FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Joe Prado, Director
Public Health Department

David Cardona, M.D.
At-large

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

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Timothy Haydock,
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: October 23, 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, October 29, 2026
2:00 pm to 3:30 pm

Where to attend:

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

Meeting materials have been emailed to you.

Currently, there are **11** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
October 29, 2026
2:00 pm - 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	**Madera County BOS Appointed At-Large Commission Seat** • Reappointment of Dr. Aftab Naz *Action: Ratify appointment*	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 Attachment 4.J Attachment 4.K Attachment 4.L Attachment 4.M Attachment 4.N	**Consent Agenda:** • Commission Minutes dated 7/16/26 • Commission Minutes dated 7/28/26 • Finance Committee Minutes dated 5/21/26 • Finance Committee Minutes dated 7/16/26 • QI/UM Committee Minutes dated 5/21/26 • QIUM Committee Minutes dated 7/16/26 • PPC Minutes dated 6/3/26 • Commission Calendar • Finance Committee Calendar • Public Policy Committee Calendar • QIUM Committee Calendar • Credentialing Sub-Committee Calendar • Peer Review Sub-Committee Calendar • Equity Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5. Action		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item:** **A. Conference with Legal Counsel - Anticipated Litigation.** Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Section 54956.9 of the California Government Code. **B. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Medical Officer Per Government Code Section 54957(b)(1)	J. Nkansah, CEO

6. Action	Attachment 6.A	**Financial Audit Report for Fiscal Year 2026** • Baker Tilly LLP Board Presentation of Audit *Action: Approve Audit Report*	R. Siucco, Baker Tilly LLP
7. Information	Attachment 7.A	**Member Experience**	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 8-11* ***One vote will be taken for combined items 8-11***	
8. Action	Attachment 8.A Attachment 8.B	**2026 Heath Equity** • Executive Summary • Work Plan Mid-Year Evaluation *Action: See item 11 for Action*	P. Marabella, MD, CMO
9. Action	Attachment 9.A Attachment 9.B	**2026 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: See item 11 for Action*	P. Marabella, MD, CMO
10. Action	Attachment 10.A Attachment 10.B	**2026 Utilization Management Care Management Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: See item 11 for Action*	P. Marabella, MD, CMO
11. Action	Attachment 11.A	**Member Satisfaction Annual Regulatory CAHPS Summary Report** *Action: Approve the 2026 Health Equity Executive Summary and Work Plan Mid-Year Evaluation; 2026 Quality Improvement Health Equity Transformation Program; 2026 Quality Improvement, Health Education, & Wellness Work Plan Mid-Year Evaluation; and 2026 Utilization Management Care Management Work Plan Mid-Year Evaluation.*	P. Marabella, MD, CMO
12. Action		**Standing Reports**	
	Attachment 12.A Attachment 12.B	**Finance Report** • Financials as of August 31, 2026 • Baker Tilly Audit Proposal	D. Maychen, CFO
	Attachment 12.C	**Compliance** • Compliance Report	M. Simpson, CCO
	Attachment 12.D	**Medical Management** • Appeals and Grievances Report	P. Marabella, MD, CMO

Attachment 12.E Attachment 12.F Attachment 12.G Attachment 12.H	• Key Indicator Report • Quarterly Summary Report • Credentialing Sub-Committee Quarterly Report – Q3 2026 • Peer Review Sub-Committee Quarterly Report – Q3 2026	
Attachment 12.I	**Executive Report** • Executive Dashboard *Action: Accept Standing Reports*	J. Nkansah, CEO
13.	**Final Comments from Commission Members and Staff**	
14.	**Announcements**	
15.	**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.*	
16.	**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 November 19, 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

Madera County BOS
Reappointed Commissioner

BOARD OF SUPERVISORS
COUNTY OF MADERA

Agendas available: www.MaderaCounty.com
YouTube Videos: Madera County Boards & Commissions

MEMBERS OF THE BOARD

JORDAN WAMHOFF, District No. 1
DAVID ROGERS, District No. 2
ROBERT L. POYTHRESS, District No. 3
LETICIA GONZALEZ, District No. 4
BOBBY MACAULAY, District No. 5

ROBERT MACAULAY, CHAIR
KAREN SCRIVNER, CHIEF CLERK TO THE BOARD

BOARD LETTER & MINUTE ORDER

MEETING DATE: August 11, 2026

AGENDA # 7.f

DEPARTMENT:
BOS-015963: BOARD OF SUPERVISORS DEPARTMENT

DEPARTMENT CONTACT:	**PLACEMENT**	**DOC. ID #**
Tatiana Echevarria	CONSENT	BOS-015963

