. Ensures member confidentiality is maintained during Committee discussions.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Committee is chaired by the CalViva Chief Medical Officer ("CMO").
   3. The CalViva Health Equity Officer shall attend the QI/UM Committee and functions in an advisory capacity.
   4. Committee size is determined by the RHA Commission with the advice of the CMO.
   5. The QI/UM Committee will be composed of:
      5.1. Participating health care providers, including external participating physicians, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network.
      5.2. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners.
      5.3. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      5.4. Participating Practitioners from other specialty areas shall be consulted as necessary to provide specialty input.
      5.5. For the purpose of meeting a quorum, the RHA Commission Chair may appoint an alternate member, who is also a provider member of the RHA Commission, to serve as a voting member of the committee.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Committee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
   1. All members of the Committee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the QI/UM Committee meetings will be at least quarterly.
   2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.

3. A quorum consists of at least 51% of the membership.
4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Notice
1. The meeting date will be determined by the Chairperson with the consensus of the Committee members.
2. Committee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
1. Minutes will be kept at every Committee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities and will be submitted to DHCS upon request.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the Committee's recommendations.
3. The minutes will be made publicly available on the CalViva Health website on at least a quarterly basis.

VII. Committee Support:

The Plan Medical Management department staff will provide Committee support, coordinate activities and perform the following as needed:

A. Regularly attend Committee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and improvement discussions,
E. Ensure a quarterly summary of Committee activity and Committee recommendations is prepared for submission to the RHA Commission.

VIII. Subcommittees and Work Groups reporting to QI/UM:

A. QI/UM Committee has two Subcommittees and three work groups:
1. Credentials Sub-Committee and Peer Review Sub Committee each with their own charter
2. QI/UM Operational Work Group consists of CalViva and Health Net staff/leadership. The QI /UM Operational Work Group has one sub group:
   - Appeals and Grievances Work Group consists of CalViva and Health Net staff to review, track, trend appeals and grievances and reports to QI/UM Operational Work Group
3. Access Work Group reports information reviewed by CalViva and Health Net staff regarding access and availability of services to QI/UM Committee.

IX. Authority

A. Health & Safety Code Sections 1370, 1370.1

B. California Code of Regulations, Title 28, Rule 1300.70
C. DHCS Contract, Exhibit A, Attachments 4 and 5
D. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

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

I. Purpose:

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

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

II. Authority:

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

III. Definitions:

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

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

IV. Committee Focus:

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

B. Principal Responsibilities:

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

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

V. Committee Membership:

Composition

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

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

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

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

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

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

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

   3.6. In selecting the members and/or CBO representatives of the PPC, the RHA selection committee shall make a good faith effort to ensure the PPC reflects the

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

B. Term of Committee Membership

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

C. Vacancies

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

D. Voting

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

VI. Meetings:

The PPC must hold its first regular meeting promptly after all initial PPC members have been selected by the PPC selection committee and quarterly thereafter. Regularly scheduled PPC meetings will be open to the public, meetings information will be posted

publicly on CalViva Health's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

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

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

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

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

2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the PPC's recommendations.

VII. Committee Support:

A. PPC Coordinator

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

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

VIII. Other Requirements:

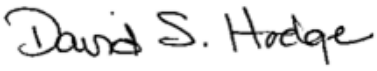
1. The Plan's Evidence of Coverage (EOC) includes a description of its system for member participation in establishing public policy.

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

IX. Authority:

1. Health & Safety Code Section 1369
2. California Code of Regulations, Title 28, Rule 1300.69
3. RHA Bylaws
4. DHCS Medi-Cal Contract
5. DHCS APL 25-009 Community Advisory Committee (CAC) Requirements

APPROVAL:

RHA Commission Chairperson		**Date**: March 19, 2026
	David Hodge, MD	

Item #5

Closed Session

Item #6
Attachment 6.A

Review of
Fiscal Year End 2026 Goals

BL 26-012

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

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www.calvivahealth.org

DATE: July 16, 2026
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Review of Goals and Objectives for Fiscal Year End 2026
BL #: 26-012
Agenda Item 6
Attachment 6.A

DISCUSSION:

Continued on pages 2 & 3

Category:	Goal:	Result:
Market Share	Maintain market share	Market Share is approximately 66% and has remained the same from the prior Fiscal Year.
Medical Management / Quality Improvement	Continue the work on both Performance Improvement Project (PIPS): (1) Clinical-- African America/Black Well Child Visits in Fresno County and (2) Nonclinical-- Follow up after ED visit for substance use disorder (SUD)/mental health (MH) issue in Fresno and Madera Counties. Successfully complete the Madera LEAN project and DHCS submissions for Follow Up after ED Visits for Substance Use Disorder or Mental Health issue in Madera County. Successfully complete the Kings County Comprehensive project and DHCS submissions for the Chronic Domain-Asthma Medication Ratio (AMR) and the Childhood Domain- All eight (8) MCAS Childhood & Adolescent measures. Successfully complete the Fresno County Transformational Project and DHCS submissions in Collaboration with Anthem Blue Cross for the Childhood Domain (Six (6) of eight (8) Childhood & Adolescent measures) working with a large FQHC. Also complete the Asthma Medication Ratio (AMR) Project from the Chronic Domain. Complete the IHI Health Equity project in Fresno County working with an FQHC and CBOs for Childhood Domain (Well Child visits). Complete the IHI Behavioral Health project in Fresno County working with Fresno County Behavioral Health and Anthem Blue Cross on the Behavioral Health Domain to improve follow up after an ED Visit for SUD/MH issues	Clinical PIP – African American/Black Well-Child Visits in Fresno County The Clinical PIP continued to focus on improving well-child visit completion among African American/Black children in Fresno County. CalViva received a high-confidence validation score for adherence to acceptable PIP methodology, with 94% of evaluation elements and 100% of critical elements met. One performance indicator demonstrated statistically significant improvement, while the second did not. The final PIP submission is due to HSAG/DHCS on August 6, 2026. Nonclinical PIP – Follow-Up After Emergency Department Visits for SUD/MH The Nonclinical PIP continued to focus on improving follow-up after emergency department visits for substance use disorder or mental health conditions in Fresno and Madera Counties. The team reviewed and updated the HSAG intervention worksheets, eligibility definitions, denominators, and supporting data in preparation for the final submission. Madera County Behavioral Health LEAN Project The Madera County LEAN project continued to improve follow-up after emergency department visits for mental health and substance use disorder.

		Overall mental health and combined FUA/FUM performance improved and exceeded goal, although SUD performance declined in November and December and required further review. The team also addressed data discrepancies, developed member and provider resource tip sheets, and evaluated referral pathways for MAT and community-based services. Kings County Comprehensive Project The Kings County Comprehensive QI and Health Equity project was completed successfully. The project identified key barriers within the Chronic Disease Management domain and established targeted strategies to strengthen provider oversight, engagement, member education, data quality, and coordination of asthma-related services in Kings County Fresno County Transformational Project The Fresno County Transformational project was completed successfully in collaboration with Anthem and United Health Centers. CalViva's clinic reached the 50th percentile for four of eight Children's Domain measures: LSC, W30-2+, IMA, and CIS-10. During the project period, 843 appointments were completed, with 352 appointments scheduled through extra hours staffing. 175 member incentives were distributed.
Funding of Community Support Program	Administer the Community Investment Funding Program	Twelve (12) grants were awarded under Provider Network Support Five (5) grants were awarded under Education Scholarships & Community Workforce Support Five (5) grants were awarded under Community Infrastructure Support Eleven (11) grants were awarded under Community Based Organizations Nineteen (19) grants were awarded under Youth Recreation Sports Fifteen (15) grants were awarded under a State/Federal Local Community Support Response A total of sixty-seven (67) Community Support grants were awarded throughout the Fresno, Kings, and Madera Counties

Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirement and meet the DHCS reserve standard of at least one month's contract revenues based on CalViva's average monthly contract revenues for the previous twelve months.	Met the DMHC and DHCS minimum TNE/reserve requirements.
Community Outreach	Continue to participate in local community initiatives.	Participated in Cradle to Career, See 2 Succeed Vision Program, The Children's Movement of Fresno (TCM Fresno), Reading Heart Advisory Group, DHCS Community Reinvestment initiatives, EFSP Community Relief Tour, and 150+ CBO sponsorships and community partnerships.
State and Federal Advocacy	Continue to advocate Local Initiative Plan Interest	Continued as a Local Health Plan Association and Mid State MGMA Board Member.
Health Plan Accreditation	Maintain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation Certifications	CalViva Health is NCQA Health Plan and NCQA Health Equity Accredited as of June 30, 2026.
Diversity, Equity, and Inclusion	Continue to monitor various ongoing Equity projects and identify any new opportunities to improve around Diversity, Equity, and Inclusion. Continue to monitor changes in member population health gaps and disparities to keep DEI annual training up to date with trends. Offer DEI training as per DHCS and NCQA requirement. Take part in QIUM meetings and assist/ add input with quality as it relates to Health Equity and ensure that Health Equity reports meet DHCS and NCQA standards. Complete HN internal annual Audit.	Perimenopause and Menopause project initiative was completed Q4 2025. DEI 2025 training completed Q4 2025. All HE P/P are up to date and meet the standard for DHCS and NCQA. HN annual oversight audit was completed Q3 2025.

Item #7
Attachment 7.A

Goals & Objectives
FY 2027

BL 26-013

Jeffrey Nkansah
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DATE: July 16, 2026
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Goals and Objectives for Fiscal Year 2027
BL #: BL 26-013
Agenda Item: 7
Attachment: 7.A

DISCUSSION:

Category:	**Goal:**
Market Share	Maintain market share.
Member Experience & Member Retention Strategy	Implement 100% of the specific, high-impact actions outlined in our roadmap which received a formal vote to move into the implementation phase
Medical Management / Quality Improvement	Comply with DHCS requirements to develop and implement any required quality improvement projects as directed.
Funding of Community Support & DHCS Community Reinvestment Program	Administer the Community Support Funding Program and DHCS Community Reinvestment Funding Program.
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirement and meet the DHCS reserve standard of at least one month's contract revenues based on CalViva's average monthly contract revenues for the previous twelve months.
Community Outreach	Continue to participate in local community initiatives.
State and Federal Advocacy	Continue to advocate Local Initiative Plan Interest
Health Plan Accreditation	Maintain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation Certifications
Health Equity	Continue to support Health Equity initiatives by monitoring member disparities, population health trends, and emerging community needs. Maintain Cultural Competency training, reporting, and compliance activities in alignment with DHCS, and organizational requirements. Actively participate in Community Health Improvement Plan (CHIP) initiatives and community collaboratives to support efforts addressing identified health priorities and disparities. Provide education and technical assistance to community partners regarding available resources, programs, and county-wide initiatives, while fostering collaboration and alignment across organizations to expand reach, strengthen partnerships, and improve access to services for underserved populations. Participate in QIUM and cross-functional meetings to provide Health Equity expertise and support annual audit, assessment, and reporting activities. Complete HN internal annual audit.

Item #8
Attachment 8.A

Update on July 1, 2025
Health Net Community Solutions Contract

BL 26-014

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

Timothy 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

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DATE: July 16, 2026

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Update on July 1, 2025 Health Net Community Solutions Contract

BL #: **26-014**
Agenda Item 8
Attachment **8.A**

BACKGROUND:

On July 17, 2025, the RHA Commission were advised that the RHA and Health Net Community Solutions, Inc. ("Health Net") had reached agreement on contract(s) with an effective date of July 1, 2025. The RHA Commission were advised the next steps in the process were to obtain regulatory approval of the new modernized Administrative Services Agreement ("ASA") and Capitated Provider Services Agreement ("CPSA") and execute those new modernized agreements with Health Net with a retroactive effective date of July 1, 2025.

The RHA Commission on February 19, 2026 received an informational update on Regulatory approvals. The update informed the RHA Commission of the regulatory review(s) conducted by the Department of Managed Health Care and that the RHA would be proceeding in the near future to submit the contract(s) to the Department of Health Care Services.

INFORMATIONAL UPDATE ON REGULATORY APPROVALS:

1. On February 12, 2026 the RHA provided the new unexecuted modernized Administrative Services Agreement and modernized Capitated Provider Services Agreement to the Department of Health Care Services ("DHCS") for their review.

2. On March 20, 2026, the RHA received a response from the DHCS. The majority of the comments fixated on whether DHCS required criteria were present in the new contract(s).

3. On April 8, 2026, the RHA responded to the DHCS. The responses included providing clarification(s) to DHCS of where the DHCS required criteria were present in the contract(s), not applicable, and/or adding the technical language(s) DHCS was seeking. None of the clarification(s) and/or insertion(s) impacted the materiality of the new contract(s).

4. On April 29, 2026, the DHCS accepted the RHA's clarifications and technical changes and on May 5, 2026, the updated contract(s) encompassing the DHCS technical changes were shared with the Department of Managed Health Care ("DMHC").

5. On June 2, 2026, the DMHC provided their approval and requested a copy of the executed contracts.

5. On June 5 and June 12, 2026 respectively, Health Net and the RHA executed the new modernized ASA and CPSA and the executed copies have been filed by the RHA with the DHCS and DMHC.

Item #9
Attachment 9.A

Care Management

2025 Program Evaluation &
Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health Regional Health Authority Commissioners CalViva Health QI/UM Committee
FROM:	Carrie-Lee Patnaude, Director Care Management
COMMITTEE DATE:	July 16, 2026
SUBJECT:	CalViva Care Management Program Evaluation 2025 & Executive Summary

Summary:

Care Management (CM) processes have been consistent, and evaluation/monitoring of CM metrics continue to be a priority. Care Management monitors the effectiveness of programs in order to better serve our members.

Purpose of Activity:

CalViva Health has delegated responsibilities for care management (CM) activities to Health Net Community Solutions. CalViva Health's CM activities are handled by qualified staff in Health Net's State Health Program (SHP) division.

The Care Management Program is designed for all CalViva Health members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely and effective manner.
CalViva Medical Management staff maintains clinical oversight of services provided through review/discussion of routine reports and regular oversight audits.

The 2025 CM Program Evaluation encompasses a review of care management programs through the documentation of current and future strategic initiatives and goals. The evaluation tracks key performance metrics and provides for an assessment of our progress and identifies critical barriers.

Analysis/Findings/Outcomes:

I. Cases Managed

The goal to increase cases managed in 2025 over 2024 was met (7,520 in 2024 and 8,816 in 2025). Overall, 2.03% of the total population was managed in 2025 amongst physical health CM, behavioral health CM, perinatal CM, First Year of Life (FYOL), and the Transitional Care Services (TCS) program. The average population of members in 2025 was 434,102. The overall percentage of population managed in Physical Health CM was 0.38%. Behavioral Health demonstrated 0.18%. The population managed in Perinatal CM was 0.26%. First Year of Life managed 0.19%, and Transitional Care Services demonstrated 1.03%.

II. Monitoring audits for compliance with regulatory standards

The Plan completed file reviews and audits as planned in 2025. As a result, it was identified that each program met the goal of 90% or greater audit scores in 2025. Additional training and individual coaching were completed in 2025 for staff with below goal scores.

III. Care Management Outcomes

a. Physical Health and Behavioral Health Outcomes

Measures of effectiveness for care management are evaluated using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM. Measures of effectiveness include the following indicators: Readmission rates; ED Utilization' Overall health care costs.

Claims data demonstrated a reduction in readmissions for the care managed members, 7.7% decrease (pre 31.7% vs post 24%) in readmission rate based on claims. This was well above the 5% goal. There was also a 17.8% reduction in ED utilization for this population by 301 ED visits and a reduction of 651 ED visits per 1,000 members per year. Comparing health care costs, 90 days pre and post care management enrollment showed that managed members demonstrated a reduction in inpatient claims of 490, a decrease of 1,344 for outpatient services, and a decrease of 444 for pharmacy.

b. Perinatal Outcomes

The Perinatal CM program was evaluated based on the member's compliance with completing their first prenatal visit within the first trimester and their post-partum visit. In addition, the rate of pre-term delivery of high-risk members managed was evaluated.

Members in the Perinatal CM program demonstrated a 15.5% percentage increase in compliance with completing the first prenatal visit in their first trimester, exceeding the goal of ≥8%. The percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program was 11.9% which met the goal of ≥10%. There were 5.1% fewer pre-term deliveries for high-risk members managed than high-risk members not managed which exceeded the 2% reduction goal.

IV. Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. The goal for member satisfaction is > than 90%. 2/13 survey questions had responses scoring over 90%. 4/13 survey questions scored 85% or higher. 92% (69/75) of respondents were satisfied with the Care Management Program. 93% (55/59) of

respondents reported they feel more in control of their health now that they have started the Care Management Program.
There were five grievances related to care management in 2025. The goal for member complaints/grievances < 1/10,000 members was met.

V. Summary and Priorities

In 2025, the key accomplishments for the CM Program were:

- Exceeded our goal to reduce readmissions for CM engaged members in BH, PH and TCS programs.
- Exceeded our goals to reduce ED visits.
- Exceeded our Perinatal program goals
- Increased referrals in all programs in 2025 compared to 2024 (PH 31%, BH 50%, PCM&FYOL 55%, and TCS 45% increased)
- Continue to enhance the Transitional Care Services program to meet PHM requirements:
    - Onsite staff at additional Hospitals (opened communication with Valley Children's)
    - Launched texting program with members

The primary goals for 2026 are to complete activities related to:

- Enhancements in Transitional Care Services program to meet updated PHM requirements.
    - Increase length of stay for PP TCS cases
    - Increasing Staffing
    - Create birthing checklist in portal and system
    - Increase the number of hospitals we have on site staff presence at.
- Launch enhanced Pregnancy Program
    - Utilize trimester-based assessments
    - Ensure alignment with PHM policy update for postpartum member requirements
- Manage more members across CM programs.
- Increase use of texting programs with members
- Utilize texting platform to conduct timely Satisfaction Survey
- Increase the reduction in ED visit goal for members in CM

Care Management Program Evaluation 2025

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Care Management Program Evaluation - 2025

I. Overview

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera. Under California's Medi-Cal managed care program, the RHA dba CalViva Health ("CalViva") is designated as the Local Initiative. CalViva a National Committee for Quality Assurance (NCQA) accredited health plan is contracting with Health Net Community Solutions (HNCS or Health Net), also a NCQA accredited Medi-Cal managed care plan, for capitated provider services, network, and administrative services to be provided for the majority of CalViva's membership.

Health Net provides Care Management to CalViva members, which were available to 434,102 assigned CalViva members in Fresno, Kings, and Madera counties in 2025.

In 2025, focus remained on strategic initiatives and Population Health Management activities, while strengthening relationships across departments and with community partners. Activities included increased outreach of acute inpatient admits, increasing enrollment in Transitional Care Services program, increasing member outreach, and managing more members across all Care Management Programs. CalViva continued to support our members, providers, community partners, and staff.

CalViva Health is dedicated to improving access to care and providing quality health care to families in the Fresno, Kings, and Madera County area. We provide the right care at the right place and the right time.

Beliefs

- "We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enable meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities."

Purpose of Self-Assessment

The purpose of this self-assessment is to provide information about our Care Management (CM) Program and evaluate the effectiveness of the program. Performance is measured against internal and established external standards of care. This self-assessment is reflective of 2025 and findings are used to establish goals for 2026.

II. Program Infrastructure and Evaluation

Medical Management Committees

Oversight and operating authority of CM activities is delegated to CalViva's Quality Improvement Utilization Management Committee (QIUM) by CalViva's Regional Health Authority Commissioners. The annual review and revision of the CM Program Description and the annual CM Program Evaluation are presented to the QIUM Committee for review and approval.

This model supports integrated care delivery and reduces fragmentation across physical and behavioral health services.

Care Management Program

The CM Program is a collaborative process of assessment, planning, coordinating, monitoring, and evaluation of the services required to meet an individual's needs. Care Management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of CM is the provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. The care manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner. In order to optimize the outcome for all concerned, CM services are best offered in a climate that allows direct communication between the Care Manager, the member (or designated representative), and appropriate service personnel. This communication focuses on maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. Coordination of care and services is a key function of CM across the continuum, including acute, chronic, complex, and special needs cases.

Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The care manager must ensure appropriate referrals are made for the member to the appropriate provider or community resource, even if these services are outside of the required core benefits of the health plan. The care manager shall ensure each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable. The Plan shall ensure each member's privacy is protected during all communications with external parties. Transfer of protected health information (PHI) will be conducted by phone, secure fax or secure email in order to ensure maintenance of member privacy at all times with only the minimum necessary information being shared.

Behavioral Health (BH) Program

When a member has behavioral health needs that fall into the mild to moderate service category (as identified by state criteria All Plan Letter 22-006) the plan manages the ongoing care and coordination of services. If a member has behavioral health care needs that require more intensive treatment, and meets specialty mental health criteria, the plan works jointly with our

Health Net Behavioral Health team and the local county behavioral health department to facilitate a referral. The Care Manager works together with these internal and external teams to ensure continuity of care for the shared member.

Members who have co-morbid conditions requiring coordination of care to manage both behavioral health and physical health issues are provided with integrated care services. In these instances, a physical health and a behavioral health professional work together to jointly develop a single plan of care that addresses the full needs of the individual.

Continued participation in this process strengthens relationships and provides an opportunity to maintain current points of contact with the intent of facilitating access to appropriate levels of service. Of major importance was maintaining the standards regarding release of information and data collection that protect the rights of the members under HIPAA guidelines and provides the information required for continuity and quality of care that was developed in prior years. Through the application of clinical and financial information the plan will be able to move forward collaboratively with other agencies to target specific interventions for the members and decrease duplication of services and enhance overall service provision to members. The shared communication among plan partners enables us to advance population health and better trend the needs of the population across service types.

Care Management Referrals

Members for CM were identified through a variety of sources including the concurrent review process, reports such as the Notification of Pregnancy, Health Risk Screening, Sickle Cell, Concurrent Review, Pharmacy, Impact Pro, and Population Health Management, as well as providers and preferred provider groups (PPGs), county entities, and member self-referrals. Overall, the volume of referrals for 2025 was 16,382 for CM programs. The volume of referrals for physical health demonstrated an average of 400 per month for the entire year. The volume of referrals to behavioral health averaged 141 per month. Referrals for the Pregnancy Program and First Year of Life programs are combined and averaged 213 per month. The volume of referrals for Transitional Care Services demonstrated an average of 612 per month for the entire year. Care management cases requiring clinical expertise were managed by licensed care managers and cases only requiring assistance with social needs such as housing, finance, and other resources were managed by support staff with social work experience.

The data for the Care Management program is divided into four main categories: Physical Health, Behavioral Health, Perinatal Care Management/FYOL, and Transitional Care Services. Overall referral volume reflects continued reliance on data-driven identification processes and increased collaboration across internal and external partners.

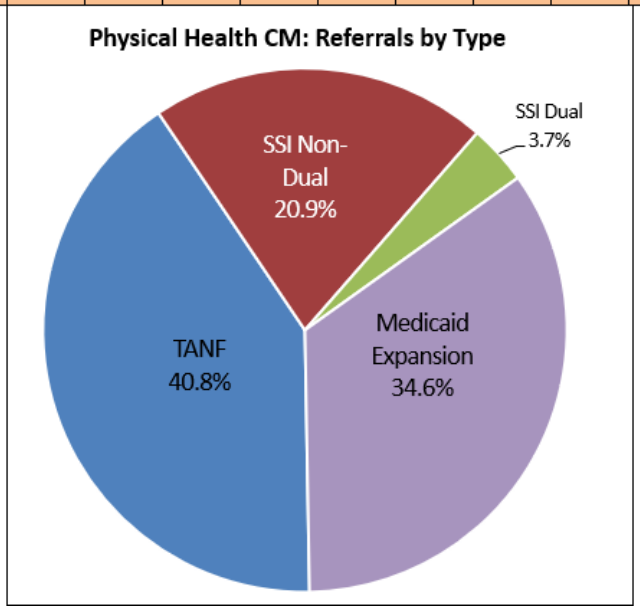
Physical Health

- Referrals by Type:
  - Total number of referrals for 2025 was 4,800
  - 24.6% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 34.6 % of the members referred were Medi-Cal Expansion.
  - 40.8 % of the members referred were TANF.