PREVIOUS BOARD ACTION(S):
5.G- ID 10038 09-19-2023

BOARD ACTING AS:	**VOTE REQ.**
BOARD OF SUPERVISORS	3/5

This Section is reserved for Clerk of the Board's Office Use Only

BOARD'S ACTION:

APPROVED
MOVED BY: Supervisor Rogers
SECONDED BY: Supervisor Poythress
AYES(5) Supervisor Wamhoff, Chair Pro Tem, Supervisor Rogers, Supervisor Poythress, Supervisor Gonzalez, and Supervisor Macaulay, Chair

Processed By: Tatiana Echevarria, Deputy Clerk II

RECOMMENDED ACTION:

Consideration of approval to reappoint Dr. Aftab Naz, to the Fresno-Kings-Madera Regional Health Authority for a term ending September 8, 2029.

BACKGROUND SUMMARY / FISCAL IMPACT:

DISCUSSION:

On April 14 2009, the Madera County Board of Supervisors adopted Ordinance No. 637, adding chapter 2.91 to the Madera County Code and establishing the Fresno-Kings-Madera Regional Health Authority. The ordinance sets forth that one member shall be an individual who represents the interests of physician providers of MediCal covered health care services, health care consumers, community representatives or community clinics (Madera County Code 2.91.030 C3).

Dr. Naz has served since 2009 and has expressed a desire to continue serving.

FISCAL IMPACT:

There is no Fiscal Impact to the County of Madera.

CONNECTION TO THE COUNTY OF MADERA STRATEGIC PLAN:

STRATEGIC FOCUS AREAS

- Focus Area 1: Community
- Focus Area 8: Health

ATTACHMENTS:

1. Ordinance No. 637
2. Bylaws
3. Oath – A. Naz

Item #4

Attachment 4.A-N

Consent Agenda

A. Commission Minutes dated 7/16/26
B. Commission Minutes dated 7/28/26
C. Finance Committee Minutes dated 5/21/26
D. Finance Committee Minutes 7/16/26
E. QI/UM Committee Minutes dated 5/21/26
F. QIUM Committee Minutes dated 7/16/26
G. Public Policy Committee Minutes 6/3/26
H. Commission Calendar 2027
I. Finance Calendar 2027
J. Public Policy Calendar 2027
K. QIUM Committee Calendar 2027
L. Credentialing Sub-Committee Calendar 2027
M. Peer Review Sub-Committee Calendar 2027
N. Equity Report

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
July 16, 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**, Director, Fresno County Dept. of Public Health
✓	**Joyce Fields-Keene,** Fresno County At-large Appointee		**Rose Mary Rahn**, Director, Kings County Dept. of Public Health
✓	**John Frye**, Commission At-large Appointee, Fresno	✓	**David Rogers**, Madera County Board of Supervisors
✓	**Soyla Griffin**, Fresno County At-large Appointee		**Jennifer Armendariz**, Valley Children's Hospital Appointee
	David Hodge, M.D., Chair, Fresno County At-large Appointee	✓	**Paulo Soares**, Commission At-large Appointee, Madera County
	Kerry Hydash, Commission At-large Appointee, Kings County		
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Amy Schneider**, R.N., Senior Director of Medical Management
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Cheryl Hurley**, Commission Clerk, Director Office/HR
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Sia Xiong-Lopez**, Equity Officer
✓	**Mary Lourdes Leone**, Chief Compliance Officer	✓	**Morgan Simpson**, Senior Director of Compliance
	General Counsel and Consultants		
✓	**Jason Epperson**, General Counsel		
✓= Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
● = Attended via Teleconference			