Table A. Physical Health CM Referrals by Population Type

CalViva Physical Health Case Management Referrals By Type: 1/1/2025 - 12/31/2025

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	80	84	239	253	254	132	96	210	188	198	98	128	**1,960**
SSI Non-Dual	59	49	101	102	103	94	124	72	89	98	54	57	**1,002**
SSI Dual	25	17	21	17	15	13	17	14	9	10	11	8	**177**
Medicaid Expansion	87	86	137	233	181	204	117	134	144	110	119	109	**1,661**
TOTAL REFERRALS	**251**	**236**	**498**	**605**	**553**	**443**	**354**	**430**	**430**	**416**	**282**	**302**	**4,800**

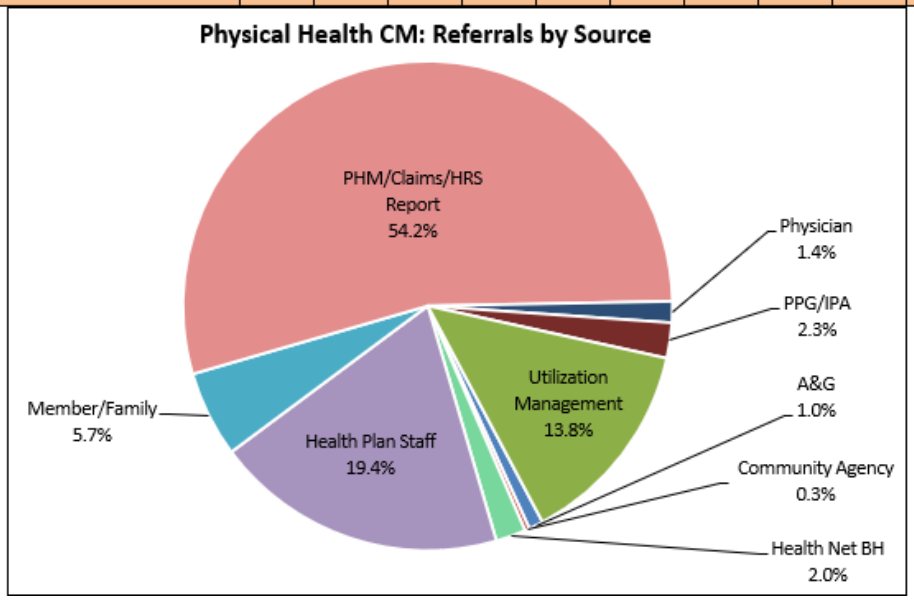


- Referral sources:
  - 19.4% of referrals came from within the Health Plan.
  - 54.2% PHM/Claims/HRS Report.
  - 13.8% Utilization Management
  - 1.4% Physician.
  - 5.7% Member and Family.
  - The remainder of physical health referrals were from a variety of sources – A&G, PPG/IPA, Health Net Behavioral Health, and Community Agencies.

Table B. Physical Health CM Referrals by Source

CalViva Physical Health Case Management Referrals By Source: 1/1/2025 - 12/31/2025

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
A&G	2	0	3	3	4	3	1	4	7	2	7	10	**46**
Community Agency	0	0	1	1	0	3	4	1	2	0	0	3	**15**
Health Net BH	2	0	2	4	5	3	3	6	5	57	5	3	**95**
Health Plan Staff	61	46	63	60	72	137	79	107	93	79	65	67	**929**
Member/Family	28	35	21	30	34	37	10	12	22	17	13	14	**273**
PHM/Claims/HRS Report	95	68	340	433	375	188	201	240	219	158	143	141	**2,601**
Physician	5	2	2	7	17	5	3	1	6	10	6	3	**67**
PPG/IPA	3	7	5	11	7	11	10	15	18	9	9	7	**112**
Utilization Management	55	78	61	56	39	56	43	44	58	84	34	54	**662**
TOTAL REFERRALS	**251**	**236**	**498**	**605**	**553**	**443**	**354**	**430**	**430**	**416**	**282**	**302**	**4,800**

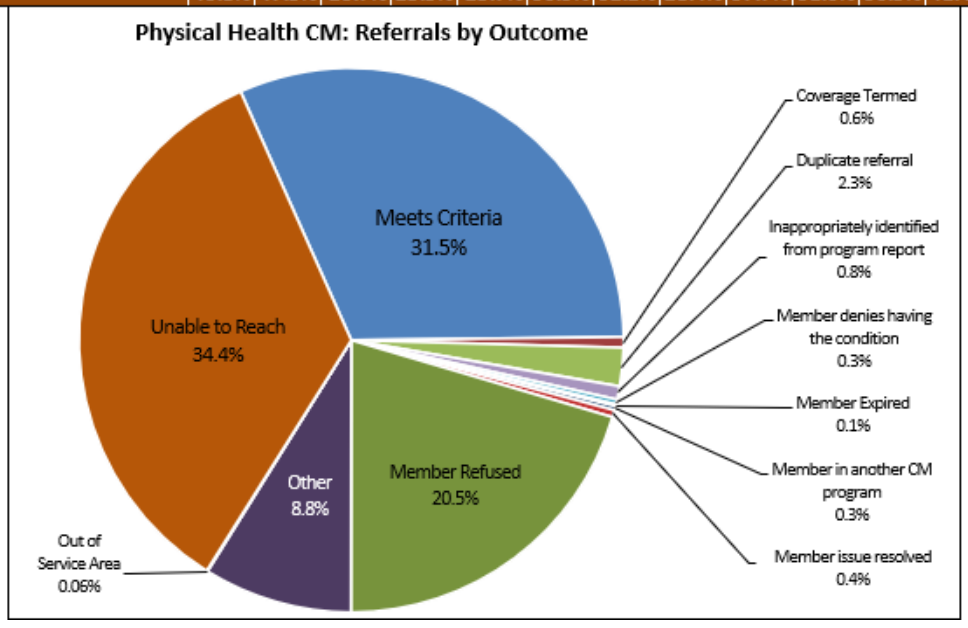


- Referral Outcome:
  - 31.5% meet criteria and agreed to CM.
  - 34.4% of the members were unable to be reached.
  - 20.5% of the members/representatives refused CM.
  - 8.8% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, other (including members requesting information only not a referral to CM), coverage termination, duplicate referrals, expired, member issue resolved.
  - 84% of members who met criteria and initially agreed to CM resulted in an open case.

Table C. Physical Health CM Referral Outcome

CalViva Physical Health Case Management Referrals By Outcome: 1/1/2025 - 12/31/2025

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	110	112	118	154	142	137	114	122	162	129	86	125	**1,511**
Coverage Termed	2	0	4	3	1	3	5	0	3	1	6	2	**30**
Duplicate referral	7	8	6	7	7	17	4	14	11	16	5	7	**109**
Inappropriately identified from prog	2	0	4	9	0	4	3	4	3	2	3	4	**38**
Member denies having the condition	0	0	2	3	1	1	0	1	2	1	3	0	**14**
Member Expired	0	0	0	0	1	1	0	0	1	1	1	0	**5**
Member in another CM program	1	1	0	1	0	1	3	1	2	0	2	0	**12**
Member issue resolved	1	1	1	0	1	1	3	5	1	2	3	1	**20**
Member Refused	42	28	141	139	138	88	68	89	74	64	56	55	**982**
Other	11	9	45	41	65	38	22	39	35	73	25	21	**424**
Out of Service Area	0	1	0	0	1	0	0	0	1	0	0	0	**3**
Unable to Reach	75	76	177	248	196	152	132	155	135	127	92	87	**1,652**
TOTAL REFERRALS	**251**	**236**	**498**	**605**	**553**	**443**	**354**	**430**	**430**	**416**	**282**	**302**	**4,800**
%Meets Criteria	**43.8%**	**47.5%**	**23.7%**	**25.5%**	**25.7%**	**30.9%**	**32.2%**	**28.4%**	**37.7%**	**31.0%**	**30.5%**	**41.4%**	**31.5%**



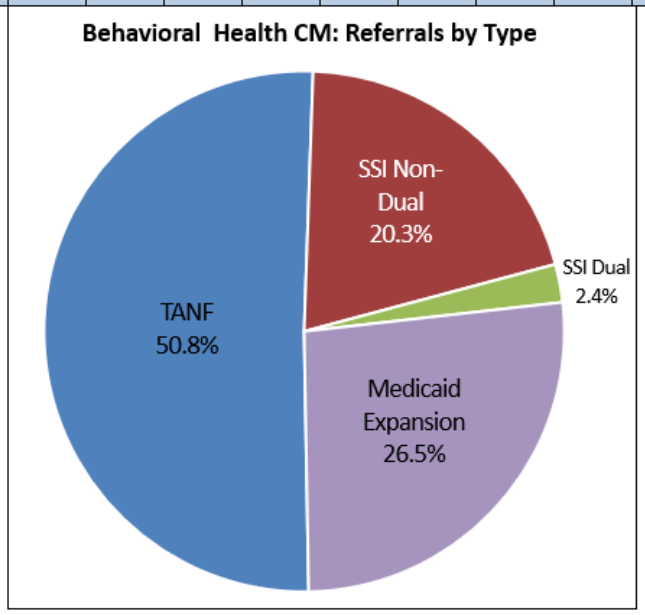
Behavioral Health

- Referrals by Type:
  - Total number of referrals 1,690.
  - 22.7% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 26.5% of the members referred were Medi-Cal Expansion.
  - 50.8% of the members referred were TANF.

Table D. Behavioral Health CM Referrals by Population Type

CalViva Behavioral Health Case Management Referrals By Type: 1/1/2025 - 12/31/2025

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	76	58	75	87	82	79	61	70	54	125	54	38	**859**
SSI Non-Dual	28	20	35	24	23	32	33	21	34	57	17	19	**343**
SSI Dual	3	6	6	7	4	7	3	1	0	1	2	0	**40**
Medicaid Expansion	44	32	55	51	31	36	36	43	42	36	22	20	**448**
TOTAL REFERRALS	**151**	**116**	**171**	**169**	**140**	**154**	**133**	**135**	**130**	**219**	**95**	**77**	**1,690**

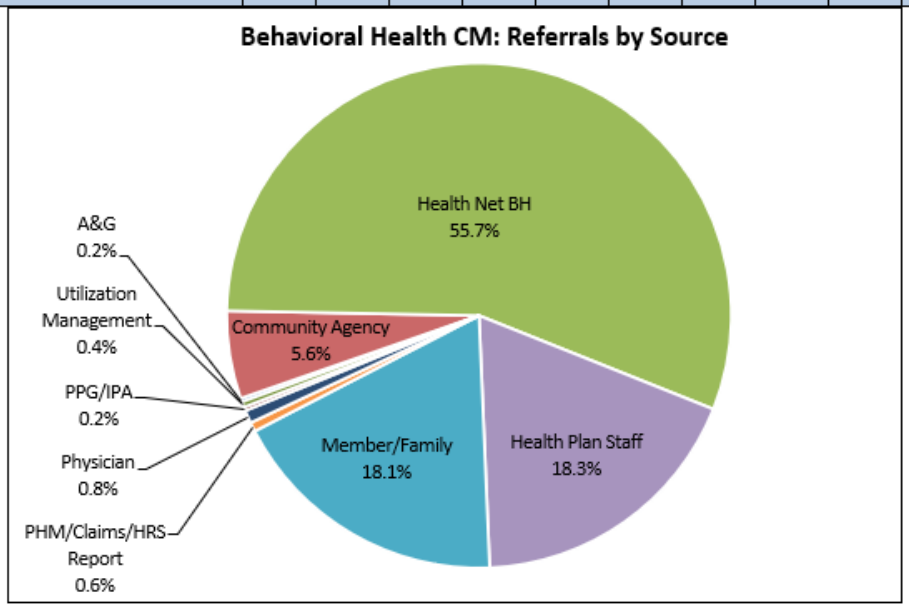


- Referral sources:
  - 55.7% of referrals came from Health Net Behavioral Health team.
  - 18.3% within the health plan.
  - 18.1% Member and Family.
  - 5.6% Community Agency.
  - 2.3% Comprised of other sources such as A&G, UM, PPG/IPA, Physician, and Reports.

Table E. Behavioral Health CM Referrals by Source

CalViva Behavioral Health Case Management Referrals By Source: 1/1/2025 - 12/31/2025

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
A&G	1	0	1	0	0	0	1	0	0	0	0	1	**4**
Community Agency	18	14	5	9	5	3	6	9	6	11	4	5	**95**
Health Net BH	50	32	75	64	72	104	90	86	89	171	68	41	**942**
Health Plan Staff	40	28	26	26	28	22	25	26	18	29	15	26	**309**
Member/Family	38	41	63	69	32	25	4	7	13	8	4	2	**306**
PHM/Claims/HRS Report	2	0	1	0	2	0	1	1	0	0	2	1	**10**
Physician	0	0	0	0	0	0	4	6	3	0	1	0	**14**
PPG/IPA	0	0	0	1	1	0	2	0	0	0	0	0	**4**
Utilization Management	2	1	0	0	0	0	0	0	1	0	1	1	**6**
TOTAL REFERRALS	**151**	**116**	**171**	**169**	**140**	**154**	**133**	**135**	**130**	**219**	**95**	**77**	**1,690**

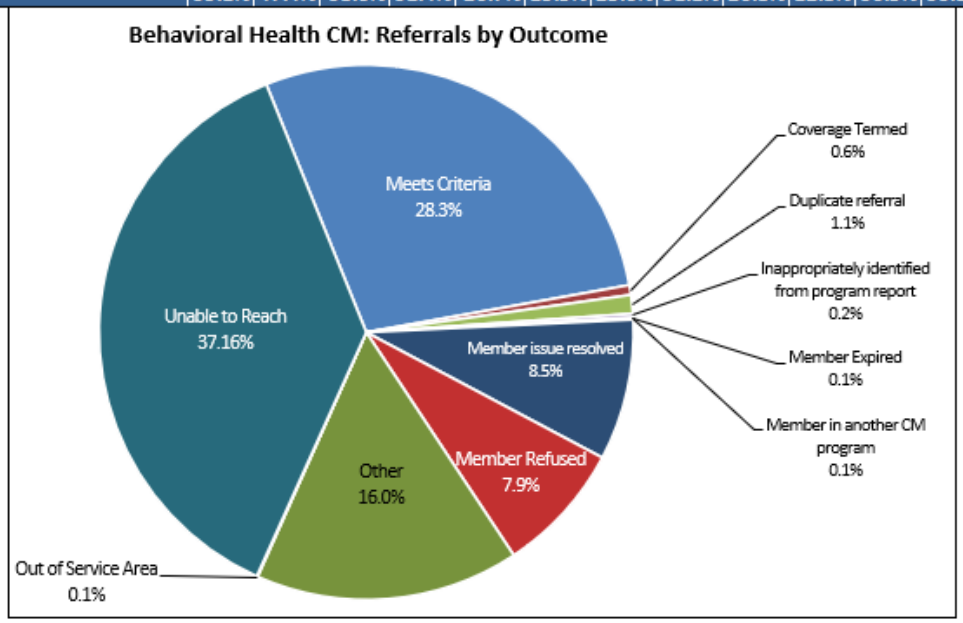


- Referral Outcome:
  - 28.3% meet criteria and agreed to CM.
  - 37.16% of the members were unable to be reached.
    - The higher rate of members unable to be reached may reflect increased referral volume and challenges with member contact accuracy.
  - 7.9% of the members/representatives refused CM.
  - 26.64% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, coverage termination, duplicate referrals, expired, member issue resolved.
  - 96% of members who met criteria and initially agreed to CM resulted in an open case.

Table F. Behavioral Health CM Referral Outcome

CalViva Behavioral Health Case Management Referrals By Outcome: 1/1/2025 - 12/31/2025

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	59	55	66	53	29	30	34	42	27	28	29	26	**478**
Coverage Termed	1	2	0	0	0	1	2	0	2	1	0	1	**10**
Duplicate referral	1	1	2	0	0	2	5	1	1	4	0	2	**19**
Inappropriately identified from prog	0	0	0	0	0	0	0	3	1	0	0	0	**4**
Member Expired	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Member in another CM program	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Member issue resolved	4	1	4	13	17	21	14	8	8	33	14	7	**144**
Member Refused	6	9	11	8	11	15	12	9	21	16	13	3	**134**
Other	24	6	23	31	36	35	11	6	23	49	10	16	**270**
Out of Service Area	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Unable to Reach	56	42	64	64	46	50	55	66	47	88	29	21	**628**
TOTAL REFERRALS	**151**	**116**	**171**	**169**	**140**	**154**	**133**	**135**	**130**	**219**	**95**	**77**	**1,690**
%Meets Criteria	**39.1%**	**47.4%**	**38.6%**	**31.4%**	**20.7%**	**19.5%**	**25.6%**	**31.1%**	**20.8%**	**12.8%**	**30.5%**	**33.8%**	**28.3%**



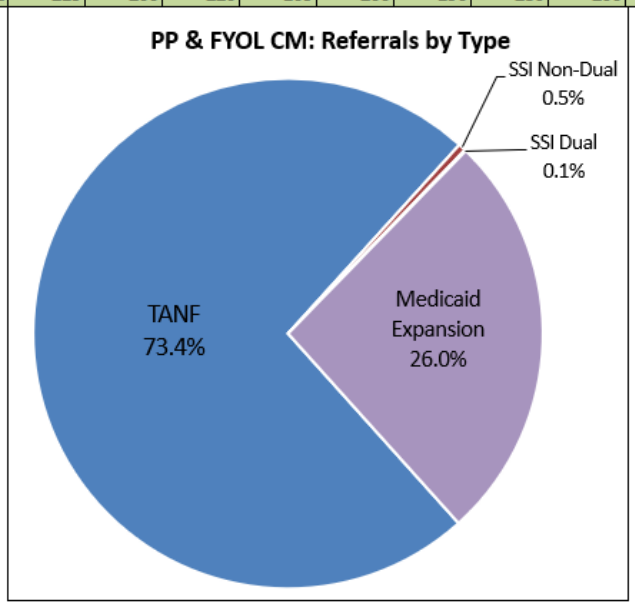
Perinatal Care Management and First Year of Life

- Referrals by Type:
  - 2,553 referrals in 2025.
  - 0.6 % for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 26.0% of the members referred were Medi-Cal Expansion members.
  - 73.4% of the members referred were TANF members.

Table G. Perinatal & FYOL CM Referrals by Population Type

CalViva Pregnancy Program and FYOL Case Management Referrals By Type: 1/1/2025 - 12/31/2025

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	125	133	166	195	166	132	158	135	185	164	158	157	**1,874**
SSI Non-Dual	2	0	1	2	2	0	0	1	3	0	1	0	**12**
SSI Dual	0	0	0	0	1	0	0	0	0	1	0	0	**2**
Medicaid Expansion	33	39	52	69	51	37	48	60	97	65	55	59	**665**
TOTAL REFERRALS	**160**	**172**	**219**	**266**	**220**	**169**	**206**	**196**	**285**	**230**	**214**	**216**	**2,553**

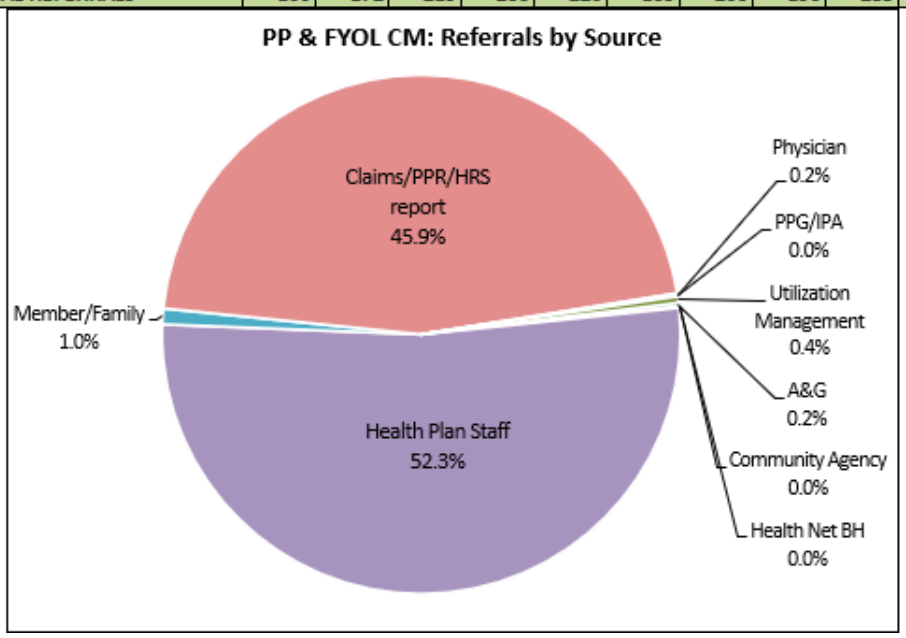


- Referral sources:
  - 52.3% of referrals came from within the Health Plan Staff.
  - 45.9% Claims/PPR/HRS report.
  - 1.0% Members/Family
  - 0.8% of the remaining referrals were comprised of other sources such as A&G, UM, and Physician.

Table H. Perinatal & FYOL CM Referrals by Source

CalViva Pregnancy Program & FYOL Case Management Referrals By Source: 1/1/2025 - 12/31/2025

REFERRAL SOURCE	JAN	FEB	MAI	APR	MA	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOT
A&G	0	0	2	1	0	2	0	0	0	0	1	0	**6**
Community Agency	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Health Net BH	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Health Plan Staff	96	78	117	149	114	110	115	87	117	126	118	107	**1,334**
Member/Family	0	4	2	3	2	7	4	3	0	0	0	0	**25**
Claims/PPR/HRS report	62	89	95	111	101	50	86	103	168	103	95	108	**1,171**
Physician	0	0	0	0	1	0	0	2	0	0	0	1	**4**
PPG/IPA	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Utilization Management	1	1	3	1	2	0	1	0	0	1	0	0	**10**
TOTAL REFERRALS	**160**	**172**	**219**	**266**	**220**	**169**	**206**	**196**	**285**	**230**	**214**	**216**	**2,553**

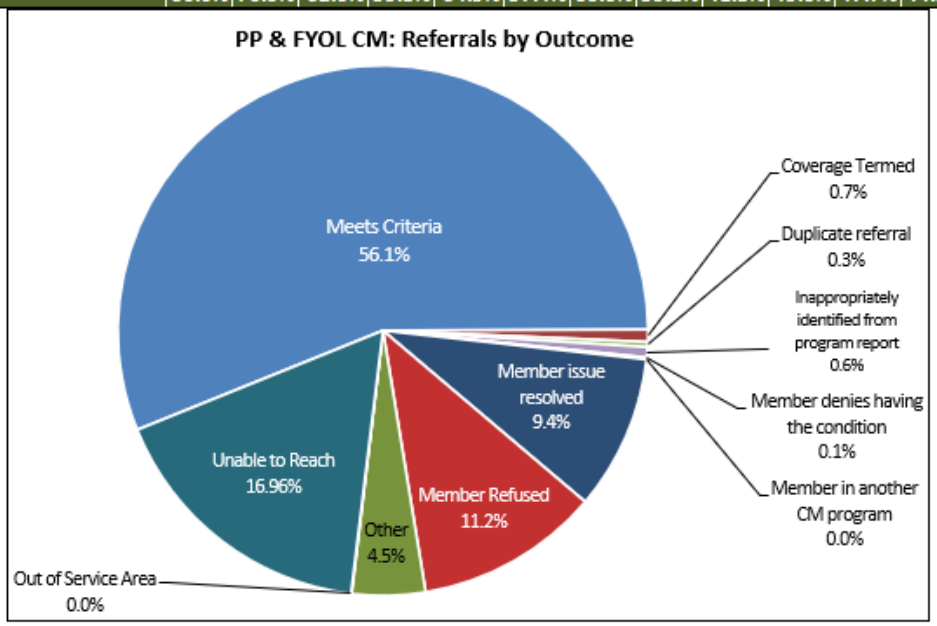


- Referral Outcome:
  - 16.9 % of the members were unable to be reached.
  - 56.1% meet criteria and agreed to CM outreach.
  - 11.2% of the members refused CM.
  - 15.8% Comprised of other, duplicate request, coverage termed, out of service area, not indicated (member reported not pregnant) and enrolled in another CM program.
  - 97% of members who met criteria and initially agreed to CM resulted in an open case.

Table I. Perinatal & FYOL CM Referral Outcome

CalViva Pregnancy Program & FYOL Case Management Referrals By Outcome: 1/1/2025 - 12/31/2025

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	96	121	137	159	142	97	131	116	119	114	102	97	**1,431**
Coverage Termed	2	0	0	1	0	2	3	2	4	0	2	3	**19**
Duplicate referral	0	0	1	2	0	0	0	1	1	2	0	1	**8**
Inappropriately identified from prog	0	1	2	4	5	2	0	0	1	0	1	0	**16**
Member denies having the condition	0	0	0	0	0	0	0	2	0	0	0	0	**2**
Member in another CM program	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Member issue resolved	18	15	12	23	20	19	18	11	29	37	24	15	**241**
Member Refused	10	12	13	20	17	16	16	19	51	24	34	55	**287**
Other	16	1	21	10	10	14	18	3	3	10	2	6	**114**
Out of Service Area	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Unable to Reach	18	22	32	47	26	19	20	42	77	43	48	39	**433**
TOTAL REFERRALS	**160**	**172**	**219**	**266**	**220**	**169**	**206**	**196**	**285**	**230**	**214**	**216**	**2,553**
%Meets Criteria	**60.0%**	**70.3%**	**62.6%**	**59.8%**	**64.5%**	**57.4%**	**63.6%**	**59.2%**	**41.8%**	**49.6%**	**47.7%**	**44.9%**	**56.1%**



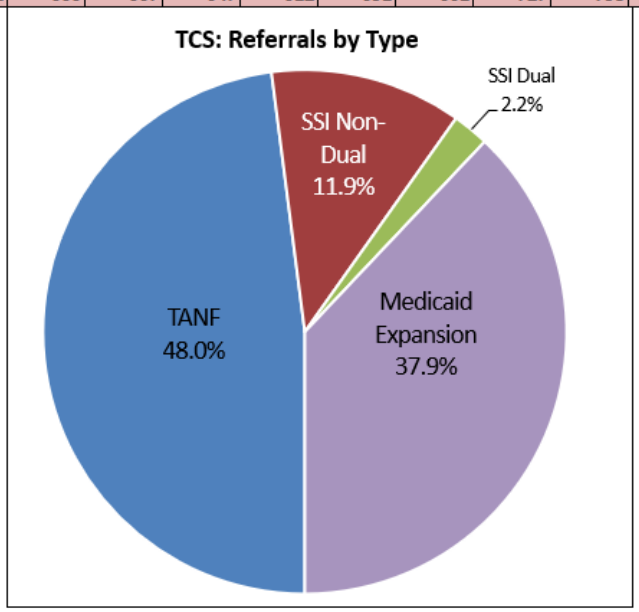
Transitional Care Services

- Referrals by Type:
  - 7,339 referrals in 2025.
  - 14.1% for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 37.9% of the members referred were Medi-Cal Expansion members.
  - 48.0% of the members referred were TANF members.

Table J. Transitional Care Services Referrals by Population Type

CalViva Transitional Care Service Referrals By Type: 1/1/2025 - 12/31/2025

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	328	295	293	261	304	225	297	302	331	361	263	260	**3,520**
SSI Non-Dual	63	53	54	53	80	72	91	78	92	82	84	68	**870**
SSI Dual	11	8	6	7	10	17	19	14	18	34	14	7	**165**
Medicaid Expansion	189	155	180	186	253	198	284	267	286	321	254	211	**2,784**
TOTAL REFERRALS	**591**	**511**	**533**	**507**	**647**	**512**	**691**	**661**	**727**	**798**	**615**	**546**	**7,339**



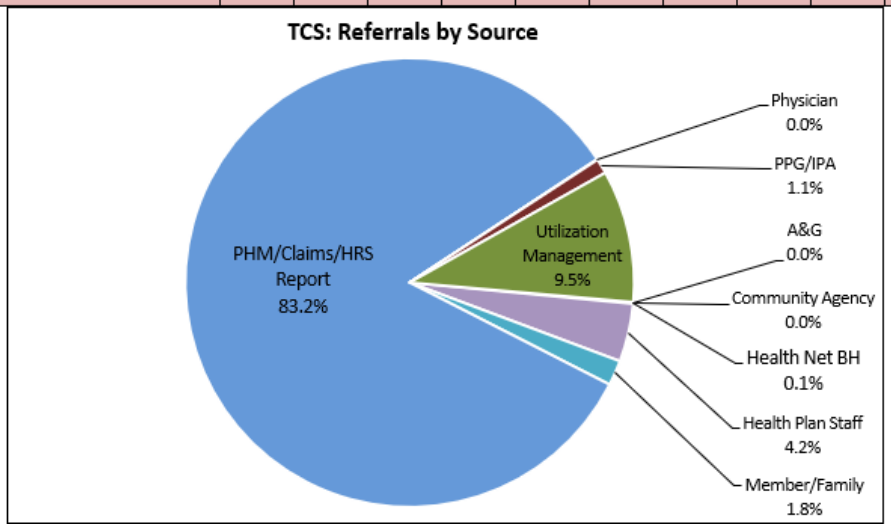
- Referral sources:
  - 83.2% of referrals came from PHM/Claims/HRS Reports.
  - 9.5% Utilization Management.
  - 7.3% of the remaining referrals to TCS were from PPG/IPAs, Health Plan Staff, Health Net Behavioral Health team, or Member/Family.

Table K. Transitional Care Services Referrals by Source

CalViva Transitional Care Service Referrals By Source: 1/1/2025 - 12/31/2025

Source: 427 Referrals

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
A&G	0	0	0	0	0	0	1	0	0	1	0	0	**2**
Community Agency	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Health Net BH	0	0	0	0	1	1	0	1	1	1	0	1	**6**
Health Plan Staff	3	1	2	2	5	5	4	28	44	72	65	76	**307**
Member/Family	5	10	6	8	5	26	12	15	15	10	11	10	**133**
PHM/Claims/HRS Report	508	443	454	408	513	403	590	573	645	669	495	408	**6,109**
Physician	0	0	1	1	0	1	0	0	0	0	0	0	**3**
PPG/IPA	5	3	0	9	4	3	6	11	7	7	8	16	**79**
Utilization Management	69	54	70	79	119	73	78	33	15	38	36	35	**699**
TOTAL REFERRALS	**591**	**511**	**533**	**507**	**647**	**512**	**691**	**661**	**727**	**798**	**615**	**546**	**7,339**



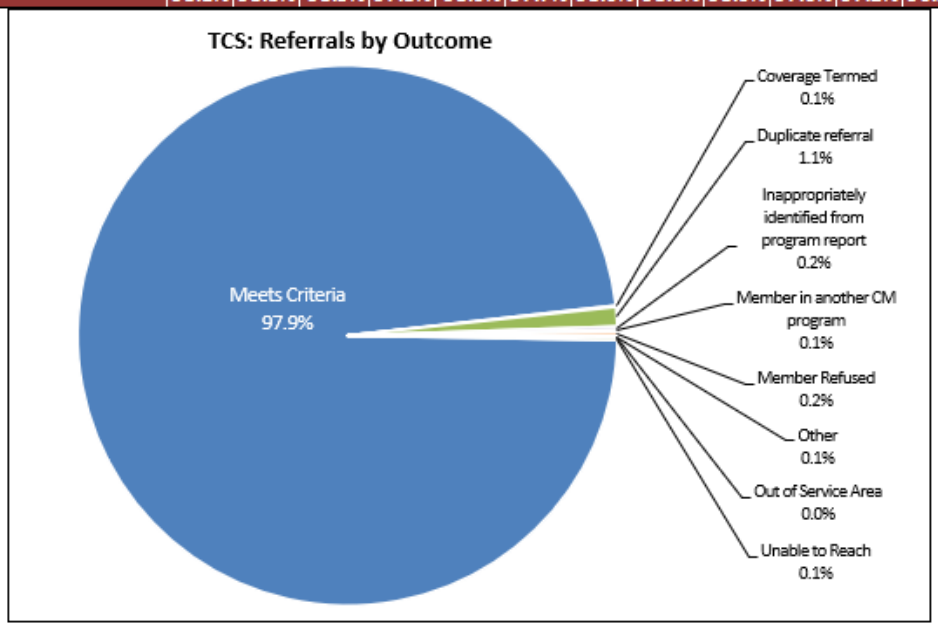
- Referral Outcome:
  - 97.9 % of the members meet criteria and agreed to CM outreach.
  - 1.1% were duplicate referrals.
  - 0.1% of the members were unable to be reached.
  - 0.9% Comprised of other, member refused, coverage termed, member in another CM program, inappropriately identified for program.
  - 58% of members who met criteria and initially agreed to CM resulted in an open case.

While 97.9% of members met criteria and agreed to outreach, 58% resulted in an open case, reflecting the short-term, intervention-based nature of the TCS model where many needs are resolved without ongoing case management.

Table L. Transitional Care Services Referrals by Outcome

CalViva Transitional Care Service Referrals By Outcome: 1/1/2025 - 12/31/2025

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	580	505	525	496	636	500	677	652	715	779	598	525	**7,188**
Coverage Termed	0	1	1	0	0	0	1	0	1	1	0	2	**7**
Duplicate referral	4	2	2	6	5	10	8	5	6	12	10	14	**84**
Inappropriately identified from prog	1	1	0	3	0	1	2	2	1	1	0	2	**14**
Member in another CM program	0	0	1	0	0	0	2	1	1	3	3	0	**11**
Member Refused	6	2	2	1	1	0	0	0	2	0	1	0	**15**
Other	0	0	1	0	3	0	0	0	0	2	2	2	**10**
Out of Service Area	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Unable to Reach	0	0	1	1	2	0	1	1	1	0	1	1	**9**
TOTAL REFERRALS	**591**	**511**	**533**	**507**	**647**	**512**	**691**	**661**	**727**	**798**	**615**	**546**	**7,339**
%Meets Criteria	**98.1%**	**98.8%**	**98.5%**	**97.8%**	**98.3%**	**97.7%**	**98.0%**	**98.6%**	**98.3%**	**97.6%**	**97.2%**	**96.2%**	**97.9%**



- Referral outcome comparison across programs:
  - Outcome category of "Other" for Physical Health, Behavioral Health CM, TCS, and Perinatal CM were appropriate and represented referrals for members who were already enrolled in CM, referrals created and/or closed in error, members requesting information only not a referral to CM, member delivered prior to referral, etc.
  - The number of program referrals was higher for all programs in 2025 compared to 2024.
    - Physical Health CM increased 31% from 3,649 to 4,800
    - Behavioral Health CM increased 50% from 1,125 to 1,690
    - Perinatal and FYOL CM increased 55% from 1,639 to 2,553
    - Transitional Care Services increased 45% from 5,051 to 7,339
  - The percentage of members unable to be reached was significantly lower for Perinatal CM increasing from 12.3% to 16.9% in 2025. Physical Health CM's unable to reach rate decreased from 36.9% to 34.4% in 2025. Behavioral Health CM's unable to reach rate increased from 29.2% to 37.2% in 2025, which is expected with the higher number of referrals. Transitional Care Services had the lowest unable to reach rate at 0.1%.
  - The percentage of members who met criteria and agreed to CM outreach was highest in the Transitional Care Services program followed by the Perinatal CM program.
  - Actions taken that supported these improvements include:
    - Continuing to address variation of success rates among CMs through individual coaching and staff development.
    - Coached and re-trained outreach staff on how they are offering CM services; staff offer follow-up call from CM to review care gaps or chronic conditions with member, which improves engagement.
    - Re-educated staff on existing alternate sources of member contact information such as OMNI, pharmacy data, HIE.
    - Collaborated with UM, Health Net Behavioral Health, and TCS teams on strategy to continue to increase referrals to BH CM, as well other programs.

Managed Population

In 2025, CM focused on processes related to the number of members managed in CM as well as the number of high-risk members managed in the CVH pregnancy program. The measures were:

- At least 1% of the total managed members in CM are high-risk PHM level 1 members
- Manage 50% of members identified as high-risk on the NOP form in CM

Physical and Behavioral Health high-risk members are identified proactively through the Population Health Management (PHM) Level I report. The PHM report combines data from multiple sources to use in its population and program eligibility process including Impact Pro. Members are stratified into 1 of 10 Population Health Categories ranging from "healthy" to "end of life". Members stratified into levels 08b High Priority Homeless/SUD, 07b High Priority PH CM, 07a high Priority BH CM, 05d Chronic Highly Complex, 05c Chronic High Risk - With Care Gap and meeting the additional criteria outlined below are evaluated for CM.
Members stratified in the above levels AND have other designated parameters such as:

- CM engagement score ≥ 80 (range 0 - 100)
- Priority Flag = Yes
- ER Likelihood= Highly Likely and Most Likely

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Screening HRA shall be referred to Care Management.

Moderate and high-risk pregnancies are proactively identified through the Notification of Pregnancy. A numeric risk score is assigned to each response, and the total score is used to categorize the member as high (≥35), medium (15-34), or low risk (<15). Members with a score of 35 or greater are referred to High-Risk OB CM; a component of the Perinatal CM Program.

High Risk OB Population Managed

The volume of high-risk members managed in the Perinatal CM Program increased from 45.13% in 2024 to 51.49% in 2025. This report includes all high-risk members regardless of when the NOP was conducted during the reporting year.

Table M. Percentage of High-Risk Members Enrolled in Perinatal CM by Month of Referral

CY 2025 CalViva Percent of High Risk NOP in Perinatal CM

CA412 Report Date	Denominator High Risk	Numorator Case Managed	Percentage
January 31, 2025	187	100	53.48%
February 28, 2025	208	112	53.85%
March 31, 2025	274	145	52.92%
April 30, 2025	322	170	52.80%
May 31, 2025	345	179	51.88%
June 30, 2025	336	174	51.79%
July 31, 2025	347	185	53.31%
August 31, 2025	327	171	52.29%
September 30, 2025	282	142	50.35%
October 31, 2025	272	131	48.16%
November 30, 2025	267	128	47.94%
December 31, 2025	263	129	49.05%
CY 2025 Average	**286**	**147**	**51.49%**

Care Management Program Evaluation - 2025

Overall Population Managed

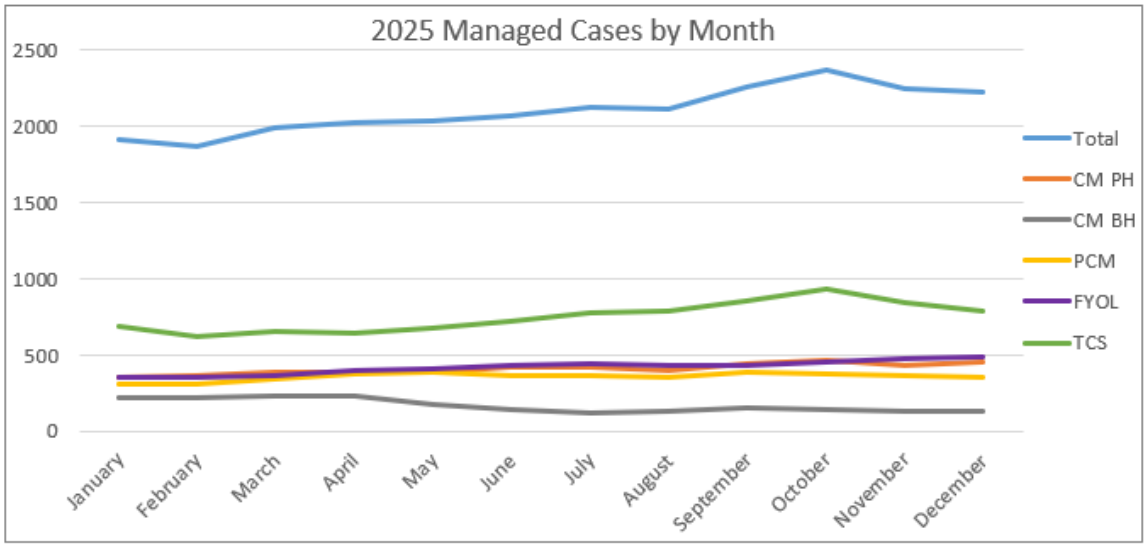
The table below reflects the number of cases managed each month per program. The number of cases managed each month includes cases active at any point during the month.

The average volume of cases managed by program per month in 2025 was:

- Physical Health CM (PH CM): 410
- Behavioral Health CM (BH CM): 168
- Perinatal CM (PCM): 357
- First Year of Life (FYOL): 418
- Transitional Care Services (TCS): 748
- 2025 Total average per month: 2,102, an increase over 2024 avg of 1,924

Table N. CM Managed Case Volume by Month and Program

Program	January	February	March	April	May	June	July	August	September	October	November	December
CM PH	353	364	388	384	388	418	419	401	440	464	437	458
CM BH	216	219	236	232	174	140	125	132	149	139	127	135
PCM	307	311	342	374	389	361	363	359	385	372	364	359
FYOL	350	355	369	393	405	427	442	428	437	455	474	483
TCS	683	617	653	639	679	721	778	793	850	938	840	789
Total	1909	1866	1988	2022	2035	2067	2127	2113	2261	2368	2242	2224



Source: CalViva Key Indicator Report.

Care Management Program Evaluation - 2025

High Risk Populations Managed

The volume of high-risk members managed in all the CM programs *across the combined Medi-Cal membership* was 11,426 (an increase of 6% compared to 2024). The goal was to manage more high-risk members than in 2024 (10,751), so the goal of >10,751 in 2025 was met. High-risk was defined as those members stratified into PHM Pyramid Level 1 (Tier 1 and 2).

Table O. High-Risk Population Managed

Case Management Metrics Key Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Defnition
High Priority Unique Members Managed	1030	925	984	961	923	886	1062	942	1018	1099	716	880	11426	Member in PHM Pyramid Level 1 Tier 1&2

Similarly, the total volume of CM cases managed per program are broken down by category and case type, complex versus noncomplex.

- PH CM
  - 9.8% Cases Complex
  - 90.2% Noncomplex
  - 34% members managed were SPD (dual and non-dual) members, followed by 34.6% Medi-Cal Expansion and 31.4% TANF

- BH CM
  - 5.5% Cases Complex
  - 94.5% Noncomplex
  - 26.2% members managed were SPD (dual and non-dual), followed by 22.4% Medi-Cal Expansion and 51.4% TANF
- PCM
  - 3.5% Cases Complex
  - 96.5% Noncomplex
  - 84.1% members managed were TANF members, followed by 15.3% Medi-Cal Expansion and 0.6% SPD (dual and non-dual)

- FYOL
  - 100% Noncomplex
  - 99% members managed were TANF members, followed by 0.0% Medi-Cal Expansion and 1% SPD (dual and non-dual)

- TCS
  - 100% Noncomplex
  - 57% members managed were TANF members, followed by 26.4% Medi-Cal Expansion and 16.6% SPD (dual and non-dual)

The goal of 10% complex cases was not met for PH and was not met for BH in 2025. The goal of 3% complex for Perinatal CM was met. The percent of complex cases managed did fluctuate over 2025 in both PH and BH programs. Ultimately the BH CM team chose to limit complex cases to staff scoring higher on audits to ensure better quality of care to that level of need, until additional staffing and training could be achieved. The increase in complex cases in the Perinatal CM program was attributed to actions taken after not meeting the goal in 2024. Actions that will be taken as a result of 2025 complex goal not being achieved include:

- Reviewing the CM process for management of complex cases and expectations with the staff. Providing additional guidance to staff around complex case criteria.
- Performance management
- Simplify the complex case criteria for CM staff (Action already taken in late 2025)

Table P. CM Managed Population by Program and Category

CalViva CM Managed Population by Program and Product in 2025

Program	Complex Case Management					Care Coordination					Total Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed
CM PH	0	66	65	32	**163**	0	502	497	486	**1,485**	0	568	562	518	**1,648**
CM BH	0	10	14	19	**43**	0	163	188	377	**728**	0	173	202	396	**771**
PCM	0	4	0	36	**40**	0	166	7	901	**1,074**	0	170	7	937	**1,114**
FYOL	0	0	0	0	**0**	0	0	4	808	**812**	0	0	4	808	**812**
TCS	0	0	0	0	**0**	0	1,178	746	2,547	**4,471**	0	1,178	746	2,547	**4,471**
Total	**0**	**80**	**79**	**87**	**246**	**0**	**2,009**	**1,442**	**5,119**	**8,570**	**0**	**2,089**	**1,521**	**5,206**	**8,816**

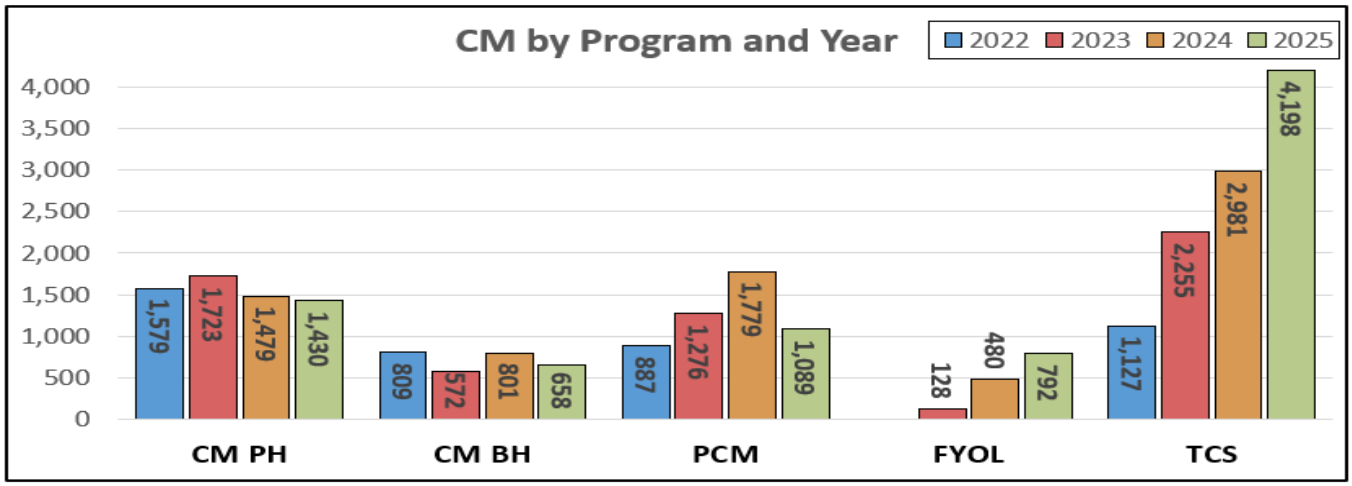
Source: CM Dossier and 412 NOP Reports

The volume of cases managed by program increased for two programs, TCS and FYOL programs compared to prior years. Comparing 2025 specifically to 2024:

- PH CM demonstrated a 3% decrease.
- BH CM demonstrated a 17.8% decrease.
- Perinatal CM demonstrated a 38.7% decrease.
- FYOL demonstrated a 65% increase.
- TCS demonstrated a 40.8% increase.