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

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Cheryl Hurley, Clerk to the Commission			
#3 Fresno County BOS Reappointed Commissioner **Action** Joe Neves, Co-Chairman	The Commission ratified the reappointment of Joyce Fields-Keene for the Fresno County BOS appointed At-Large Commission seat.		***Motion**: The appointment of Joyce Fields-Keene was ratified.* *10 – 0 – 0 – 7* *(Rogers / Soares)*
#4 Consent Agenda • *Commission Minutes dated 5/21/26* • *Finance Committee Minutes dated 3/19/26* • *QI/UM Committee Minutes dated 3/19/26* • *Public Policy Committee Minutes dated 3/4/26* • *Finance Committee Charter* • *Credentialing Committee Charter* • *Peer Review Committee Charter* • *QIUM Charter* • *Public Policy Committee Charter* **Action** Joe Neves, Co-Chairman	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *10 – 0 – 0 – 7* *(Naz / Frye)*
#5 Closed Session	Jason Epperson reported out of closed session. The commission met in closed session to discuss those items, agendized for closed session discussion, specifically item 5A, public employee appointment, employment evaluation or discipline, titled Chief Executive Officer Annual Review. Pursuant to government code section 54957(B)(1). That item was discussed by the commission in closed session. A motion was made by Dr. Naz and seconded by Mr. Frye to renew the CEO's current employment contract under its current terms except to include a 5% increase in pay as of the contract anniversary date.		***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The second item discussed in closed session was 5B, conference of 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. That item was discussed in closed session, direction was given to staff, and the commission took no other action on that or any other item. Closed session was recessed at 2:48 pm.		
#6 Review of Fiscal Year End 2026 Goals **Action** Jeff Nkansah, CEO	Results for fiscal year end 2026 goals were presented to Commissioners. There were no questions or concerns.		***No Motion***
#7 Goals & Objective for Fiscal Year 2027 **Action** Jeff Nkansah, CEO	The goals and objectives for FY 2027 were presented to Commissioners. One new goal that is new and highlighted is related to the member experience and member retention strategy. Previously, there was a closed session item that was going to be publicly disclosed in July 2026, centered around whether there would be opportunities for RHA or CalViva Health to have more of a direct influence for engagement in the Plan's members' experience, and also that those activities would help drive our member retention strategy. There was positive reception from the commission during that conversation, and this is now listed with an attempt to implement 100% of the actions that were outlined in the roadmap that was shared to move it into the implementation phase. The other areas are consistent with what has been presented historically in terms of the goals and objectives.		***Motion:*** *Review and approve Goals & Objectives for FY 2027* *10 – 0 – 0 – 7* *(Frye / Prado)*
#8 Update on July 1, 2025, HNCS Contract **Information** J. Nkansah, CEO	Follow-up was provided regarding the Health Net Community Solutions contract that was previously presented to the RHA Commission. The terms were agreed to, and the Plan was required to take it through the regulatory processes to get it approved through the regulators. It went through DMHC approval and was then sent through the Department of Health Care Services for approval. There were no material changes to the agreement, and therefore executed agreements were submitted on June 5th and June 12th respectively. The Plan filed those agreements with DHCS and DMHC retroactive back to July 1, 2025.		***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#9 Care Management **Information** P. Marabella, CMO	Dr. Marabella presented the 2025 Annual Program Evaluation for Care Management. The goals for 2025 were: • Increase number of cases managed: ○ Met - Total 8,816 cases (2025) compared to 3,649 cases (2024). 2.03% of population managed in PH, BH, FYOL, PCM or TCS. • Maintain 90% Compliance for Medical Record Documentation: ○ Met – Overall average score across programs for 2025 was 94%. Quarterly Results of Complex & Non-complex File Reviews by Program 2025, overall average scores: • Physical Health: 93% • Behavioral Health: 95% • Perinatal: 98% • Transitional Care: 91% Outcome results: • Readmissions 31.7% down to 24%. • Reduced ED Claims by 17.8% if Member in Case Management. • Inpatient & Outpatient Claims Reduced by More than 2200 After CM Completion. • Clinical Outcomes for High-Risk OB: ○ First Prenatal Visit in 1st Trimester - improved 15.5% (Goal ≥8%) ○ Reduction in Pre-term Deliveries by 5.1% (Goal 2%) ○ Timely Post-partum Visit – improved 11.9% (Goal ≥10%) Satisfaction: • Member Satisfaction: ○ 75 Responses in 2025 ○ 11 of 13 Questions had a response ○ Goal = 90% positive response (Very satisfied-Satisfied) • 92% Satisfied with CM Program (met goal) • 59% Satisfied with ability to reach their CM.		***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• 84% Reported CM helped them to reach their health goals. • 81% Reported CM helped to organize care with MD and other caregivers. 2025 Key Accomplishments: • 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 (increased PH by 31%, BH by 50%, PCM & FYOL by 55%, and TCS by 45%) • Continue to enhance the Transitional Care Services program to meet PHM requirements: ○ Onsite staff at additional Hospitals (opened communication with Valley Children's Hospital) ○ Launched texting program with Members. 2026 Goals: • Enhancements in Transitional Care Services program to meet updated PHM requirements: ○ Increase length of stay for Postpartum TCS cases ○ Increase Staffing ○ Create Birthing Checklist in portal and system ○ Increase the number of hospitals with Onsite Staff presence. • 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 Surveys. • Further reduction in ED visit goal for Members in CM.		