Table Q. CM Cases Managed Year to Year by Program

CalViva Medi-Cal



Care Management Program Evaluation - 2025

Overall, 2.03% of the total population was managed in 2025 amongst all CM programs. The average population of members in 2025 was 434,102. The overall percentage of population managed in Physical Health CM was 0.38%. Behavioral Health demonstrated 0.18%. The population managed in Perinatal CM was 0.26%. First Year of Life managed 0.19%, and Transitional Care Services demonstrated 1.03%.

Table R. Percentage of Total Population Managed

Percentage of Total Population Managed by Program and Product in 2025

Program	Average # Members (Population)					% of Population Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL	CHIP	Medicaid Expansion	SPD	TANF	TOTAL
CM PH	0	123,349	48,330	262,423	**434,102**	0.00%	0.46%	1.16%	0.20%	**0.38%**
CM BH	0	123,349	48,330	262,423	**434,102**	0.00%	0.14%	0.42%	0.15%	**0.18%**
PCM	0	123,349	48,330	262,423	**434,102**	0.00%	0.14%	0.01%	0.36%	**0.26%**
FYOL	0	123,349	48,330	262,423	**434,102**	0.00%	0.00%	0.01%	0.31%	**0.19%**
TCS	0	123,349	48,330	262,423	**434,102**	0.00%	0.96%	1.54%	0.97%	**1.03%**
Total	**0**	**123,349**	**48,330**	**262,423**	**434,102**	**0.00%**	**1.69%**	**3.15%**	**1.98%**	**2.03%**

Care Management (CM) Quality Audit Scores

Complex and Non-Complex Care Management

CM processes include specific instructions for documentation of CM activity specific to individual members who require complex or integrated care management with (BH) Behavioral Health. Required documentation focuses on the standards of CM practice, NCQA standards, and contractual obligations. All documentation is in the Plan's medical management system, TruCare.

Each month, audits of care management documentation are performed by the designated CM leads and or managers. In 2025, 33 audit elements were measured each quarter. Audit results for 2025 are comprised of 4 completed quarters. Typically, at least 2 unique cases that were open and actively managed for at least 60 days per care manager per month were audited. However, staff who maintained 90% or above on each of their two monthly audits for 3 consecutive months were audited on a quarterly basis (at the beginning of each quarter). If an employee on quarterly audits fell below the 90% threshold monthly audits were resumed.

Table S Complex and Non-Complex Care Management Audit Results show the results of the average per quarter for each program. In 2025 there were 308 non-complex cases audited across all programs, and 28 complex cases audited across the PH, BH and Perinatal programs. Trends are assessed to monitor compliance with the care management process including demonstrating member and provider collaboration. The goal for audit scores is no less than 90%. The overall average score across programs for 2025 was 94%, meeting overall goal of ≥90%. The overall

average score per program was: Physical Health 93%, Behavioral Health 95%, and Perinatal 98%, and Transitional Care Services 91%. Physical Health and Transitional Care Services each fell below goal in one quarter during 2025, however were back above goal in the next quarter.

Table S. Complex and Non-Complex Care Management Audit Results

2025 Audit Results	Physical Health				Behavioral Health				Perinatal				Transitional Care Services			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Complex	91%	94%	93%	95%	91%	94%	96%	94%	97%	100%	98%	98%	90%	89%	92%	94%
Complex	98%	93%	80%	98%	96%	n/a	n/a	98%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Overall Score	**95%**	**94%**	**87%**	**97%**	**94%**	**94%**	**96%**	**96%**	**97%**	**100%**	**98%**	**98%**	**90%**	**89%**	**92%**	**94%**

Barriers impacting audit scores:

- Staff not following the CM process (updating care plan with goal progress, completing medication review, and documenting follow up schedule/plan in notes).

Actions taken to mitigate the barriers:

- Reviewed audit findings with staff and held review sessions as needed.
- Escalated performance management for applicable staff.

Care Management Outcomes

Outcomes of the Care Management Program are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Health Plan specific state requirements/expectations.

Utilization and Clinical Outcome Measures

Measures of effectiveness for care management are evaluated no less than annually using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM, as well as our Transitional Care Services program. Measures of effectiveness include the following indicators:

- Readmission rates
- ED utilization
- Overall health care costs

These parameters were measured 90 days prior to the member's enrollment in physical and behavioral health care management and 90 days after enrollment.

The members included in the outcome measures met the following criteria:

- Had an active or closed case on or between 1/1/2025 and 12/31/2025 with claims paid through 4/21/2026
- Remained eligible 90 days after Case Open Date

One thousand eight hundred forty-nine (1,849) members met the outcome criteria for the Physical and Behavioral Health CM programs. All cause admissions and readmissions were compared using claims data 90 days pre and post member enrollment into care management. Claims data demonstrated a reduction in readmissions for the care managed members, 7.7% decrease (pre 31.7% vs post 24%) in readmission rate based on claims. This was well above the 5% goal. There was also a 17.8% reduction in ED utilization for this population by 301 ED visits and a reduction of 651 ED visits per 1,000 members per year.

Table T. CM Readmission Outcomes

CALVIVA CASE MANAGEMENT OUTCOMES REPORT — **Physical Health and Behavioral Health**

Members Case Managed Between 1/1/2025 and 12/31/2025, claims paid through 4/21/2026

Measure for Case Management	Members	90 days prior to CM enrollment			90 days following CM enrollment			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	1,849	672	213	31.7%	258	62	24.0%	-7.7%

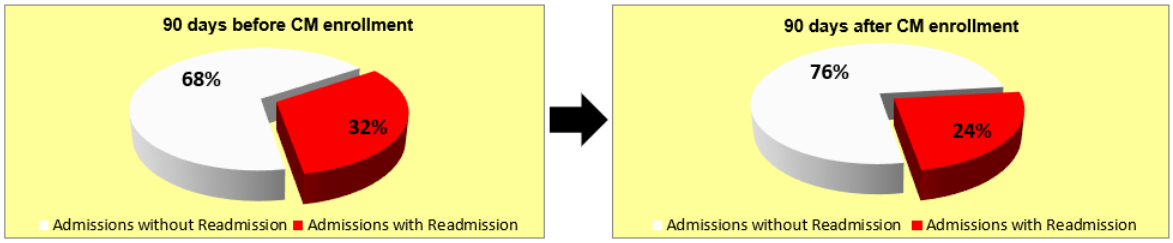
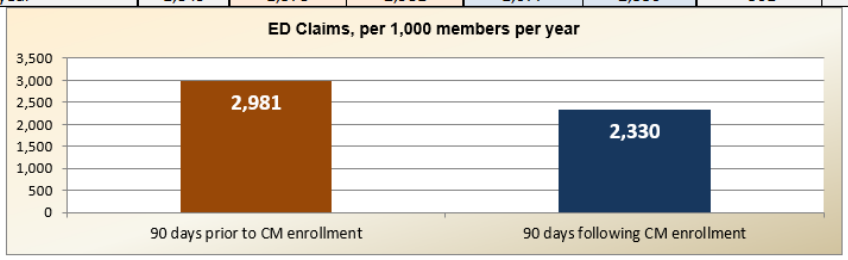


Table U. CM ED Utilization Outcomes

Measure for Case Management	Members	90 days prior to CM enrollment		90 days following CM enrollment		Difference		Difference
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	
Emergency Department (ED) Claims, per 1,000 members per year	1,849	1,378	2,981	1,077	2,330	-301	-651	-17.8%



Care Management Program Evaluation - 2025

One thousand nine hundred sixty (1,960) members met the outcome criteria for the Physical and Behavioral Health CM programs. All cause admissions and readmissions were compared using claims data 90 days pre and post member enrollment into care management. Claims data demonstrated a reduction in readmissions for the care managed members, 9.6% decrease (pre 33.2% vs post 23.6%) in readmission rate based on claims. This was well above the 5% goal. There was also a 17.8% reduction in ED utilization for this population by 318 ED visits and a reduction of 649 ED visits per 1,000 members per year.

Table V. TCS Readmission Outcomes

CALVIVA CASE MANAGEMENT OUTCOMES REPORT — Transitional Care Services

Members Case Managed Between 1/1/2025 and 12/31/2025, claims paid through 4/21/2026

Measure for Case Management	Members	90 days prior to CM enrollment			90 days following CM enrollment			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	1,960	2068	686	33.2%	712	168	23.6%	-9.6%

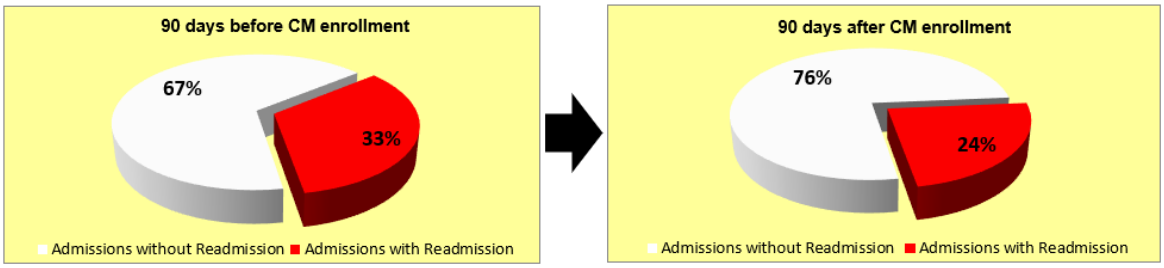
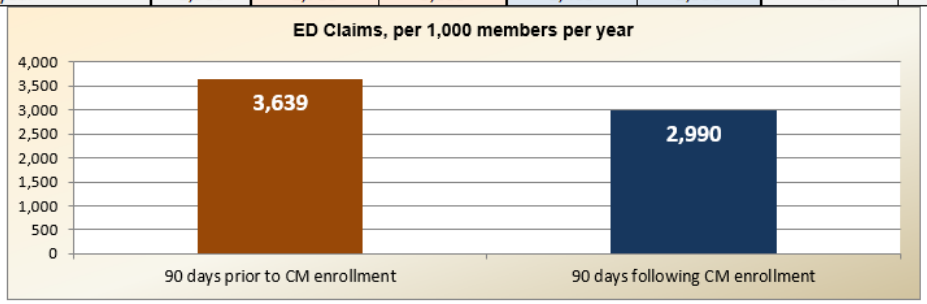


Table W. TCS ED Utilization Outcomes

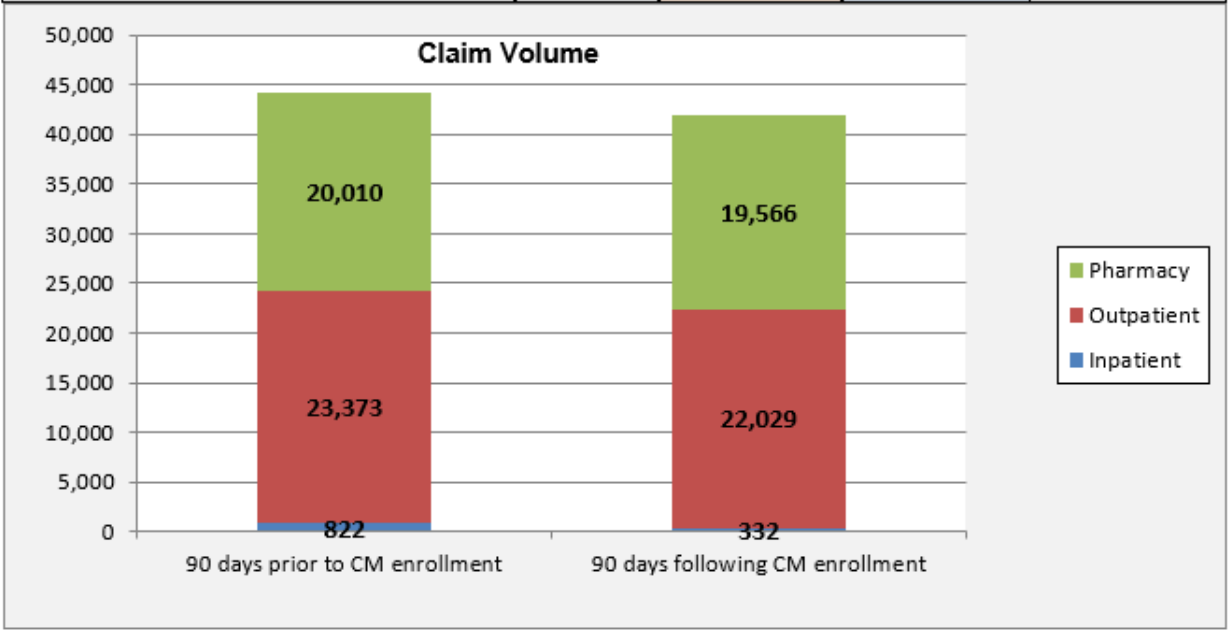
Measure for Case Management	Members	90 days prior to CM enrollment		90 days following CM enrollment		Difference	
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.
Emergency Department (ED) Claims, per 1,000 members per year	1,960	1,783	3,639	1,465	2,990	-318	-649



Comparing health care claims, 90 days pre and post care management enrollment showed that managed members demonstrated a reduction in inpatient claims of 490, a decrease of 1,344 for outpatient services, and a decrease of 444 for pharmacy.

Table X. Physical and Behavioral Health CM Utilization Outcomes

Measure for Case Management	Members	90 days prior to CM	90 days following CM	Difference
		# Claims	# Claims	# Claims
Inpatient Paid Claims	1,849	822	332	-490
Outpatient/Other Paid	1,849	23,373	22,029	-1,344
Pharmacy Paid Claims	1,849	20,010	19,566	-444
TOTAL PAID CLAIMS	**1,849**	**44,205**	**41,927**	**-2,278**



The effectiveness of the Perinatal CM program was evaluated based on the members' compliance with completing their first prenatal visit within the first trimester and their post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery of high-risk members managed to high-risk members not managed was compared. Preterm is defined as delivery prior to 37 weeks.

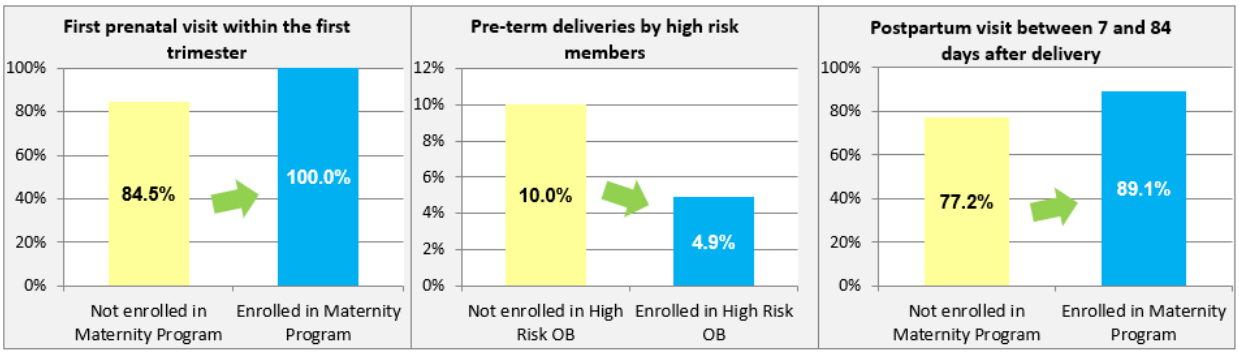
The members in the Perinatal CM program evaluated for compliance with the pre- and post-partum visits were limited to those who met the following criteria:

- Continuous enrollment
- For the prenatal metric were enrolled during their first trimester
- For the post-partum metric delivered prior to 12/31/2025.

Twenty-nine members (29) met the criteria for prenatal visit metric; one thousand six hundred twenty-two (1,622) members met the criteria for postpartum visit metric; and one hundred eighty-two (182) members met the criteria for the pre-term delivery metric.

Table Y. Clinical Outcomes for High-Risk OB Members

Measure for Maternity Program	Members not enrolled in Maternity Program		Members enrolled in Maternity Program		Difference
	Members	Rate	Members	Rate	Rate
First prenatal visit within the first trimester	5,859	84.5%	29	100.0%	15.5%
Pre-term deliveries by high risk members	490	10.0%	182	4.9%	-5.1%
Postpartum visit between 7 and 84 days after delivery	4,289	77.2%	1,622	89.1%	11.9%



Members in the Perinatal CM program demonstrated a 15.5% percentage increase in compliance with completing the first prenatal visit in their first trimester, exceeding the goal of ≥8%. The percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program was 11.9% which met the goal of ≥10%. There were 5.1% fewer pre-term deliveries for high-risk members managed than high-risk members not managed which exceeded the 2% reduction goal.

Care Management Program Evaluation - 2025

Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. Member satisfaction is evaluated quarterly using a member satisfaction survey and monitoring complaints/grievances related to CM. The goal for member satisfaction is > than 90% and the goal for member complaints/grievances is < 1/10,000 members.

Care Management Satisfaction Survey

A Member Satisfaction Survey is conducted near and or upon case closure. The survey is offered to members who have been in care management for a minimum of 45 days and are near case closure or subsequently closed for one of the following reasons: completion of all goals, successful closure, member requesting discontinuation of CM services or no longer eligible with the Plan. Members may be invited to complete the survey by email, text, and/or phone.

The survey consists of thirteen questions related to satisfaction with the care team. The survey results are loaded into a Qualtrics corporate dashboard system.

Care Team Satisfaction:

1. How happy are you with the Care Management Program?
2. How happy are you with the help you are getting or have gotten from your Care Manager?
3. How happy are you with the information you received from your Care Manager?
4. How happy are you with your ability to reach your Care Manager?
5. Do you feel more in control of your health now that you have started the Care Management Program?
6. Did your Care Manager care about your beliefs and values?
7. Did your Care Manager give you helpful tools to take care of your health?
8. Did your Care Manager Program help you reach your health goals?
9. Do you feel your care management team helped you organize the care between you and your doctors or other caregivers?
10. Is there anything that stopped you from taking your Care Managers Advice to better your health?
11. On a scale 1 to 5, how likely are you to recommend the Care Management Program to family and friend?
12. Is there anything else you would like to share about Care Manager Program or your Care Manager?
13. Do you have any ideas to help us give you better service?

Table Z. Care Team Satisfaction

CM SATISFACTION SURVEY REPORT CalViva 1/1/2025 - 12/30/2025

Question	Responses	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	% Satisfied or Better
How happy are you with the Care Management Program?	75	49	20	3	3	92%
How happy are you with the help you are getting or have gotten from your Care Manager	62	24	14	10	14	61%
How happy are you with the information you received from your Care Manager?	59	25	14	5	15	66%
How happy are you with your ability to reach your Care Manager?	58	19	15	10	14	59%
Question	Responses	Yes	No	% Yes		
Do you feel more in control of your health now that you have started the Care Management Program?	59	55	4	93%		
Did your Care Manager care about your beliefs and values?	56	50	6	89%		
Did your Care Manager give you helpful tools to take care of your health?	58	51	7	88%		
Did your Care Manager Program help you reach your health goals?	57	48	9	84%		
Do you feel your care management team helped you organize the care between you and your doctors or other caregivers?	58	47	11	81%		
Question	Responses	Yes	No	% No		
Is there anything that stopped you from taking your Care Managers Advice to better your health?	57	21	36	63%		
Question	Responses	5	4	3	2	1
Q22 - On a scale 1 to 5, how likely are you to recommend the Care Management Program to family and friend?	46	25	8	4	3	6
Question	Responses	Yes	No			
Is there anything else you would like to share about Care Manager Program or your Care Manager?	0	0	0			
Do you have any ideas to help us give you better service?	0	0	0			

Results are reported for each response option per question. The response options include "Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied", Yes or No. The positive responses were used to calculate the result. The CM satisfaction goal is 90% or higher.

Care Team Satisfaction (Table X) demonstrates that 75 members were surveyed in 2025. Responses were not captured for all questions. The discrepancy in the number of members responding to the individual questions is attributed to members not answering all the questions or the response was not captured during data entry.

- 75 members responded to questions in the Care Team Satisfaction
    - 92% (69/75) of respondents were satisfied with the Care Management Program.
    - 61% (38/62) of respondents were satisfied with the help they received from CM.

- 66% (39/59) reported they were satisfied with the information given by Care Manager.
- 59% (34/58) reported they were satisfied with their ability to reach their Care Manager.
- 93% (55/59) reported they feel more in control of their health now that they have started the Care Management Program.
- 89% (50/56) reported the Care Manager cared about their beliefs and values.
- 88% (51/58) reported Care Manager gave them helpful tools to take care of their health.
- 84% (48/57) reported the Care Manager helped them reach their health goals.
- 81% (47/58) reported they feel their care management team helped them organize the care between them and their doctor or other caregivers.
- 63% (36/57) reported nothing stopped them from taking their Care Managers Advice to better their health.
- 46 members provided a rating of how likely they would recommend the Care management Program to family and friends.
- 0 Members responded to the last two questions:
  - Is there anything else they would like to care about the Care Management Program or their Care Manager?
  - Do you have any ideas to help them receive better service?
- Care Team Satisfaction section met goal of >90% met in 2/10 questions.
  - When researching the negative responses it was found that these members had moved into care management through ECM or with a CS provider, so rating are unclear on who they represent.

- Opportunities identified include improving member understanding of CM services, strengthening Care Manager communication, and addressing overlap between CM and ECM/CS programs. Actions for 2026 will include staff training, improved member education, and enhanced outreach consistency.

Care Management Complaints/Grievances

There were five grievances related to care management in 2025. The goal for member complaints/grievances < 1/10,000 members was met.

Table AA. CM Grievances/Complaints

	Quarter 1 2025		Quarter 2 2025		Quarter 3 2025		Quarter 4 2025	
CM Complaints	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.
	2	0.046	0	0	2	0.047	1	0.024

*Based on average CalViva membership from https://cnet.centene.com/sites/CAMedi-calDataAnalytics: 2024: Q4 431,003; 2025: Q1 430,998; Q2: 433,680; Q3 425,514; Q4 424,723

Special Programs

Perinatal CM

Pregnant members are managed in the Perinatal CM program. Perinatal CM incorporates the concepts of CM, care coordination, and condition management in an effort to teach at risk pregnant members how to have healthier babies. Perinatal CM is a complete program that promotes education and communication between pregnant members, care managers, and physicians to ensure a healthy pregnancy and first year of life for babies.

Our multi-faceted approach to prenatal and postpartum care includes extensive member outreach, wellness materials, provider incentives, and intensive care management, which reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

The Perinatal CM program is comprised of multiple components which allow us to identify more pregnant members, interact with them earlier in pregnancy, reduce the rate of prematurity, shorten neonatal hospital stays, increase birth weights, and lessen the chance of repeat premature deliveries.

The Notification of Pregnancy (NOP) is generally the earliest notice to the Plan of a member's pregnancy. It can be completed by the physician, telephonically, via the Provider Portal, by the member on-line on the Plan's web site, or by completing and mailing a written form. Once the NOP is entered into the system, the pregnant member automatically receives a mailing from our Perinatal CM Program.

All members who completed an NOP and pregnant members who were referred by the Quality Department received outreach by the CM staff. If the NOP reflects the mother to be low to no risk, she was normally provided information about the Perinatal CM program and received regular periodic educational mailings that encouraged a healthy lifestyle for pregnancy, fetal development, and post-partum care. However, if the mother felt that she needed additional support she was offered the Perinatal CM program.

The mailings also encourage appropriate physician visits during the pregnancy and provide suggestions related to pediatrician selection. For those members identified as being medium or high risk for pregnancy complications the CM staff attempted to complete the full OB Assessment and offer the Maternity CM program. In addition to the benefits of the Perinatal CM program, members in the program were assigned to an experienced OB RN, or social worker, for one-on-one regular phone contact. It is at this point that a highly individualized plan of care was developed with the members consent and participation to achieve goals aimed at improving the overall health of both the pregnant member and fetus.

After consent for program participation and program enrollment was completed, ongoing telephonic contact was established with frequency varying depending on member need and

acuity. Ongoing reassessment of need and progress was reviewed at least monthly with updates and adjustments to the plan of care occurring as needed.

Providers were notified of their patient's participation in care management programs and are encouraged to provide feedback and input to the care manager regarding the patient plan of care.

Metrics associated with the Perinatal CM program managed
Analytics provided data related to NOP Completion and Percentage of Deliveries with NOP.

NOP Completion – The number of NOPs completed. NOPs can be submitted by members and providers and may also be completed during CM telephonic outreach to members identified as pregnant on the **413 No NOP** report. In 2025 1,657 NOPs were completed.

Table BB. NOP Completion per Month
2025 Pregnancy Program: Members with a Completed NOP Assessment
By Month of Frist NOP Assessment date
Source: 412 NOP report

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CalViva	139	151	197	172	157	93	149	132	121	108	106	132	1,657

Percentage of Deliveries with an NOP - The percentage of births with an NOP completed within eight months prior to delivery. There was variation in performance from a low of 25.6% in May to a high of 36.3% in July. The total at year-end average was 31.4%; a slight decrease from 32.2% in 2024. Some of this decrease may be attributed to the PCM team prioritizing outreach to members identified as high-risk on the NOP report and outreaching to members on the No-NOP report as a secondary priority.

Table CC. Percentage of Deliveries with NOP
2025 Pregnancy Program: % of Deliveries with NOP
By Month of Delivery Date
Sources: 412 NOP report and IP Validation Report

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CalViva	34.1%	27.2%	27.1%	29.8%	25.6%	34.1%	36.3%	35.0%	33.4%	35.4%	28.8%	28.4%	31.4%
NUMERATOR	148	105	114	114	113	143	170	163	153	156	126	130	1,635
DENOMINATOR	434	386	421	383	441	419	468	466	458	441	437	457	5,211

The percent of timely NOP outreach to High-Risk Members - The percentage high risk members with a call/note within 7 days of NOP entry.

NOP CM Success (30-days) - Percentage of members indicated as high risk on an NOP who are put into active care management within 30 days of the NOP.

Neonatal Rate - Percentage of NICU admits per delivery.

Enrollment in this program in 2025 was 1,431. We continued to make outreach to all risk categories including low risk. We found this to be of great importance and superior customer service as it allowed us to reach members that may need assistance who were not identified through the NOP. In 2025, outreach efforts continued, with mailing volume totaling 10,471 materials. Members may sign up for mailings outside of care management which explains more material being sent than members managed. Mailings are based on completion of an NOP for the Pregnancy mailing and presence of a completed Birth Event in TruCare for the Post-delivery Packet.

Table DD. Perinatal CM Outreach

Educational Packet	*Number of Packets Sent in 2025*
NOP mailings	6,436
Pregnancy mailings	1,028
Post-delivery packets	3,007
Total	10,471

Transition Care Services Program

The purpose of the Transition Care Services Program (TCS) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition interventions are focused on coaching the member and the member's support system during 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 TCS Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidence-based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The program includes:

- Outreach to members before discharge to assist with care coordination.
- Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, use of a personal health record.
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.
- Preparation for discussions with other health care professionals.
- Supporting the patient's self-management role.
- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge.

During the post discharge period, staff evaluate the member to provide the best support to the member in managing their continued needs.

In 2025 7,339 members were referred to the Transitional Care Services Program and 7,188 (97.9%) participated. The number of members participating in the program increased from 4,860 in 2024. The increase in participation is a result of the outreach done while members are inpatient, the collaboration with hospitals and having staff see members while inpatient (CRMC) and increasing staffing for delivery (postpartum TCS) report outreach.

Care Coordination Activities

In addition to providing care management to members, the CM department supports care coordination with other entities within the community.

California Children Services

The plan works with CCS counties to support members turning 21 who will be aging out of the CCS program. Outreach to members begins six months prior to the 21st birthday to educate on plan benefits and determine if the member needs assistance in transitioning to in network specialty and/or ancillary providers as well as ongoing authorizations for durable medical equipment. Additionally, the CM team provides outreach to members new to CCS services to offer support and facilitate care coordination between the member's PCP and CCS providers.

Private Duty Nursing (PDN) Care Management for Eligible Members Under 21

In 2020 the Department of Health Care Services published All Plan Letter (APL) 20-012 dated 05/15/20, mandating all Managed Care Plans care manage members under the age of 21 receiving PDN services to make sure that authorized PDN services were being monitored to ensure medically necessary services were being delivered even if those services were carved out to California Children Services. Care Management developed a process to manage these referrals to promote continuity of services for members receiving PDN. The CM team in conjunction with Public Programs and Delegation Oversight obtained monthly reports from CCS and the delegated PPGs of members approved for PDN. The CM team collaborated with the parents and/or members, CCS, and home care agencies regarding ongoing care and assisted with transition to Home and Community-Based Services one year prior to 21st birthday.

Regional Centers

Care Management also works collaboratively with the Regional Centers that are associated with the CalViva Health counties for members active in care management and have a need as described below. These needs include members:

- Under the age of 18 who are at risk or have a developmental disability that may require supportive services not otherwise provided such as early intervention for infants and families (Early Start)
- Requiring lifelong individual planning, and service coordination, placement, and monitoring for 24-hour out of home care, and advocacy for legal, civil, and service rights.

The CM team continues to receive an Early Intervention/Developmentally Disabled member list monthly. The team filters the list for any members under the age of 12 months, and those members are outreached by our First Year of Life program staff. The remaining members on the list are reviewed by any diagnosis and risk category information that may be available in the report, to help determine if any of the members would be appropriate for CM outreach.

Targeted Case Management

Support continued for collaboration in counties that continue to offer targeted case management. Programs offered through targeted case management vary by county. There continued to be very limited participation on behalf of the counties in 2025. The CalViva counties do not currently offer targeted case management. The Service Coordination liaison will continue to monitor for any changes in county programs.

CalAIM

CalAIM is a multi-year 5+ framework program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the Plan's most vulnerable members. It also provides for non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Supports (CS) are the first two programs that launched on January 01, 2022. Populations of Focus (POF) include Adults and Their Families Experiencing Homelessness; Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Adults with Intellectual or Developmental Disabilities (I/DD); Adults who are Pregnant or Postpartum; Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community; Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; Children & Youth Populations of Focus; Birth Equity; Individuals Transitioning from Incarceration; and Pre-Release Medi-Cal Services.

- **Enhanced Care Management (ECM**) is a Plan benefit that provides a community based, high-touch, person-centered/whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need members through systematic coordination of services.
- **Community Supports (CS)** are designed to be used to provide health related services as an alternative to covered Medi-Cal benefits. It will integrate care management for members at high levels of risk and intended to address SDoH. Support services may include Asthma Remediation; Community Transition Services/Nursing Facility Transition Services to a Home; Day Habilitation programs; Environmental Accessibility Adaptation (Home Modification); Housing Deposit; Housing Tenancy and Sustaining Services; Housing Transition Navigation; Medically Tailored Meals; Nursing Facility Transition/Diversion to Assisted Living Facilities; Personal Care Services and Homemaker Services; Recuperative Care; Respite Services; Short-Term Post-Hospitalization Housing; and Sobering Centers.

Members can self-refer to ECM and assigned staff will make contact to determine if they fall within the POF. If they do, CM staff will send notification to have the member assigned to an ECM provider. Care Management staff may also refer members to ECM services if they identify members in a POF and would benefit from ECM services. Care Management staff also regularly refer members to CS. Members accepted into ECM cannot be in the Plan's Complex Care Management program due to duplication of services, but can still be referred to Community Support services, Condition Specific Disease Management programs, and the Transition of Care program.

Population Health Management

We are committed to evolving to a collaborative community-wide approach to Population Health Management. We recognize that to achieve that goal requires knowledge of the community, appropriate information management tools and the application of evidence-based interventions derived from industry standards.[1] The Institute of Medicine (IOM) has defined three principal domains that effect successful health population management: [2]

1. The social, economic and environmental conditions that often act as the primary determinants of individual and population health.
2. Health care services for individuals.
3. Public health activities that target populations and address individual health behaviors, such as smoking and excessive alcohol consumption.

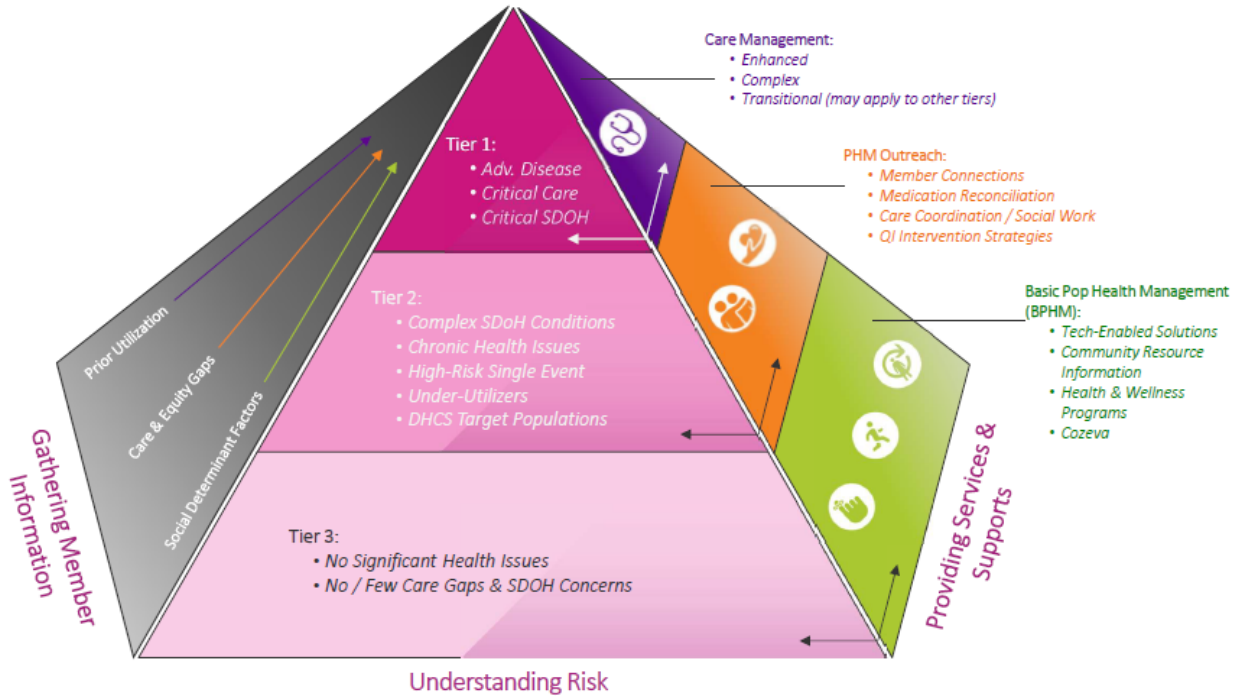
A population assessment is completed which provides the interdisciplinary team with a vehicle by which to analyze and prioritize health needs. Review of this information facilitates the identification of new initiatives, the ability to establish goals, evaluate and measure progress, while improving the quality, transparency and community engagement. The population health needs assessment is completed annually by the Plan's Population Health Management Team and is reported to the QIUM Committee.

Population Assessment and CM Criteria

In 2025, we continued to utilize a comprehensive Population Health Management report to support an integrated care model; care management being one component. This data is used to identify members for various programs. Impact pro data is included in the algorithm for this report.

[1] Institute of Medicine, *Primary Care and Public Health* (Washington D.C., 2012) [pre-publication copy], p. S-1

[2] IBID.



Impact Pro is a predictive modeling and care management analytic tool with a built-in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. The PHM report is broken up into 5 levels, with level 1 being the most critical and level 5 being the most healthy. Members are stratified into one of ten Clinical Analytics Population Categories: 01: Healthy, 02: Acute Event, 03: Care Coordination, 04Low Priority, 05A: Chronic Low Risk, 05B: Chronic Moderate Risk, 05C Chronic High Risk, Level 05D Chronic Highly Complex 07A: High Priority BH CM, 07B: High Priority PH CM, 08 High Priority Homeless/SUD, 09 Transition Of Care (TOC), 10: Palliative Care/Terminally ill. Members stratified into categories 05B through 08 are identified as higher risk and impactable and are referred to care management as described below.

Members identified on the PHM Level 1 report who are stratified into categories 5B, 5C, 5D, 7A, 7B, 8 AND have other designated parameters such as:

- CM engagement score ≥ 80
- Priority Flag = Yes
- ER Likelihood = Most Likely and Highly Likely

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Health Information Form/Health Risk Screening and/or who requested an individualized care plan or individualized care team may be referred to Care Management.

III. Summary and Priorities

In 2025, the key accomplishments for the CM Program were:

- Exceeded our goal to reduce readmissions for CM engaged members in BH, PH and TCS programs.
- Exceeded our goals to reduce ED visits.
- Exceeded our Perinatal program goals
- Increased referrals in all programs in 2025 compared to 2024 (PH 31%, BH 50%, PCM&FYOL 55%, and TCS 45% increased)
- Continue to enhance the Transitional Care Services program to meet PHM requirements:
    - Onsite staff at additional Hospitals (opened communication with Valley Children's)
    - Launched texting program with members

The primary goals for 2026 are to complete activities related to:

- Enhancements in Transitional Care Services program to meet updated PHM requirements.
    - Increase length of stay for PP TCS cases
    - Increasing Staffing
    - Create birthing checklist in portal and system
    - Increase the number of hospitals we have on site staff presence at.
- Launch enhanced Pregnancy Program
    - Utilize trimester-based assessments
    - Ensure alignment with PHM policy update for postpartum member requirements
- Manage more members across CM programs.
- Increase use of texting programs with members
- Utilize texting platform to conduct timely Satisfaction Survey
- Increase the reduction in ED visit goal for members in CM

Item #10

Attachment 10.A

Financials as of May 31, 2026

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of May 31, 2026

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	293,493,923.92
5	Total Bank Accounts	$ 293,493,923.92
6	Accounts Receivable	
7	Accounts Receivable	208,819,301.40
8	Total Accounts Receivable	$ 208,819,301.40
9	Other Current Assets	
10	Interest Receivable	603,144.73
11	Investments - CDs	0.00
12	Prepaid Expenses	329,364.83
13	Security Deposit	0.00
14	Total Other Current Assets	$ 932,509.56
15	Total Current Assets	$ 503,245,734.88
16	Fixed Assets	
17	Buildings	5,558,843.47
18	Computers & Software	0.00
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	116,390.95
22	Total Fixed Assets	$ 8,836,653.52
23	Other Assets	
24	Investment -Restricted	304,919.79
25	Lease Receivable	2,511,971.66
26	Total Other Assets	$ 2,816,891.45
27	TOTAL ASSETS	$ 514,899,279.85
28	LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	114,003.95
33	Accrued Admin Service Fee	4,561,810.00
34	Capitation Payable	136,926,453.56
35	Claims Payable	76,427.68
36	Directed Payment Payable	824,392.25
37	Total Accounts Payable	$ 142,503,087.44
38	Other Current Liabilities	
39	Accrued Expenses	1,312,205.59
40	Accrued Payroll	79,721.67
41	Accrued Vacation Pay	513,843.00
42	Amt Due to DHCS	36,547,085.03
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	125,583,333.34
48	Total Other Current Liabilities	$ 164,689,496.82
49	Total Current Liabilities	$ 307,192,584.26
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	$ 307,236,512.55
55	Deferred Inflow of Resources	$ 2,092,662.13
56	Equity	
57	Retained Earnings	184,108,458.37
58	Net Income	21,461,646.80
59	Total Equity	$ 205,570,105.17
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 514,899,279.85

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2025 - May 2026 Income Statement

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	Interest Income	8,867,967.81	4,650,000.00	4,217,967.81
3	Premium/Capitation Income	2,168,414,480.23	1,851,987,168.00	316,427,312.23
4	**Total Income**	**2,177,282,448.04**	**1,856,637,168.00**	**320,645,280.04**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	1,396,486,023.72	1,089,191,188.00	307,294,835.72
7	Medical Claim Costs	4,845,655.29	6,050,000.00	(1,204,344.71)
8	**Total Costs of Medical Care**	**1,401,331,679.01**	**1,095,241,188.00**	**306,090,491.01**
9	**Gross Margin**	**775,950,769.03**	**761,395,980.00**	**14,554,789.03**
10	**Expenses**			
11	Admin Service Agreement Fees	51,428,487.00	47,986,422.00	3,442,065.00
12	Bank Charges	0.00	6,600.00	(6,600.00)
13	Computer & IT Services	187,390.35	248,532.00	(61,141.65)
14	Consulting & Accreditation Fees	155,734.98	499,583.00	(343,848.02)
15	Depreciation Expense	320,199.49	341,000.00	(20,800.51)
16	Dues & Subscriptions	239,102.37	297,000.00	(57,897.63)
17	Grants (Community Reinvestment)	4,092,933.54	4,121,182.00	(28,248.46)
18	Insurance	362,926.80	445,374.00	(82,447.20)
19	Labor	4,317,007.99	4,937,278.00	(620,270.01)
20	Legal & Professional Fees	176,992.65	343,292.00	(166,299.35)
21	License Expense	1,179,866.28	1,632,444.00	(452,577.72)
22	Marketing	1,402,712.77	1,495,000.00	(92,287.23)
23	Meals and Entertainment	21,258.14	29,250.00	(7,991.86)
24	Office Expenses	95,669.50	114,583.00	(18,913.50)
25	Parking	281.79	1,430.00	(1,148.21)
26	Postage & Delivery	1,616.90	4,510.00	(2,893.10)
27	Printing & Reproduction	695.61	5,042.00	(4,346.39)
28	Recruitment Expense	46,566.31	158,125.00	(111,558.69)
29	Rent	0.00	11,000.00	(11,000.00)
30	Seminars & Training	5,789.62	31,600.00	(25,810.38)
31	Supplies	13,171.99	13,750.00	(578.01)
32	Taxes	690,708,333.34	690,708,333.35	(0.01)
33	Telephone & Internet	18,949.88	44,000.00	(25,050.12)
34	Travel	20,210.52	27,800.00	(7,589.48)
35	**Total Expenses**	**754,795,897.82**	**753,503,130.35**	**1,292,767.47**
36	**Net Operating Income**	**21,154,871.21**	**7,892,849.65**	**13,262,021.56**
37	**Other Income**			
38	Other Income	306,775.59	325,865.00	(19,089.41)
39	**Total Other Income**	**306,775.59**	**325,865.00**	**(19,089.41)**
40	**Net Other Income**	**306,775.59**	**325,865.00**	**(19,089.41)**
41	**Net Income**	**21,461,646.80**	**8,218,714.65**	**13,242,932.15**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

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

		Total	
		July 2025 - May 2026 (Current Year)	July 2024 - May 2025 (Prior Year)
1	Income		
2	Interest Income	8,867,967.81	10,840,106.52
3	Premium/Capitation Income	2,168,414,480.23	2,136,245,257.35
4	**Total Income**	**2,177,282,448.04**	**2,147,085,363.87**
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,396,486,023.72	1,271,072,792.48
7	Medical Claim Costs	4,845,655.29	7,010,819.82
8	**Total Costs of Medical Care**	**1,401,331,679.01**	**1,278,083,612.30**
9	**Gross Margin**	**775,950,769.03**	**869,001,751.57**
10	Expenses		
11	Admin Service Agreement Fees	51,428,487.00	52,622,812.00
12	Computer & IT Services	187,390.35	136,186.36
13	Consulting & Accreditation Fees	155,734.98	49,013.00
14	Depreciation Expense	320,199.49	312,016.70
15	Dues & Subscriptions	239,102.37	220,286.81
16	Grants (Community Reinvestment)	4,092,933.54	4,042,107.25
17	Insurance	362,926.80	324,343.48
18	Labor	4,317,007.99	3,908,425.36
19	Legal & Professional Fees	176,992.65	157,745.03
20	License Expense	1,179,866.28	1,363,110.18
21	Marketing	1,402,712.77	1,186,618.55
22	Meals and Entertainment	21,258.14	17,104.79
23	Office Expenses	95,669.50	87,578.49
24	Parking	281.79	328.37
25	Postage & Delivery	1,616.90	1,716.70
26	Printing & Reproduction	695.61	2,309.71
27	Recruitment Expense	46,566.31	(90.00)
28	Rent	0.00	0.00
29	Seminars & Training	5,789.62	11,901.67
30	Supplies	13,171.99	10,616.37
31	Taxes	690,708,333.34	785,583,333.34
32	Telephone & Internet	18,949.88	44,719.41
33	Travel	20,210.52	18,926.87
34	**Total Expenses**	**754,795,897.82**	**850,101,110.44**
35	**Net Operating Income**	**21,154,871.21**	**18,900,641.13**
36	Other Income		
37	Other Income	306,775.59	287,056.99
38	**Total Other Income**	**306,775.59**	**287,056.99**
39	**Net Other Income**	**306,775.59**	**287,056.99**
40	**Net Income**	**21,461,646.80**	**19,187,698.12**

Item #10

Attachment 10.B

Compliance Report

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 YTD Total
# of DHCS Filings													
Administrative/ Operational	27	19	16	19	14	19	1						115
Member Materials Filed for Approval;	6	3	3	7	3	5							27
Provider Materials Reviewed & Distributed	16	4	19	17	19	22							97
# of DMHC Filings	9	2	8	10	10	12							51

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	4	2	0						14
High-Risk	0	0	1	0	0	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 May 21, 2026, meeting.

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Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 YTD Toal
# of New MC609 Cases Submitted to DHCS	0	5	2	5	6	3	1						22
# of Cases Open for Investigation (Active Number)	29	31	34	33	38	41	41						

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 5/21/2026 Compliance Regulatory Report to the Commission, there were 6 new MC609 filings. The filings were related to the following:

- Inappropriate Billing: 2 cases
- Phantom Provider & Possible Services Not Rendered: 3 cases
- Impossible Days: 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, and 2026 Marketing. The following audits that have been completed since May 21, 2026, report to the Commission: Provider Network (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 after it issues the final Transportation APL at which time they will close the CAP and allow 90 days to implement any additional required changes.
Department of Health Care Services ("DHCS") 2025 Medical Audit	The Plan has completed all Corrective Action Plan (CAP) responses and submitted them to DHCS. The Plan is currently awaiting DHCS review, feedback, and final closure.
MY 2024 Health Equity and Quality Performance	On July 1, 2026, DMHC issued its Health Equity and Quality Performance Findings Report for Measurement Year 2024. The Plan exceeded benchmarks for most quality measures and had no administrative deficiencies; however, four aggregate measures and several health equity disparities require a Corrective Action Plan, which is due to DMHC by September 29, 2026.