#10 Standing Reports • **Finance Reports**	**Finance** <u>Financials as of May 31, 2026</u>		***Motion**: Commission approved standing reports*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Daniel Maychen, CFO	As of May 2026, total current assets were approximately $503.2M; total current liabilities were approximately $307.2M. Current ratio is approximately 1.64. TNE as of the end of May 2026 was approximately $205.6M which is approximately 690% above the minimum DMHC required TNE amount. For the DHCS standard, the minimum required TNE is approximately $197M, which the Plan is approximately $8.4M above the DHCS standard. Interest income actual recorded was approximately $8.9M which is approximately $4.2M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $2.17B which is approximately $316.4M more than budgeted primarily due to rates and enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $1.4B which is approximately $306.1M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $51.4M which is approximately $3.4M more than budgeted due to enrollment being higher than projected. Labor expense actual recorded was approximately $4.3M which is approximately $621K less than projected mainly due to open positions during the current fiscal year. License expense actual recorded was approximately $1.2M, which is approximately $453K less than budgeted due to the DMHC license fee being less than projected. All other expenses are in line or below budgeted amounts. Total net income through May 2026 was approximately $21.5M, which is approximately $13.2M more than budgeted primarily due to interest income being approximately $4.2M more than budgeted and enrollment and rates being higher than projected.		*10 – 0 – 0 – 7* *(Rogers / Naz)*
• **Compliance** M.L. Leone, CCO	**Compliance Report** Compliance Report		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Year to date there have been 115 Administrative & Operational regulatory filings for 2026; 27 Member Materials filed for approval; 97 Provider Materials reviewed and distributed, and 51 DMHC filings. There have been 15 potential Privacy & Security breach cases reported year to date, with one being high risk. Since the 5/21/2026 Compliance Regulatory Report to the Commission, there were 6 new MC609 filings. The filings relate to the following: • Inappropriate Billing: 2 cases • Phantom Provider & Possible Services Not Rendered: 3 cases • Impossible Days: 1 case The Annual Oversight Audits currently in progress since last reported include Marketing, Credentialing, Call Center, Health Education, Q4 2025 Claims/PDRs, and Health Equity. Audit completed since the last Commission meeting was the Provider Network CAP. Regarding the 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. Regarding the 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. Regarding the DMHC 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding the 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. Regarding the 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. On June 25, 20206 the Plan received final DMHC/DHCS approval for the executed ASA and CPSA with Health Net. The agreements are effective retroactively to July 1, 2025. 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. Since the last Commission Meeting, the Plan has executed the Correctional Facilities Fresno County MOU. DHCS has postponed the elimination of dental benefits for the UIS population until 7/1/2027. 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. The Commission was provided a complete listing of DHCS and DMHC APLs that have been issued in CY 2026. The last PPC meeting was held on June 3, 2026. The following reports were presented:		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	• 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 There were no recommendations or action items requiring a response from the Commission. The next PPC meeting will be held on September 2, 2026, 11:30am - 1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave #109, Fresno 93711. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievance Data Analysis CAHPS Through May 2026. • The total number of grievances at the end of May remained consistent with previous months. The Quality-of-Service category represents the highest volume of total grievances. • For the Quality of Service (QOS) category, the types of cases noted to contribute the most to case volume are Access-Other, Administrative, Balance Billing, Community Supports, Other, and Transportation-Other. • The volume of Exempt Grievances has declined considerably since last reported. • Total Appeals volume has increased since last reported. The majority of cases being Community Supports, Durable Medical Equipment (DME), and Advanced Imaging related. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through May 2026.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through May 2026. • Membership continues to slowly decrease. Admits and Acute Admits remain consistent with previous months. Readmission rates for all categories have remained consistent since last reported. ER visits have decreased since last reported. • Turn-Around-Time Compliance (TAT) categories met compliance goals with the exception of Expedited Pre-Service case type. • Case Management (CM) engagement rates remain consistent since last reported. <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q2 2026. One QI/UM Committee meeting was held on May 21st, 2026. The following guiding documents were approved at the May meeting: 2025 Health Equity End of Year Evaluation, 2026 Health Equity Program Description, 2026 Health Equity Work Plan, 2025 Health Equity Language Assistance Program Report, 2026 PHM Strategy Description 2026, and the 2026 Long Term Care Quality Assurance & Performance Improvement Plan. In addition, the results from 2025 UMCM Oversight Audit of measurement year (MY) 2024 were presented and approved. The following general documents were adopted/approved, Medical Policies, and Appeals & Grievances Policies & Procedures Annual Review. The following Quality Improvement Reports were reviewed and approved: Appeal and Grievance Dashboard & Quarterly A&G Reports; Potential Quality Issues (PQI) Report, and additional QI Reports for Q2. The Utilization Management & Case Management (UMCM) reports reviewed were the Key Indicator Report and UM Concurrent Review Report, the Over/Under Utilization Report 2026, and additional UMCM reports.