2026 DMHC/DHCS Joint Medical Survey Audit	The DMHC/DHCS joint medical survey audit was conducted onsite from June 16, 2026, through June 18, 2026. Additional DHCS interviews were held virtually from June 22, 2026, to June 25, 2026. The Plan is currently awaiting the preliminary audit report.
2026 Network Adequacy Validation (NAV) Audit	On May 11, 2026, the Plan received the Audit Document Request Packet from HSAG. The Plan successfully submitted the Information Systems Capabilities Assessment Tool (ISCAT) and corresponding documents on June 18, 2026. The virtual audit will be conducted on August 25, 2026.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has executed the following MOUs: • Correctional Facilities Fresno County
Revised ASA and CPSA with Health Net	On June 25, 20206 the Plan received final DMHC/DHCS approval for the executed ASA and CPSA. The agreements are effective retroactively to July 1, 2025.
DMHC APL 25-019 & J-19 Compliance Grid	To demonstrate full compliance with the DMHC updated network adequacy regulations under APL 25-019, the Plan completed its required policy updates and successfully submitted all required policies and J-19 Compliance Grid by July 1, 2026
Plan Administration:	**Status**
2026 Updated EOC Errata 2	DHCS has postponed the elimination of dental benefits for the UIS population until 7/1/2027.
Funding for Abortion Clinics Resumes	The federal ban on funding Planned Parenthood funding other abortion clinics expired on 7/5/2026 when Congress failed to pass an extension. Plans can resume making payments to these clinics.
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026.
Committee Report:	**Status**
Public Policy Committee (PPC)	The last PPC meeting was held on June 3, 2026. The following reports were presented: Health Ed 2025 Summary Work Plan Evaluation Health Ed 2026 Work Plan Health Equity 2025 Summary and Work Plan Evaluation Health Equity 2025 Summary and Language Assistance Program Health Equity 2026Summary and Program Description

	Health Equity 2026 Summary and Work Plan Q1 2026 Appeal and Grievance Report Review and Discussion of A&G trends from Dr Marabella The next PPC meeting will be held on September 2, 2026, 11:30am-1:30pm in the CalViva Health Commission Room, 7625 N. Palm Ave #109, Fresno 93711.

APPENDIX A

2026 DHCS All Plan Letters:

- APL 25-004 Community Reinvestment Requirements - TECHNICAL CHANGE
- 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
- APL 26-008 Interoperability Final Rules, Incl Prior Authorizations
- APL 26-009 PRIVATE DUTY NURSING CASE MANAGEMENT RESPONSIBILITIES
- APL 26-010 SKILLED NURSING FACILITIES
- APL 26-011 SUBACUTE CARE FACILITIES
- APL 26-012 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES
- APL 26-013 H.R. 1 Federal Payment to Prohibited Entities Important Update End of One Year Restriction on Federal Payments

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 #10
Attachment 10.C

Medical Management

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2026

Current as of End of the Month: May
Revised Date: 06/16/2026

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	14	18	0	32	0	0	0	0	0	0	0	0	73	111
Standard Grievances Received	200	191	221	612	206	194	0	400	0	0	0	0	0	0	0	0	1012	2295
Total Grievances Received	**207**	**206**	**240**	**653**	**220**	**212**	**0**	**432**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1085**	**2406**
Grievance Ack Letters Sent Noncompliant	1	1	1	3	0	2	0	2	0	0	0	0	0	0	0	0	5	8
Grievance Ack Letter Compliance Rate	**99.5%**	**99.5%**	**99.5%**	**99.5%**	**100.0%**	**99.0%**	**0.0%**	**99.5%**	**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	14	18	0	32	0	0	0	0	0	0	0	0	72	110
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	217	216	0	433	0	0	0	0	0	0	0	0	978	2292
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**231**	**234**	**0**	**465**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1050**	**2403**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**158**	**186**	**211**	**555**	**215**	**221**	**0**	**436**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**991**	**2259**
Access - Other - DMHC	29	30	36	95	36	42	0	78	0	0	0	0	0	0	0	0	173	431
Access - PCP - DHCS	4	9	13	26	11	25	0	36	0	0	0	0	0	0	0	0	62	153
Access - Physical/OON - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Access - Spec - DHCS	1	6	4	11	6	5	0	11	0	0	0	0	0	0	0	0	22	73
Administrative	31	36	29	96	27	22	0	49	0	0	0	0	0	0	0	0	145	438
Balance Billing	19	26	42	87	36	30	0	66	0	0	0	0	0	0	0	0	153	313
Community Supports	6	8	4	18	12	9	0	21	0	0	0	0	0	0	0	0	39	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	31	28	0	59	0	0	0	0	0	0	0	0	122	213
Behavioral Health	6	2	2	10	4	6	0	10	0	0	0	0	0	0	0	0	20	1
Other	14	14	11	39	8	3	0	11	0	0	0	0	0	0	0	0	50	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	1	1	0	2	0	0	0	0	0	0	0	0	7	15
Transportation - Access	6	11	12	29	16	15	0	31	0	0	0	0	0	0	0	0	60	126
Transportation - Behavior	1	6	7	14	2	4	0	6	0	0	0	0	0	0	0	0	20	49
Transportation - Other	20	19	22	61	24	31	0	55	0	0	0	0	0	0	0	0	116	209
Quality Of Care Grievances	**12**	**10**	**8**	**30**	**16**	**13**	**0**	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**59**	**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	1	0	1	0	0	0	0	0	0	0	0	2	2
Other	3	2	2	7	5	3	0	8	0	0	0	0	0	0	0	0	15	26
PCP Care	8	4	2	14	6	4	0	10	0	0	0	0	0	0	0	0	24	58
PCP Delay	1	0	1	2	4	4	0	8	0	0	0	0	0	0	0	0	10	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	1	0	1	0	0	0	0	0	0	0	0	6	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	1	0	0	1	0	0	0	0	0	0	0	0	2	4
Exempt Grievances Received	**171**	**154**	**154**	**479**	**126**	**116**	**0**	**242**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**721**	**1798**
Access - Avail of Appt w/ PCP	3	5	2	**10**	1	3	0	**4**	0	0	0	**0**	0	0	0	**0**	**14**	**27**
Access - Avail of Appt w/ Specialist	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	**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**	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	**3**	**2**
Access - Panel Disruption	0	2	7	**9**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**10**	**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**	1	4	0	**5**	0	0	0	**0**	0	0	0	**0**	**15**	**15**
Attitude/Service - Provider	9	4	11	**24**	9	5	0	**14**	0	0	0	**0**	0	0	0	**0**	**38**	**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**	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	**8**	**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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**6**	**17**
Eligibility Issue - Member not eligible per Health Plan	1	1	2	**4**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**5**	**40**
Eligibility Issue - Member not eligible per Provider	10	9	14	**33**	8	8	0	**16**	0	0	0	**0**	0	0	0	**0**	**49**	**100**
Health Plan Materials - ID Cards-Not Received	36	25	20	**81**	19	12	0	**31**	0	0	0	**0**	0	0	0	**0**	**112**	**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	3	0	**3**	0	0	0	**0**	0	0	0	**0**	**5**	**7**
Behavioral Health Related	2	3	1	**6**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**9**	**16**
PCP Assignment/Transfer - Health Plan Assignment - Change Request	42	36	36	**114**	24	22	0	**46**	0	0	0	**0**	0	0	0	**0**	**160**	**533**
PCP Assignment/Transfer - HCO Assignment - Change Request	13	9	5	**27**	7	3	0	**10**	0	0	0	**0**	0	0	0	**0**	**37**	**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**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	**24**
PCP Assignment/Transfer - Rollout of PPG	3	0	0	**3**	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	**6**	**3**
PCP Assignment/Transfer - Mileage Inconvenience	5	3	2	**10**	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	**12**	**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**	2	8	0	**10**	0	0	0	**0**	0	0	0	**0**	**14**	**4**
Transportation - Access - Provider Late	0	1	1	**2**	2	3	0	**5**	0	0	0	**0**	0	0	0	**0**	**7**	**3**
Transportation - Behaviour	0	0	1	**1**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**4**	**5**
Transportation - Other	14	9	14	**37**	18	17	0	**35**	0	0	0	**0**	0	0	0	**0**	**72**	**85**
OTHER - Other	4	3	3	**10**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**13**	**27**
Claims Complaint - Balance Billing from Provider	18	26	23	**67**	21	17	0	**38**	0	0	0	**0**	0	0	0	**0**	**105**	**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	4	4	0	8	0	0	0	0	0	0	0	0	16	49
Standard Appeals Received	51	63	75	189	72	83	0	155	0	0	0	0	0	0	0	0	344	564
Total Appeals Received	**55**	**64**	**78**	**197**	**76**	**87**	**0**	**163**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**360**	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	4	4	0	**8**	0	0	0	**0**	0	0	0	0	15	49
Expedited Appeals Compliance Rate	**66.7%**	**100.0%**	**100.0%**	**85.7%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**93.8%**	**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	62	69	0	131	0	0	0	0	0	0	0	0	298	562
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**66**	**73**	**0**	**139**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**314**	**611**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**54**	**48**	**69**	**171**	**65**	**73**	**0**	**138**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	**309**	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	2	3	0	5	0	0	0	0	0	0	0	0	**13**	16
Community Supports	13	16	15	44	22	11	0	33	0	0	0	0	0	0	0	0	**77**	95
DME	12	9	13	34	14	18	0	32	0	0	0	0	0	0	0	0	**66**	111
Experimental/Investigational	1	4	3	8	3	2	0	5	0	0	0	0	0	0	0	0	**13**	34
Mental Health	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	**1**	5
Advanced Imaging	9	7	13	29	11	8	0	19	0	0	0	0	0	0	0	0	**48**	127
Other	2	4	9	15	3	22	0	25	0	0	0	0	0	0	0	0	**40**	75
Pharmacy/RX Medical Benefit	7	3	6	16	2	2	0	4	0	0	0	0	0	0	0	0	**20**	61
Surgery	8	3	5	16	8	4	0	12	0	0	0	0	0	0	0	0	**28**	58
SNF-Long Term Care	0	1	0	1	0	2	0	2	0	0	0	0	0	0	0	0	**3**	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**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**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	1	0	0	1	0	0	0	0	0	0	0	0	**4**	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**	22	30	0	52	0	0	0	0	0	0	0	0	127	272
Uphold Rate	**44.4%**	**50.0%**	**36.6%**	**42.9%**	**33.3%**	**41.1%**	**0.0%**	**37.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.4%**	**44.5%**
Overturns - Full	18	14	25	**57**	32	32	0	**64**	0	0	0	**0**	0	0	0	**0**	121	272
Overturn Rate - Full	**33.3%**	**28.0%**	**35.2%**	**32.6%**	**48.5%**	**43.8%**	**0.0%**	**46.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**38.5%**	**44.5%**
Overturns - Partials	12	6	12	**30**	11	10	0	**21**	0	0	0	**0**	0	0	0	**0**	51	42
Overturn Rate - Partial	**22.2%**	**12.0%**	**16.9%**	**17.1%**	**16.7%**	**13.7%**	**0.0%**	**15.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**16.2%**	**6.9%**
Withdrawal	0	5	8	**13**	1	1	0	**2**	0	0	0	**0**	0	0	0	0	15	25
Withdrawal Rate	**0.0%**	**10.0%**	**11.3%**	**7.4%**	**1.5%**	**1.4%**	**0.0%**	**1.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.8%**	**4.1%**
Membership	420,475	418,423	416,089		412,652	410,203	-		0	0	0		0	0	0			
Appeals - PTMPM	0.13	0.12	0.17	**0.42**	0.16	0.18	-	**0.51**	-	-	-	**-**	-	-	-	-	**0.45**	0.24
Grievances - PTMPM	0.40	0.47	0.53	**1.40**	0.56	0.57	-	**1.70**	-	-	-	**-**	-	-	-	-	**1.52**	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**	12	18	0	30	0	0	0	0	0	0	0	0	**65**	87
Standard Grievances Received	171	158	185	**514**	170	167	0	337	0	0	0	0	0	0	0	0	**851**	1870
Total Grievances Received	**177**	**171**	**201**	**549**	**182**	**185**	**0**	**367**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**916**	**1957**
Grievance Ack Letters Sent Noncompliant	1	1	1	**3**	0	1	0	1	0	0	0	0	0	0	0	0	**4**	7
Grievance Ack Letter Compliance Rate	**99.4%**	**99.4%**	**99.5%**	**99.4%**	**100.0%**	**99.4%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.5%**	**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	11	18	0	29	0	0	0	0	0	0	0	0	**64**	87
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	181	181	0	362	0	0	0	0	0	0	0	0	**817**	1864
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**192**	**199**	**0**	**391**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**881**	**1951**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**129**	**157**	**177**	**463**	**179**	**187**	**0**	**366**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**829**	**1832**
Access - Other - DMHC	25	26	30	81	29	37	0	66	0	0	0	0	0	0	0	0	**147**	358
Access - PCP - DHCS	4	7	10	21	11	21	0	32	0	0	0	0	0	0	0	0	**53**	124
Access - Physical/OON - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	**1**	1
Access - Spec - DHCS	1	4	4	9	6	5	0	11	0	0	0	0	0	0	0	0	**20**	54
Administrative	25	34	26	85	22	15	0	37	0	0	0	0	0	0	0	0	**122**	353
Balance Billing	14	20	39	73	30	26	0	56	0	0	0	0	0	0	0	0	**129**	251
Community Supports	4	6	4	14	11	8	0	19	0	0	0	0	0	0	0	0	**33**	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	26	26	0	52	0	0	0	0	0	0	0	0	**106**	173
Behavioral Health	5	2	1	8	0	4	0	4	0	0	0	0	0	0	0	0	**12**	1
Other	12	12	8	32	8	2	0	10	0	0	0	0	0	0	0	0	**42**	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	1	0	1	0	0	0	0	0	0	0	0	**5**	15
Transportation - Access	4	10	10	24	13	11	0	24	0	0	0	0	0	0	0	0	**48**	104
Transportation - Behaviour	1	4	6	11	1	3	0	4	0	0	0	0	0	0	0	0	**15**	37
Transportation - Other	16	15	15	46	21	28	0	49	0	0	0	0	0	0	0	0	**95**	159
Quality Of Care Grievances	**11**	**9**	**7**	**27**	**13**	**12**	**0**	**25**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**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	4	3	0	7	0	0	0	0	0	0	0	0	**14**	20
PCP Care	7	3	2	12	6	4	0	10	0	0	0	0	0	0	0	0	**22**	46
PCP Delay	1	0	1	2	3	4	0	7	0	0	0	0	0	0	0	0	**9**	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	1	0	1	0	0	0	0	0	0	0	0	**5**	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	2	3	0	5	0	0	0	0	0	0	0	0	**11**	36
Standard Appeals Received	39	49	55	143	57	66	0	123	0	0	0	0	0	0	0	0	**266**	444
Total Appeals Received	**42**	**50**	**57**	**149**	**59**	**69**	**0**	**128**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**277**	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	2	3	0	5	0	0	0	0	0	0	0	0	**10**	36
Expedited Appeals Compliance Rate	**50.0%**	**100.0%**	**100.0%**	**80.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**90.0%**	**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	47	55	0	102	0	0	0	0	0	0	0	**0**	**229**	444
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**49**	**58**	**0**	**107**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**240**	**480**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**36**	**53**	**131**	**48**	**58**	**0**	**106**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**237**	**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	2	0	2	0	0	0	0	0	0	0	0	**10**	14
Community Supports	11	13	11	35	20	9	0	29	0	0	0	0	0	0	0	0	**64**	73
DME	11	8	11	30	10	14	0	24	0	0	0	0	0	0	0	0	**54**	91
Experimental/Investigational	1	3	2	6	3	2	0	5	0	0	0	0	0	0	0	0	**11**	27
Behavioral Health	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	**1**	5
Advanced Imaging	5	5	9	19	8	7	0	15	0	0	0	0	0	0	0	0	**34**	105
Other	2	1	7	10	2	17	0	19	0	0	0	0	0	0	0	0	**29**	50
Pharmacy/RX Medical Benefit	7	3	5	15	2	2	0	4	0	0	0	0	0	0	0	0	**19**	52
Surgery	3	2	3	8	3	3	0	6	0	0	0	0	0	0	0	0	**14**	40
SNF-Long Term Care	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	**1**	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**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**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	1	0	0	1	0	0	0	0	0	0	0	0	**2**	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**	13	22	0	**35**	0	0	0	0	0	0	0	**0**	**89**	204
Uphold Rate	**38.1%**	**54.1%**	**33.3%**	**40.6%**	**26.5%**	**37.9%**	**0.0%**	**32.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.1%**	**42.5%**
Overturns - Full	16	10	21	**47**	27	29	0	**56**	0	0	0	0	0	0	0	**0**	**103**	223
Overturn Rate - Full	**38.1%**	**27.0%**	**38.9%**	**35.3%**	**55.1%**	**50.0%**	**0.0%**	**52.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.9%**	**46.5%**
Overturns - Partials	10	4	10	**24**	8	6	0	**14**	0	0	0	0	0	0	0	**0**	**38**	33
Overturn Rate - Partial	**23.8%**	**10.8%**	**18.5%**	**18.0%**	**16.3%**	**10.3%**	**0.0%**	**13.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**15.8%**	**6.9%**
Withdrawal	0	3	5	**8**	1	1	0	**2**	0	0	0	0	0	0	0	**0**	**10**	20
Withdrawal Rate	**0.0%**	**8.1%**	**9.3%**	**6.0%**	**2.0%**	**1.7%**	**0.0%**	**1.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.2%**	**4.2%**
Membership	332,462	330,913	329,090		326,488	324,541												
Appeals - PTMPM	0.13	0.11	0.16	**0.40**	0.15	0.18	-	**0.49**	-	-	-	**0.00**	-	-	-	0.00	**0.22**	0.29
Grievances - PTMPM	0.42	0.50	0.56	**1.48**	0.59	0.61	-	**1.80**	-	-	-	**0.00**	-	-	-	0.00	**0.82**	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	18	13	0	31	0	0	0	0	0	0	0	0	71	196
Total Grievances Received	**17**	**13**	**15**	**45**	**18**	**13**	**0**	**31**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**76**	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	0	0	1	0	0	0	0	0	0	0	0	5	11
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	16	17	0	33	0	0	0	0	0	0	0	0	74	196
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**17**	**17**	**0**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**79**	**207**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**16**	**12**	**43**	**16**	**17**	**0**	**33**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**76**	**197**
Access - Other - DMHC	2	2	1	5	2	2	0	4	0	0	0	0	0	0	0	0	9	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	4	6	0	10	0	0	0	0	0	0	0	0	16	35
Balance Billing	2	4	1	7	3	2	0	5	0	0	0	0	0	0	0	0	12	26
Community Supports	1	2	0	3	1	1	0	2	0	0	0	0	0	0	0	0	5	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	3	2	0	5	0	0	0	0	0	0	0	0	9	24
Behavioral Health	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	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	1	0	0	1	0	0	0	0	0	0	0	0	2	0
Transportation - Access	0	0	2	2	0	2	0	2	0	0	0	0	0	0	0	0	4	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	1	2	0	3	0	0	0	0	0	0	0	0	13	26
Quality Of Care Grievances	**1**	**0**	**1**	**2**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**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	1	0	0	1	0	0	0	0	0	0	0	0	1	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	1	0	1	0	0	0	0	0	0	0	0	1	7
Standard Appeals Received	3	3	5	11	6	7	0	13	0	0	0	0	0	0	0	0	24	36
Total Appeals Received	**3**	**3**	**5**	**11**	**6**	**8**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	25	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	0	1	0	0	0	0	0	0	0	0	1	7
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**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	0	3	4	7	4	7	0	11	0	0	0	0	0	0	0	0	18	37
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**4**	**8**	**0**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**44**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**3**	**3**	**6**	**4**	**8**	**0**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**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	1	0	1	0	0	0	0	0	0	0	0	1	2
Community Supports	0	1	2	3	2	2	0	4	0	0	0	0	0	0	0	0	7	10
DME	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	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	1	0	1	0	0	0	0	0	0	0	0	2	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	2	1	0	3	0	0	0	0	0	0	0	0	3	4
SNF-Long Term Care	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	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**	1	4	0	**5**	0	0	0	0	0	0	0	**0**	10	23
Uphold Rate	**0.0%**	**66.7%**	**75.0%**	**71.4%**	**25.0%**	**50.0%**	**0.0%**	**41.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**52.6%**	**52.3%**
Overturns - Full	0	1	1	**2**	1	1	0	**2**	0	0	0	0	0	0	0	**0**	4	13
Overturn Rate - Full	**0.0%**	**33.3%**	**25.0%**	**28.6%**	**25.0%**	**12.5%**	**0.0%**	**16.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**21.1%**	**29.5%**
Overturns - Partials	0	0	0	**0**	2	3	0	**5**	0	0	0	0	0	0	0	**0**	5	7
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**37.5%**	**0.0%**	**41.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**26.3%**	**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**		37,590	37,474										**0**		
Appeals - PTMPM	-	0.08	0.11	**0.06**	0.11	0.21	-	**0.16**	-	-	-	**0.00**	-	0	-	0.00	**0.06**	**0.16**
Grievances - PTMPM	0.42	0.42	0.34	**0.39**	0.45	0.45	-	**0.45**	-	-	-	**0.00**	-	0	-	0.00	**0.21**	**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	2	0	0	2	0	0	0	0	0	0	0	0	3	13
Standard Grievances Received	13	22	23	58	18	14	0	32	0	0	0	0	0	0	0	0	90	229
Total Grievances Received	**13**	**22**	**24**	**59**	**20**	**14**	**0**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**93**	**242**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**92.9%**	**0.0%**	**96.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.9%**	**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	2	0	0	2	0	0	0	0	0	0	0	0	3	13
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	20	18	0	38	0	0	0	0	0	0	0	0	87	232
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**22**	**18**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**90**	**245**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**13**	**22**	**49**	**20**	**17**	**0**	**37**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**86**	**230**
Access - Other - DMHC	2	2	5	9	5	3	0	8	0	0	0	0	0	0	0	0	17	41
Access - PCP - DHCS	0	1	3	4	0	4	0	4	0	0	0	0	0	0	0	0	8	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	1	1	0	2	0	0	0	0	0	0	0	0	7	50
Balance Billing	3	2	2	7	3	2	0	5	0	0	0	0	0	0	0	0	12	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	2	0	0	2	0	0	0	0	0	0	0	0	7	16
Behavioral Health	1	0	1	2	3	2	0	5	0	0	0	0	0	0	0	0	7	0
Other	1	1	3	5	0	1	0	1	0	0	0	0	0	0	0	0	6	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	3	2	0	5	0	0	0	0	0	0	0	0	8	14
Transportation - Behaviour	0	1	0	1	1	1	0	2	0	0	0	0	0	0	0	0	3	5
Transportation - Other	0	1	4	5	2	1	0	3	0	0	0	0	0	0	0	0	8	24
Quality Of Care Grievances	**0**	**1**	**0**	**1**	**2**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**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	1	0	1	0	0	0	0	0	0	0	0	1	0
Other	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	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	1	0	0	1	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
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	2	0	0	2	0	0	0	0	0	0	0	0	4	4
Standard Appeals Received	9	11	15	35	9	10	0	19	0	0	0	0	0	0	0	0	54	59
Total Appeals Received	**10**	**11**	**16**	**37**	**11**	**10**	**0**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	58	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	2	0	0	2	0	0	0	0	0	0	0	0	4	4
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	11	7	0	18	0	0	0	0	0	0	0	**0**	51	63
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**13**	**7**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**55**	**87**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**12**	**9**	**13**	**34**	**13**	**7**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**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	2	0	0	2	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	4	2	0	6	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	3	1	0	4	0	0	0	0	0	0	0	0	0	5
Other	0	2	2	4	1	4	0	5	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	3	0	0	3	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**	8	4	0	12	0	0	0	0	0	0	0	**0**	**28**	**45**
Uphold Rate	**66.7%**	**30.0%**	**38.5%**	**45.7%**	**61.5%**	**57.1%**	**0.0%**	**60.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.9%**	**51.7%**
Overturns - Full	2	3	3	**8**	4	2	0	6	0	0	0	0	0	0	0	**0**	**14**	36
Overturn Rate - Full	**16.7%**	**30.0%**	**23.1%**	**22.9%**	**30.8%**	**28.6%**	**0.0%**	**30.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**25.5%**	**41.4%**
Overturns - Partials	2	2	2	**6**	1	1	0	2	0	0	0	0	0	0	0	**0**	**8**	2
Overturn Rate - Partial	**16.7%**	**20.0%**	**15.4%**	**17.1%**	**7.7%**	**14.3%**	**0.0%**	**10.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**14.5%**	**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%**	**9.1%**	**4.6%**
Membership	49,776	49,438	49,090		48,574	48,188										-		
Appeals - PTMPM	0.24	0.20	0.26	**0.71**	0.27	0.15	-	**0.62**	-	-	-	0.00	-	0	-	0.00	**0.33**	**0.38**
Grievances - PTMPM	0.28	0.28	0.45	**1.01**	0.45	0.37	-	**1.24**	-	-	-	0.00	-	0	-	0.00	**0.56**	**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	2	6	0	8	0	0	0	0	0	0	0	0	19	31
Standard Grievances Received	26	21	78	125	62	66	0	128	0	0	0	0	0	0	0	0	253	658
Total Grievances Received	**29**	**25**	**82**	136	**64**	**72**	**0**	**136**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**272**	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.6%**	**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	2	5	0	7	0	0	0	0	0	0	0	0	19	34
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	71	69	0	140	0	0	0	0	0	0	0	0	300	718
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**73**	**74**	**0**	**147**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**319**	**752**
Grievance Descriptions - Resolved Cases	**53**	**64**	**55**	**172**	**73**	**74**	**0**	**147**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**319**	**752**
Access to primary care	1	1	2	4	0	4	0	4	0	0	0	0	0	0	0	0	8	43
Access to specialists	0	4	1	5	2	2	0	4	0	0	0	0	0	0	0	0	9	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	14	19	0	33	0	0	0	0	0	0	0	0	80	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	4	0	0	4	0	0	0	0	0	0	0	0	14	29
QOS Non Access	30	37	36	103	53	49	0	102	0	0	0	0	0	0	0	0	205	428
Exempt Grievances Received	**22**	**24**	**25**	**71**	**7**	**14**	0	**21**	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**92**	**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**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	3	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**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	3	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**	3	1	0	**4**	0	0	0	**0**	0	0	0	**0**	20	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	2	0	**2**	0	0	0	**0**	0	0	0	**0**	11	44
PCP Assignment/Transfer - HCO Assignment - Change Request	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	1	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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	1	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	2	0	**2**	0	0	0	**0**	0	0	0	**0**	19	34
OTHER - Other	1	1	1	**3**	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	6	7
Claims Complaint - Balance Billing from Provider	0	3	3	**6**	0	4	0	**4**	0	0	0	**0**	0	0	0	**0**	10	42

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	1	0	0	1	0	0	0	0	0	0	0	0	3	16
Standard Appeals Received	9	9	21	39	28	43	0	71	0	0	0	0	0	0	0	0	110	159
Total Appeals Received	**9**	**9**	**23**	**41**	**29**	**43**	**0**	**72**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	113	**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%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	0	0	1	0	0	0	0	0	0	0	0	3	17
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	21	33	0	54	0	0	0	0	0	0	0	**0**	115	164
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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**	**22**	**33**	**0**	**55**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**118**	**181**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**17**	**24**	**22**	**63**	**22**	**22**	**0**	**44**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**107**	**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	8	5	0	13	0	0	0	0	0	0	0	0	35	34
DME	4	6	6	16	8	11	0	19	0	0	0	0	0	0	0	0	35	40
Experimental/Investigational	0	0	2	2	1	1	0	2	0	0	0	0	0	0	0	0	4	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	2	1	0	3	0	0	0	0	0	0	0	0	9	25
Other	0	2	6	8	0	2	0	2	0	0	0	0	0	0	0	0	10	20
Pharmacy/RX Medical Benefit	2	2	0	4	0	1	0	1	0	0	0	0	0	0	0	0	5	13
Surgery	2	0	0	2	3	1	0	4	0	0	0	0	0	0	0	0	6	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**	7	6	0	**13**	0	0	0	**0**	0	0	0	**0**	**47**	85
Uphold Rate	**47.1%**	**70.8%**	**40.9%**	**54.0%**	**31.8%**	**18.2%**	**0.0%**	**23.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**39.8%**	**47.0%**
Overturns - Full	6	5	5	**16**	9	11	0	**20**	0	0	0	**0**	0	0	0	**0**	**36**	70
Overturn Rate - Full	**35.3%**	**20.8%**	**22.7%**	**25.4%**	**40.9%**	**33.3%**	**0.0%**	**36.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**30.5%**	**38.67%**
Overturns - Partials	3	0	4	**7**	6	5	0	**11**	0	0	0	**0**	0	0	0	**0**	**18**	15
Overturn Rate - Partial	**17.6%**	**0.0%**	**18.2%**	**11.1%**	**27.3%**	**15.2%**	**0.0%**	**20.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**15.3%**	**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%**	**5.1%**	**6.1%**
Membership	43,916	43,978	43,870		43,309	43,418												
Appeals - PTMPM	0.39	0.55	0.50	**1.43**	0.51	0.76	-	**1.90**	-	-	-	**0.00**	0	-	-	0.00	**0.83**	**0.79**
Grievances - PTMPM	1.21	1.46	1.25	**3.92**	1.69	1.70	-	**5.08**	-	-	-	**0.00**	0	-	-	0.00	**2.25**	**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

Categories	Description
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

Categories	Description
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here
Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it's an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligibilty or lackthereof.
Health Care Benefits	When it's an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
The Outlier Tab	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.

Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #10
Attachment 10.D

Medical Management

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 5/1/2026 to 5/31/2026

Report created 6/22/2026

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

Exhibits:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Shima Lotfi
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.com
Authorization Metrics	John Gonzalez

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/1/2026 to 5/31/2026
Report created 6/22/2026

ER utilization based on Claims data	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2025-Trend	2026-01	2026-02	2026-03	2026-04	2026-05	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	123,026	123,322	123,901	122,392	121,296	121,003	120,883	120,655		119,264	118,394	117,406	116,197	114,780		121,576	122,898	122,530	120,847	118,355		121,963	117,208	
Adult/Family/O TLIC Mbr Mos	262,247	262,070	262,013	260,399	258,290	257,463	257,291	257,397		255,067	253,880	252,988	251,878	250,132		261,819	262,076	260,234	257,384	253,978		260,378	252,789	
Aged/Disabled Mbr Mos	48,038	48,242	48,532	48,562	48,579	48,705	48,603	48,463		47,702	47,574	46,195	46,988	46,712		47,683	48,039	48,558	48,590	47,157		48,218	47,034	
COUNTS																								
Admits - Count	2,059	2,093	2,130	2,152	2,027	2,128	2,110	2,217		2,153	2,050	2,153	2,050	2,019		2,128	2,063	2,103	2,152	2,119		2,112	2,167	
Expansion	756	781	788	811	742	832	761	764		793	737	774	772	769		774	754	780	786	768		774	796	
Adult/Family/O TLIC	875	848	901	885	863	880	900	976		898	884	923	842	846		899	858	883	919	902		890	919	
Aged/Disabled	428	464	441	456	422	416	449	477		462	429	456	436	404		455	451	440	447	449		448	452	
Admits Acute - Count	1,332	1,371	1,342	1,381	1,238	1,336	1,348	1,396		1,440	1,359	1,443	1,383	1,360		1,409	1,369	1,320	1,360	1,414		1,365	1,450	
Expansion	603	633	604	640	576	672	607	610		646	586	646	638	633		613	608	607	630	626		614	652	
Adult/Family/O TLIC	397	393	404	389	357	353	402	414		430	458	444	392	378		446	410	383	390	444		407	440	
Aged/Disabled	332	345	334	352	305	311	339	372		364	315	353	353	349		351	350	330	341	344		343	359	
Readmit 30 Day - Count	238	267	264	260	240	281	271	275		283	263	296	307	300		241	250	255	276	281		255	295	
Expansion	105	116	105	98	98	130	119	117		125	114	119	145	142		97	102	100	122	119		105	131	
Adult/Family/O TLIC	56	60	70	68	64	66	67	56		65	67	68	62	58		58	59	67	63	67		62	65	
Aged/Disabled	77	91	89	94	78	85	85	102		93	82	109	100	100		86	89	87	91	95		88	99	
**ER Visits - Count	17,798	16,313	16,062	16,825	17,374	17,070	16,537	17,709		18,020	17,023	18,555	15,919	6,926		17,040	17,012	16,754	17,105	17,866		16,978	15,289	
Expansion	5,398	5,236	5,409	5,526	5,517	5,279	5,007	5,395		5,558	4,934	5,550	4,599	2,097		4,860	5,219	5,484	5,227	5,347		5,198	4,548	
Adult/Family/O TLIC	10,223	8,930	8,443	9,072	9,799	9,593	9,414	10,111		10,267	9,981	10,725	9,346	4,123		10,156	9,657	9,105	9,706	10,324		9,656	8,888	
Aged/Disabled	2,177	2,147	2,210	2,227	2,058	2,198	2,116	2,203		2,195	2,108	2,280	1,974	706		2,024	2,136	2,165	2,172	2,194		2,124	1,853	
PER/K																								
Admits Acute - PTMPY	36.9	37.9	37.1	38.4	34.7	37.5	37.9	39.3		40.9	38.8	41.6	40.0	39.6		39.2	37.9	36.7	38.2	40.4		38.0	41.7	
Expansion	58.8	61.6	58.5	62.7	57.0	66.6	60.3	60.7		65.0	59.4	66.0	65.9	66.2		60.5	59.4	59.4	62.5	63.5		60.5	66.7	
Adult/Family/O TLIC	18.2	18.0	18.5	17.9	16.6	16.5	18.7	19.3		20.2	21.6	21.1	18.7	18.1		20.4	18.8	17.7	18.2	21.0		18.8	20.9	
Aged/Disabled	82.9	85.8	82.6	87.0	75.3	76.6	83.7	92.1		91.6	79.5	91.7	90.2	89.7		88.2	87.5	81.6	84.1	87.5		85.4	91.5	
Bed Days Acute - PTMPY	170.0	184.7	169.3	175.1	171.3	173.4	190.4	199.1		201.1	189.1	200.9	197.4	197.5		204.1	188.4	171.9	187.6	197.0		188.0	202.4	
Expansion	290.2	306.6	270.1	300.0	293.5	324.3	315.7	326.0		322.5	304.9	329.4	370.7	327.1		348.3	300.0	287.8	322.0	318.9		314.4	338.4	
Adult/Family/O TLIC	61.0	65.2	74.2	66.7	64.1	59.0	64.6	74.2		73.8	72.6	74.2	66.1	82.0		75.2	75.6	68.4	65.9	73.5		71.3	76.9	
Aged/Disabled	456.9	522.1	425.0	441.3	435.7	403.1	544.7	546.7		578.6	522.9	567.9	472.5	497.1		544.1	518.3	434.0	498.0	556.4		498.4	538.0	
ALOS Acute	4.6	4.9	4.6	4.6	4.9	4.6	5.0	5.1		4.9	4.9	4.8	4.9	5.0		5.2	5.0	4.7	4.9	4.9		4.9	4.9	
Expansion	4.9	5.0	4.6	4.8	5.2	4.9	5.2	5.4		5.0	5.1	5.0	5.6	4.9		5.8	5.1	4.8	5.1	5.0		5.2	5.1	
Adult/Family/O TLIC	3.4	3.6	4.0	3.7	3.9	3.6	3.4	3.8		3.6	3.4	3.5	3.5	4.5		3.7	4.0	3.9	3.6	3.5		3.8	3.7	
Aged/Disabled	5.5	6.1	5.1	5.1	5.8	5.3	6.5	5.9		6.3	6.6	6.2	5.2	5.5		6.2	5.9	5.3	5.9	6.4		5.8	5.9	
Readmit % 30 Day	11.6%	12.8%	12.4%	12.1%	11.8%	13.2%	12.8%	12.4%		13.1%	12.8%	13.7%	15.0%	14.9%		11.3%	12.1%	12.1%	12.8%	13.2%		12.1%	13.6%	
Expansion	13.9%	14.9%	13.3%	12.1%	13.2%	15.6%	15.6%	15.3%		15.8%	15.5%	15.4%	18.8%	18.5%		12.5%	13.5%	12.9%	15.5%	15.5%		13.6%	16.4%	
Adult/Family/O TLIC	6.4%	7.1%	7.8%	7.7%	7.4%	7.5%	7.4%	5.7%		7.2%	7.6%	7.4%	7.4%	6.9%		6.5%	6.9%	7.6%	6.9%	7.4%		7.0%	7.1%	
Aged/Disabled	18.0%	19.6%	20.2%	20.6%	18.5%	20.4%	18.9%	21.4%		20.1%	19.1%	23.9%	22.9%	24.8%		18.8%	19.7%	19.8%	20.3%	21.1%		19.7%	22.0%	
**ER Visits - PTMPY	492.9	451.4	443.7	468.1	486.9	479.5	465.0	498.2		512.4	486.5	534.5	460.2	201.9		474.3	471.5	466.1	480.9	511.1		473.2	439.9	
Expansion	526.5	509.5	523.9	541.8	545.8	523.5	497.0	536.6		559.2	500.1	567.3	475.0	219.2		479.7	509.6	537.1	519.0	542.2		511.4	465.6	
Adult/Family/O TLIC	467.8	408.9	386.7	418.1	455.3	447.1	439.1	471.4		483.0	471.8	508.7	445.3	197.8		465.5	442.2	419.8	452.5	487.8		445.0	421.9	
Aged/Disabled	543.8	534.1	546.4	550.3	508.4	541.5	522.4	545.5		552.2	531.7	592.3	504.1	181.4		509.3	533.6	535.0	536.5	558.4		528.7	472.7	

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

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026 - Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	Q1-2026	Q2-2026	2026 - Quarters Trend	YTD-2025	YTD-2026	Year trends
	Perinatal Case Management															**Perinatal Case Management**								**Perinatal Case Management**		
Total Number Of Referrals	320	221	274	204	272	236	216	233		222	241	343	322	298		777	907	750	685		806	620		3,119	1,426	
Pending	-	-	-	-	-	1	-	13		-	-	-	1	3		-	-	-	14		-	4		14	4	
Ineligible	22	13	19	12	13	6	7	8		19	7	10	16	8		50	53	44	21		36	24		168	60	
Total Outreached	298	208	255	192	259	229	209	212		203	234	333	305	287		727	854	706	650		770	592		2,937	1,362	
Engaged	197	122	162	127	182	164	141	157		154	151	219	197	178		441	544	471	462		524	375		1,918	899	
Engagement Rate	66%	59%	64%	66%	70%	72%	67%	74%		76%	65%	66%	65%	62%		61%	64%	67%	71%		68%	63%		65%	66%	
Total Screened and Declined	6	3	3	1	6	4	2	12		3	2	4	1	1		9	14	10	18		9	2		51	11	
Unable to Reach	95	83	90	64	71	61	66	43		46	81	110	107	108		277	296	225	170		237	215		968	452	
Total Cases Managed	389	361	363	359	385	372	364	359		321	295	304	293	278		477	494	530	448		430	319		1,089	501	
Total Cases Closed	74	85	81	61	61	63	58	69		71	55	56	41	38		185	221	203	190		182	79		799	261	
Cases Remained Open	310	270	266	289	311	303	289	284		225	169	131	97	81		277	270	311	284		131	81		284	81	
	Physical Health Case Management															**Physical Health Case Management**								**Physical Health Case**		
Total Number Of Referrals	516	385	334	403	397	337	267	351		481	579	535	506	405		771	1,445	1,134	955		1,595	911		4,305	2,506	
Pending	-	-	-	1	3	2	3	55		1	1	1	3	42		-	-	4	60		3	45		64	48	
Ineligible	16	10	18	15	18	6	16	10		36	20	8	4	2		10	54	51	32		64	6		147	70	
Total Outreached	500	375	316	387	376	329	248	286		444	558	526	499	361		761	1,391	1,079	863		1,528	860		4,094	2,388	
Engaged	273	215	175	227	226	206	136	182		266	339	308	300	262		413	780	628	524		913	562		2,345	1,475	
Engagement Rate	55%	57%	55%	59%	60%	63%	55%	64%		60%	61%	59%	60%	73%		54%	56%	58%	61%		60%	65%		57%	62%	
Total Screened and Refused/Decline	57	32	28	30	18	17	18	19		24	34	44	23	10		87	122	76	54		102	33		339	135	
Unable to Reach	170	128	113	130	132	106	94	85		154	185	174	176	89		261	489	375	285		513	265		1,410	778	
Total Cases Closed	81	88	104	90	95	96	74	112		118	129	108	142	126		240	273	289	282		355	268		1,084	623	
Cases Remained Open	287	308	297	295	314	345	355	329		342	345	407	413	422		277	308	314	329		407	422		329	422	
Total Cases Managed	388	418	419	401	440	464	437	458		500	526	548	579	578		528	572	634	558		796	720		1,430	1,075	
Complex Case	28	37	38	49	59	76	73	78		92	95	96	103	97		48	42	70	81		129	116		148	161	
Non-Complex Case	360	381	381	352	381	388	364	380		408	431	452	476	481		480	530	564	477		667	604		1,282	914	
	Transitional Care Services															**Transitional Care Services**								**Transitional Care Services**		
Total Number Of Referrals	623	502	660	640	710	801	591	563		719	714	623	610	619		1,590	1,639	2,010	1,955		2,056	1,229		7,194	3,285	
Pending	-	-	-	-	-	2	-	15		-	-	-	-	7		-	-	-	17		-	7		17	7	
Ineligible	2	2	4	4	5	3	14	6		48	22	9	3	2		10	7	13	23		79	5		53	84	
Total Outreached	621	500	656	636	705	796	577	542		671	692	614	607	610		1,580	1,632	1,997	1,915		1,977	1,217		7,124	3,194	
Engaged	558	442	581	519	602	637	462	470		604	624	554	574	534		1,437	1,466	1,702	1,569		1,782	1,108		6,174	2,890	
Engagement Rate	90%	88%	89%	82%	85%	80%	80%	87%		90%	90%	90%	95%	88%		91%	90%	85%	82%		90%	91%		87%	90%	
Total Screened and Refused/Decline	6	-	6	8	6	18	9	6		4	9	7	2	9		21	12	20	33		20	11		86	31	
Unable to Reach	57	58	69	109	97	141	106	66		63	59	53	31	67		122	154	275	313		175	98		864	273	
Total Cases Closed	253	303	321	323	348	399	340	387		327	281	431	339	355		837	841	992	1,126		1,039	694		3,796	1,733	
Cases Remained Open	367	364	395	418	445	478	450	386		392	488	436	490	459		324	364	445	386		436	459		386	459	
Total Cases Managed	679	721	778	793	850	938	840	789		781	836	928	883	890		1,207	1,227	1,493	1,164		1,535	1,229		4,198	2,268	

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026 - Trend	Q1-2025	Q2-2025	Q3-2025	Q4-2025	2025 - Quarters Trend	Q1-2026	Q2-2026	2026 - Quarters Trend	YTD-2025	YTD-2026	Year trends
Behavioral Health Care Management																**Behavioral Health Care Management**								**Behavioral Health Care**		
Total Number Of Referrals	132	133	114	120	129	241	95	106		130	161	155	173	163		387	423	363	442		446	336		1,615	782	
Pending	-	-	-	-	1	-	-	15		-	-	-	-	4		-	-	1	15		-	4		16	4	
Ineligible	4	1	-	2	4	-	1	1		11	4	1	-	-		7	11	6	2		16	-		26	16	
Total Outreached	128	132	114	118	124	241	94	90		119	157	154	173	159		380	412	356	425		430	332		1,573	762	
Engaged	94	100	79	74	86	152	65	65		82	109	111	110	109		267	308	239	282		302	219		1,096	521	
Engagement Rate	73%	76%	69%	63%	69%	63%	69%	72%		69%	69%	72%	64%	69%		70%	75%	67%	66%		70%	66%		70%	68%	
Total Screened and Refused/Decline	1	-	-	-	2	2	3	1		4	-	1	2	4		2	1	2	6		5	6		11	11	
Unable to Reach	33	32	35	44	36	87	26	24		33	48	42	61	46		111	103	115	137		123	107		466	230	
Total Cases Closed	65	54	29	29	27	42	28	25		37	36	37	63	55		159	209	85	95		110	118		548	228	
Cases Remained Open	101	70	86	97	110	88	93	104		114	136	158	168	160		169	70	110	104		158	160		104	160	
Total Cases Managed	174	140	125	132	149	139	127	135		163	187	216	237	236		338	282	209	168		287	299		658	409	
Complex Case	9	9	9	10	11	10	10	11		15	18	20	26	32		22	16	15	12		24	35		39	41	
Non-Complex Case	165	131	116	122	138	129	117	124		148	169	196	211	204		316	266	194	156		263	264		619	368	
First Year of Life Care Management																**First Year of Life Care Management**								**First Year of Life Care**		
Total Number Of Referrals	47	47	62	40	45	55	40	47		51	37	61	45	43		124	149	147	142		149	88		562	237	
Pending	1	-	3	2	-	-	-	2		-	-	-	-	1		1	2	5	2		-	1		10	1	
Ineligible	-	1	1	-	1	2	1	4		7	2	-	-	-		1	1	2	7		9	-		11	9	
Total Outreached	46	46	58	38	44	53	39	41		44	35	61	45	42		122	146	140	133		140	87		541	227	
Engaged	46	46	51	37	41	51	39	40		43	31	59	42	41		117	146	129	130		133	83		522	216	
Engagement Rate	100%	100%	88%	97%	93%	96%	100%	98%		98%	89%	97%	93%	98%		96%	100%	92%	98%		95%	95%		96%	95%	
Total Screened and Refused/Decline	-	-	-	-	1	-	-	1		-	-	-	-	-		-	-	1	1		-	-		2	-	
Unable to Reach	-	-	7	1	2	2	-	-		1	4	2	3	1		5	-	10	2		7	4		17	11	
Total Cases Closed	24	29	46	28	27	20	23	33		29	41	49	37	47		78	87	101	76		119	84		342	203	
Cases Remained Open	375	395	396	400	405	432	450	449		452	441	435	450	440		327	395	405	449		435	440		449	440	
Total Cases Managed	405	427	442	428	437	455	474	483		489	482	497	489	488		424	479	510	503		567	525		792	644	

Item #10
Attachment 10.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: July 16th, 2026

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 2 2026 (July 2026)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Care Management, and Population Health Management performance, programs and regulatory activities in Quarter 2 of 2026.

I. Meetings

One QI/UM meeting was held in Quarter 2, on May 21st, 2026. The following **guiding documents** were approved at the May meeting:

1. 2025 Health Equity End of Year Evaluation
2. 2026 Health Equity Program Description
3. 2026 Health Equity Work Plan
4. 2025 Health Equity Language Assistance Program Report
5. 2026 PHM Strategy Description 2026
6. 2026 Long Term Care: Quality Assurance & Performance Improvement Plan

The following **Annual Oversight Audit** results were presented and accepted at the May meeting:

1. 2025 UMCM Oversight Audit of MY2024

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

1. Medical Policies
2. Appeals & Grievances Policies & Procedures Annual Review

II. QI Reports -

The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard & Quarterly A & G Reports** through March 2026 were presented with a general overview. An explanation was provided of how Members and providers submit grievances via phone, fax, email, or online, and each of these is categorized and reported on the dashboard and in other narrative reports. Standardized criteria as outlined in our policies and procedures are used to classify each case in order to include them in the appropriate area on the monthly dashboard.
   Each monthly Excel file includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. These data logs are included on tabs such as Formal Resolved, CCC Exempt Grievances, and BH Exempt. The Outlier tab provides an analysis of the data trends.

The A & G CAHPS Member Experience Analysis report for Quarter 1 was presented to highlight member satisfaction based on the resolved appeal and grievance cases and to identify risks, root causes, and potential actions for improvement.

Trends included:

a. **Grievances:** Grievances increased in Fresno and Kings counties compared to Q1 2025. 29% of grievances were categorized under Access to Care and 5 Drivers made up 39% of those access-related cases:
   i. Prior Authorization Delay
   ii. Inappropriate Payment Demand (balance billing)
   iii. Vendor Complaints
   iv. Transportation (missed appointment)
   v. Provider related
b. **Appeals:** There was an increase in appeals volume in Fresno and Madera counties compared to Q1 2025. 37% of appeals were concentrated in 4 Drivers.
c. The Top 4 Drivers were:
   i. Not Medically Necessary - Durable Medical Equipment
   ii. Not Medically Necessary – Other Diagnostic Services- MRI
   iii. Community Supports - Medically Tailored Meals
   iv. Community Supports – Housing Deposits

2. The **Potential Quality Issues (PQI) Report** provides a summary of issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.
PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q1 was reviewed for all case types including the follow up actions taken when indicated.

- There were two (2) non-member-generated Physical Health (PH) PQIs in Q1 in Fresno County, one (1) scoring level zero (0) and the other scoring level two (2).
- Member-generated PQIs decreased compared to previous quarters, inclusive of both physical and behavioral health cases. Outcome scores were reported as 17 at level zero (0), two (2) at level one (1), and nine (9) cases scored at level two (2); one (1) case at level four (4).

3. Additional Quality Improvement Reports presented were A & G Interrater Reliability, Member Letter Monitoring, Expedited Grievance Report, A & G Classification Audit, Call Center Inquiry Calls, NCQA System Controls Credentialing Oversight Report, and the A & G Validation Audit Report and others scheduled for presentation at the QI/UM Committee during Q2.

III. UMCM Reports -

The following is a summary of the reports and topics reviewed:

1. **The Key Indicator Report (KIR) & UM Concurrent Review Report** provided data through March 31st, 2026. Quarterly comparisons were reviewed with the following results:
   a. Utilization for most risk types remained consistent with the prior year except for a minor increase noted in admissions and utilization for the TANF population.
   b. Acute Bed Days increased in Q1 in all populations. Monitoring will continue.
   c. Average Length of Stay (ALOS) remained within acceptable ranges except for an increase that was noted in the SPD population. Monitor closely.
   All Turn-around Time (TAT) metrics met the 100% goal in March.
   d. Care Management results demonstrated positive referral and engagement trends through Quarter 1 in all programs with some random variation noted.
2. **The Over/Under Utilization Report 2026** evaluates utilization patterns to detect potential under- or over-utilization of services, ensuring services are medically necessary, accessible, and appropriate to the population served. This assessment promotes high-quality care, and supports optimal resource utilization. It also assesses the UM Program's ability to detect and correct potential under and over-

utilization through comprehensive monitoring efforts. The data reflects a steady multi-year decline in adjusted IP count across all three (3) counties. These trends suggest improved ambulatory care management, effective case management, and avoidance of preventable admissions, rather than inappropriate access barriers. Implications for CM:

a. Strengthen post-discharge planning to reduce readmissions, especially for high-growth surgical and chronic condition cohorts.
b. Implement targeted complex CM for frequent utilizers.
c. Address social determinants impacting ER utilization through stronger community resource partnerships.

3. **Additional UMCM Reports** include Concurrent Review IRR Report, CCS Report, Turning Point, PA Member Letter Monitoring Report and others scheduled for presentation at the QI/UM Committee during Q2.

IV. Access Related Reporting for Q2 included the

1. **Access Work Group Quarterly Report.**
2. **Access Workgroup Minutes:** January 2026
3. **Other Access-related reporting** included the Provider Office Wait Time Report.

V. Pharmacy Quarterly Reports include Pharmacy Executive Summary, Operations Metrics, Top 25 Medication Prior Authorization (PA) Requests, and the Quality Assurance Reliability Results (IRR) which were all reviewed for Quarter 1. 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 turnaround time rate of 100%. Prior authorization volumes were lower in Q1 compared to Q4 2025 with no outliers identified.

Quality Assurance (Interrater Reliability) reports are based upon a sample of cases that are audited each month to ensure they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The goal is ninety-five percent (95%) with a threshold for action of ninety percent (90%.)

- The 90% threshold was met. The 95% goal was met. The overall score was 96%.
- Three (3) sample cases had potential criteria application or documentation issues after Plan review.

Results have been shared with PA Managers in order to provide review and feedback with individual staff involved in the decisions. Feedback includes Criteria Application review of expectations as well as proper documentation of clinically relevant information.

VI. HEDIS® Activity

In Q2, HEDIS® related activities were focused on finalizing and preparing **Measurement Year** (**MY)2025 full HEDIS® Data for submission** to HSAG & DHCS for the Managed Care Accountability Set (MCAS) measures. Final Attestations and IDSS submission were completed on June 12th. Medi-Cal Managed Care (MCMC) health plans currently have 18 quality measures (MCAS) on which we will be evaluated this year. The Minimum Performance Level (MPL) remains at the 50th percentile.

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-in progress.

VII. Findings/Outcomes

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

Two areas of non-compliance were identified through routine monitoring during Quarter 3 2025 with one corrective action plan closed and one remains open through Quarter 2 2026:

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

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

Item #10
Attachment 10.F

Medical Management

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: July 16, 2026

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Q2 2026

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 2nd Quarter 2026 CalViva Health (CVH) Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on May 21st, 2026. At the May meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering Q4 2025 were reviewed for delegated entities and Q1 2026 for HN, including Behavioral Health. Q4 2025 data for all organizations is summarized in Table 1 below. There were no unanticipated credentialing patterns identified in this reporting period.

Table 1. Q4 2025 CalViva Health Credentialing/Recredentialing by Organization

	BH	HN	Adventist	ASH	CVMP	ChildNet	CSV	Envolve	Grow	IMG	LaSalle	Mindpath	Santé	Teladoc	UPN	Totals
Initial Credentialing	9	14	5	0	22	10	3	2	27	11	17	16	1	37	96	270
Recredentialing	31	3	24	1	32	35	2	1	66	19	34	5	22	26	7	308
Suspensions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	40	17	29	1	54	45	5	3	93	30	51	21	23	63	103	578

III. **The 2026 Adverse Events Report** for Q1 2026 (January through March) was presented to the Credentialing Sub-Committee. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CVH CMO requests to be forwarded to the Peer Review Committee.

- The Investigations team submitted no (0) new cases involving an individual practitioner to the Credentialing Committee in Q1 2026.
- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026.
- There were zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q1 2026.
- Reviews completed in January, February, and March did not identify any practitioners requiring removal from the Plan's network.

- January, February, and March 90-day monitoring, and termination rosters for practitioners whose license status was documented as delinquent on the state licensing board were submitted and approved via live or electronic Credentialing Committee meetings to meet business needs.
- Zero (0) cases required reporting for 805 in Q1 2026.

IV. The **Access & Availability Substantial Harm Report Q1 2026** 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 Q1 2026 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).

V. The **Credentialing Adverse Actions** report for Q1 2026 for CalViva Credentialing Sub-Committee from HN Credentialing Committee was presented. No (0) cases were presented for discussion for January, February, and March 2026.

VI. The **NCQA Information Integrity Credentialing Oversight Report** Q1 2026 was presented and reviewed. This report aims to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe:
1. What primary source verification information is received, dated, and stored.
2. How modified information is tracked and dated from its initial verification.
3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.
4. Annual training, to ensure incidents of data integrity are reported.
5. The security controls in place to protect the information from unauthorized modification.
6. How the organization monitors its compliance with the policies and procedures.
7. Initiate a Corrective Action Plan (CAP) for findings.
8. Assess CAP findings to ensure validity of corrections/actions.
Quarterly audits were performed using a 5% sampling methodology (50 cases, 25 credentialing, and 25 recredentialing). There was a total of 159 cases completed for CVH providers in 2025, and all of these were considered. The fifty (50) cases were evaluated and three (3) cases met threshold criteria for inclusion due to modifications made. All files with modifications (3) were included in this review, The audit results for CVH reflect 100% compliance with audit criteria. There were no incidents of non-compliance with policies in the 3-case universe. Ongoing and annual monitoring will continue.

VII. The county-specific **Credentialing Subcommittee Reports** of significant sub-committee activities for January through March 2026 were presented. There were no (0) new cases identified in Fresno, Kings, or Madera Counties for Q1 2026.

VIII. Follow-up activities will be scheduled, and ongoing monitoring and reporting will continue.

Item #10
Attachment 10.G

Medical Management

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD, Chief Medical Officer Amy R. Schneider, RN, Senior Director, Medical Management
COMMITTEE DATE:	July 16, 2026
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Q2 2026

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the CalViva Health (CVH) Peer Review Sub-Committee activities. All Peer Review information is confidential and protected by law under the Knox Keene Health Care Services Plan Act of 1975, Section 1370, which prohibits disclosure to any parties outside the peer review process.

I. The Peer Review Sub-Committee met on May 21st, 2026. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 1 2026 were reviewed for approval. There were no significant cases to report.

II. The **2026 Adverse Events Report for Q1** was reviewed. This report provides a summary of ongoing monitoring of Potential Quality Issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CVH CMO requests to be forwarded to the Peer Review Committee. A review of adverse events, outside of the ongoing monitoring process, identified one case in the first quarter of 2026 that met the criteria in which an adverse injury occurred during a procedure by a contracted practitioner.

- There were **eleven (11) cases** identified in **Q1 2026** that met the criteria and were submitted to the Peer Review Committee.
  - Three (3) cases involved practitioners, and eight (8) cases involved organizational providers (facilities).
  - Of the eleven (11) cases, three (3) were tabled, one (1) was tabled and placed on a corrective action plan with a letter of concern, one (1) was closed to track and trend with a letter of concern, and six (6) were closed to track and trend.

    - Eight (8) cases were quality of care grievances, three (3) were a potential quality issues, and zero (0) were track and trend.
    - Two (2) cases involved seniors and persons with disabilities.
    - Zero (0) cases involved behavioral health.
- The Investigations Team submitted six (6) previously presented, remaining open, cases to the Peer Review Committee in the first quarter of 2026.
    - Four (4) cases were regarding practitioners, and two (2) cases involved organizational providers (facilities).
    - Of the six (6) cases, one (1) was placed on a corrective action plan with monitoring, one (1) was closed to track and trend with a letter of concern, and four (4) were closed to track and trend.
    - Five (5) cases were quality of care grievances, one (1) was a potential quality issue, and zero (0) were track and trend.
    - One (1) case involved seniors and persons with disabilities.
    - Zero (0) cases involved behavioral health.
- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026.
- Grievance data reviews (NCQA CR 5.A.3-4) completed in December, January, and February did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. [NN1.1]
- Two (2) cases were placed on corrective action in the first quarter of 2026.
- Grievance data reviews for health equity, site review, chaperone, or medical records, completed in January, February, and March, did not identify any providers/ practitioners who met the Peer Review trended criteria for escalation.
- There was one (1) new case and two previously reported cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner (NCQA CR.5.A.4).
- The reviewing Medical Directors determined that further outreach was required for six (6) 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. [NN2.1]
- Ten (10) cases were referred to peer review for further review. Further review includes trended grievances and a license and sanction/exclusion review. Zero (0) cases required escalation for presentation at the Peer Review Committee.
- Zero (0) cases required reporting for 805.01 in Q1 2026.

III. The **Access & Availability Substantial Harm Report for Q1 2026** 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.

- Seventeen (17) cases were submitted to the Peer Review Committee in Q1 2026.

    - Of the seventeen (17) cases, four (4) cases were related to appointment availability issues without significant harm, and two (2) 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 Q1 2026.

IV. The **Q1 2026 Peer Count Report** was presented at the meeting with a total of 17 cases reviewed. Case outcomes included:

- Twelve (12) cases were closed and cleared.
- Zero (0) cases were closed and terminated.
- Zero (0) cases were deferred.
- Three (3) cases were tabled for further information.
- Two (2) cases were closed with CAP outstanding/continued monitoring, and
- Zero (0) cases were pending closure for CAP compliance.

V. The **Peer Review Sub-Committee reports** for January through March 2026 were reviewed. These reports summarize the outcomes of Peer Review cases for Fresno, Kings, and Madera counties. There were zero (0) cases reported in Q1 2026.

VI. Follow-up will be initiated to obtain additional information for the tabled cases, and ongoing monitoring and reporting will continue.

Item #10
Attachment 10.H

Equity

Health Equity Report

Current Health Equity Project(s) and Initiative(s):	Objective	Status
FCHIP HOPE HUB	Central Valley Disabilities Service Provider (CVDSP) network to CVH's HE initiative in 2026	Update 07/2026 Context: The workgroup was originally established to create a collaborative space for providers supporting individuals with disabilities to share resources, discuss challenges, and provide peer support. In April, CalViva Health (CVH) joined the workgroup to help identify barriers affecting families' access to developmental disability evaluations, services, and supports. Since the last meeting, an equity-focused family survey has been developed to better understand service demographics, the quality of provider interactions, timelines from evaluation to services, barriers contributing to delayed access, family perceptions and experiences, navigation support needs, and other unmet needs. A key concern raised by the workgroup was ensuring the survey would be accessible to all families, regardless of internet access, technology limitations, language barriers, or literacy levels. In June, Reading and Beyond was identified as the Community Health Worker (CHW) partner to lead community outreach and survey implementation. Their team will provide multiple methods for families to complete the survey, including in-person assistance, support for individuals with limited literacy, internet access, or technology, and translation services in threshold languages through both in-person assistance and the online survey platform.

		Building on this partnership, Reading and Beyond, in collaboration with the Fresno County Health Improvement Partnership (FCHIP) and CalViva Health, is planning to launch its first in-person developmental disability education and resource event for families in August. (Specific date TBD) Findings from the family survey will be analyzed and presented during an FCHIP-hosted webinar on October 27 to inform providers, community partners, and stakeholders about opportunities to improve equitable access to developmental disability services and supports.

Health Equity Annual Activities	Status
NCQA Update	June 2026- NCQA has replaced Health Equity Accreditation (HEA) with Health Outcomes Accreditation (HOA). Because DHCS determined the new HOA standards do not provide the same level of health equity accountability, Managed Care Plans will no longer be required to maintain NCQA HEA after the current contract period. Local Health Plans follow up with DHCS 6/29/2026- Although accreditation is no longer required, DHCS expects MCPs to continue: • Maintaining a strong internal health equity infrastructure. • Supporting executive leadership for health equity. • Using data to identify and reduce health disparities. • Continuing health equity improvement efforts through MCP contracts rather than NCQA accreditation. DHCS is reviewing all former HEA standards and determining which should be added to future Medi-Cal contracts. Current priorities include: language Access, Health Equity Data (race, ethnicity, and language- however, gender identify has not yet been confirmed at this time), Health Equity Leadership (requiring plans to maintain organizational health equity infrastructure and leadership oversight, disparities stratification to ensure quality is measured by race and ethnicity, and delegation oversight and the plans accountability. **Proposed Future Role of the CHEO** DHCS discussed expanding the CHEO role to include: • Oversight of race, ethnicity, language, disability, geography, and other demographic data collection.

	• Leading health equity analyses and disparity reduction strategies. • Developing a multi-year Health Equity Plan. • Overseeing culturally and linguistically appropriate Quality Improvement Projects (QIPs). • Leading health literacy initiatives. • Participating in Community Advisory Committees (CACs) and member engagement efforts. • Providing executive oversight of priorities to close health equity gaps.
Diversity, Equity and Inclusion Survey and training	6/2026- A DEI survey feedback was administered to both leadership and staff. Responses were anonymous. Overall, both staff and leadership viewed the cultural engagement activities positively, with more than 87% reporting a positive experience. The activities have strengthened team relationships and increased cultural awareness. Staff expressed interest in additional opportunities for cultural engagement, while leadership recommended maintaining voluntary participation and ensuring activities remain inclusive and accessible. We had delayed distribution of the 2026 CVH Health Equity Survey pending DHCS guidance regarding future organizational health equity requirements. Based on the DHCS proposal review between LHPC and DHCS on June 29, which continues to emphasize maintaining organizational health equity infrastructure and references concepts from 2024 NCQA Health Equity Accreditation in Standard 1, Factor 2, we will move forward with distributing the 2026 CVH Equity Survey to internal staff in the coming weeks. The survey will help identify opportunities to strengthen diversity, equity, inclusion, and organizational culture within CalViva Health.
Health Equity Annual Oversight Audit- HN	Oversight Audit Schedule to start- April 2026: Evidence for compliance of HE oversight is currently under review.

Health Equity Community Activities/ Updates	Who	Activity
June 2026	DHCS, Chief Medical Officers and Chief Health Equity Officers' from Health Plans across CA, both commercial and Medicaid plans,	Meeting takeaway: DHCS is shifting from simply measuring quality to measuring **overall value** by integrating health outcomes, equity, access, member experience, and cost. Future Medi-Cal efforts will prioritize stronger accountability, sustainable CalAIM implementation, standardized statewide performance measures, and continued investment in Enhanced Care Management and Community Supports while adapting to significant

		federal and state policy changes. **Key Follow-Up Points from DHCS** • **UIS Transition:** Additional guidance, planning forums, and transition communications are coming in the next 1–2 months. • **NCQA Health Equity Accreditation:** DHCS will hold a follow-up meeting with CHEOs on upcoming HEA changes and impacts. • **CCI/CHCF Project:** Summary of key themes will be shared with Managed Care Plans. • **Community Reinvestment:** DHCS will continue stakeholder engagement and provide updates as the initiative moves forward.

Item #10

Attachment 10.I

Executive Dashboard

	2025	2025	2025	2025	2025	2025	2025	2025	2026	2026	2026	2026	2026
Month	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**
CVH Members													
Fresno	344,786	345,260	345,340	342,450	340,709	339,554	339,029	338,291	334,955	332,883	331,574	329,434	326,859
Kings	38,656	38,654	38,730	38,789	38,783	38,729	38,689	38,719	38,543	38,391	38,329	37,893	37,698
Madera	50,466	50,725	50,974	50,958	50,850	50,648	50,627	50,523	50,017	49,650	49,306	48,811	48,347
Total	433,908	434,639	435,044	432,197	430,342	428,931	428,345	427,533	423,515	420,924	419,209	416,138	412,904
SPD	47,873	48,033	48,339	48,274	48,274	48,382	48,315	48,254	47,340	47,218	46,990	46,357	46,347
CVH Mrkt Share	66.79%	66.79%	66.78%	66.81%	66.79%	66.83%	66.84%	66.89%	66.83%	66.85%	66.89%	66.93%	66.96%
ABC Members													
Fresno	151,951	151,925	151,700	149,921	148,987	147,973	147,293	146,465	144,988	143,482	142,360	141,087	139,469
Kings	25,042	25,020	25,119	25,190	25,146	25,108	25,166	25,184	25,211	25,126	25,016	24,783	24,665
Madera	27,553	27,607	27,669	27,375	27,240	27,076	26,930	26,742	26,472	26,186	25,888	25,405	25,112
Total	204,546	204,552	204,488	202,486	201,373	200,157	199,389	198,391	196,671	194,794	193,264	191,275	189,246
Kasier													
Fresno	9,356	9,681	10,001	10,252	10,551	10,714	10,976	11,117	11,321	11,662	11,971	12,085	12,210
Kings	206	209	215	231	239	246	259	259	269	270	265	263	265
Madera	1,608	1,656	1,700	1,741	1,775	1,811	1,843	1,864	1,923	1,986	2,013	2,019	2,042
Total	11,170	11,546	11,916	12,224	12,565	12,771	13,078	13,240	13,513	13,918	14,249	14,367	14,517
Default													
Fresno	60.31%	61.10%	61.03%	58.94%	61.52%	59.59%	60.44%	63.29%	64.73%	63.89%	65.20%		
Kings	44.07%	57.76%	60.13%	56.57%	46.17%								
Madera	46.80%	61.63%	49.28%	45.13%	50.43%								
County Share of Choice as %													
Fresno	61.33%	60.48%	61.50%	59.30%	61.73%	60.40%	60.85%	61.54%	59.09%	59.04%	60.04%		
Kings		52.59%	54.22%	55.81%	56.51%		55.43%	56.30%	53.62%	50.16%	57.80%		
Madera	63.59%	65.45%	64.90%	65.07%	61.08%	63.92%	65.14%	57.46%	55.67%	66.46%	60.44%		

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	**2.6 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communications and Systems.		

Member Call Center CalViva Health Website		**Year**	**2024**	**2025**	**2025**	**2025**	**2025**	**2026**
		Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	(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. Q2 2026 numbers are not yet available.							

Provider Network & Engagement Activities	**Year**	**2025**	**2025**	**2026**	**2026**	**2026**	**2026**	**2026**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Hospitals	**11**	**11**	**11**	**11**	**11**	**11**	**11**
	Clinics	**167**	**168**	**169**	**169**	**170**	**171**	**171**
	PCP	**453**	**457**	**447**	**440**	**438**	**435**	**434**
	PCP Extender	**504**	**511**	**515**	**506**	**514**	**522**	**530**
	Specialist	**1629**	**1633**	**1553**	**1528**	**1549**	**1539**	**1564**
	Ancillary	**338**	**341**	**341**	**344**	**343**	**344**	**346**
	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**	**2025**	**2025**	**2025**	**2025**	**2026**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	% of PCPs Accepting New Patients - Goal (85%)	**94%**	**91%**	**89%**	**89%**	**92%**	**92%**	**93%**
	% Of Specialists Accepting New Patients - Goal (85%)	**97%**	**96%**	**96%**	**96%**	**97%**	**92%**	**97%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**98%**	**99%**	**99%**	**99%**	**95%**	**94%**	**94%**
	Year	**2025**	**2025**	**2026**	**2026**	**2026**	**2026**	**2026**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Providers Interactions by Provider Relations	**326**	**445**	**375**	**623**	**564**	**606**	**716**
	Reported Issues Handled by Provider Relations	**17**	**23**	**55**	**69**	**46**	**43**	**37**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**9**	**0**	**3**	**23**	**22**	**33**	**14**
	Interventions Deployed for PCP Quality Performance Improvement	**9**	**0**	**3**	**23**	**22**	**33**	**14**
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.							

Claims Processing	**Year**	**2024**	**2024**	**2024**	**2025**	**2025**	**2025**	**2025**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	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	Q1 2026 numbers are not yet available. Q4 2025 numbers were presented during the last RHA Commission Meeting on May 21, 2026							

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	Q1 2026 numbers are not yet available. Q4 2025 numbers were presented during the last RHA Commission Meeting on May 21, 2026							