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The Access Related Reporting for Q2 included the Access Work Group Quarterly Report, the Access Workgroup Minutes from January 2026, and other Access-related reporting. The quarterly Pharmacy reports reviewed were Pharmacy Executive Summary, Operations Metrics, Top 25 Medication Prior Authorization (PA) Requests, the Quality Assurance Interrater Reliability Results (IRR) and Quality Assurance Results. 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 during Quarter 2 2025 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 or Mental Health Issue. Quality Improvement activities also included the Institute for Healthcare Improvement (IHI) Health Equity Focused Well-Child Sprint Collaborative (Phase 2) in Fresno County. Overall, during Quarter 2 Medical Management identified two areas of non-compliance through routine monitoring. Of these two areas, one corrective action plan closed, and one remains open through the end of Quarter 2 2026: • Utilization Management Turnaround Times for Prior Authorization Deferrals - Closed • Blood Lead Screening in Children – provision of anticipatory guidance by providers – Open. Health Net has been notified of the unsatisfactory performance in these areas and Corrective Action Plans were received. Oversight and monitoring processes will continue.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<u>Credentialing Sub-Committee Quarterly Report</u> 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. Reports covering Q4 2025 were reviewed for delegated entities and Q1 2026 for HN, including Behavioral Health. 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. 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. The Access & Availability Substantial Harm Report Q1 2026 was presented and reviewed. 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). 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The NCQA Information Integrity Credentialing Oversight Report Q1 2026 was presented and reviewed. 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. 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. Follow-up activities will be scheduled, and ongoing monitoring and reporting will continue <u>Peer Review Sub-Committee Quarterly Report</u> The Peer Review Sub-Committee met on 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. The 2026 Adverse Events Report for Q1 was reviewed. 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Eight (8) cases were quality of care grievances, three (3) were 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Equity Report** S. Xiong-Lopez, EqO	review. Zero (0) cases required escalation for presentation at the Peer Review Committee. Zero (0) cases required reporting for 805.01 in Q1 2026. 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. **Equity** <u>Equity Report</u> Current updated activities for Health Equity include the following: <u>FCHIP HOPE HUB</u>: 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		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	opportunities to improve equitable access to developmental disability services and supports. 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	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. The Plan 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: Evidence for compliance of HE oversight is currently under review. Health Equity Community Activities/ Updates June 2026: DHCS, Chief Medical Officers and Chief Health Equity Officers from Health Plans across CA, both commercial and Medicaid plans met in June in Okland to discuss upcoming changes in the State. 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 include: • UIS Transition: Additional guidance, planning forums, and transition communications are coming in the next 1–2 months.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	• 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. **Executive Report** <u>Executive Dashboard</u> Enrollment as of May 2026 is 412,904. Enrollment for Anthem is approximately 189,246, and the enrollment for Kaiser is approximately 14,517. Market Share is currently approximately 66.96%. 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. Regarding State activities and the budget, the unsatisfactory immigration status members are going to be leaving the Medi-Cal managed care plan and going into fee for service effective January 1, 2027. The Plan anticipates this will impact potentially approximately 50,000 of our members. In addition, the outstanding issue is trying to plan in terms of how the transition is going to occur with DHCS. Medi-Cal managed care plans are wanting to serve a role in care coordination. That advocacy work is taking place to see if DHCS is receptive. If the state wants to engage Medi-Cal managed care plans in some kind of care coordination activities, it will more than likely warrant an agreement. If there's an agreement that's warranted, it would have to come to the Plan's Commission, as the CEO may lack the authority to execute agreement. If this is deemed accurate, the Board would have to decide whether to be involved in that kind of work or not.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
11. Final Comments from Commission Members & Staff	Jeff Nkansah announced the retirement of Mary Lourdes Leone, Chief Compliance Officer, effective 7/31/26. She was presented with a certificate and plaque in honor and recognition of her 11 years with CalViva Health. Jeff Nkansah also recognized Lisa Lewis, PhD, for her time serving on the FKM RHA Commission. Dr. Lewis was not present for the meeting. A special meeting may be called to further discuss item discussed in Closed Session.		
12. Announcements	None.		
13. Public Comment	None.		
14. Adjourn	The meeting adjourned at 3:40 pm. The next Commission meeting is scheduled for September 17, 2026, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
"Special" Meeting Minutes
July 28 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**, 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	✓	**Jordan Wamhoff**, Madera County Board of Supervisors (Alternate)
✓*	**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 1:00 pm. A quorum was present.		
#2 Roll Call	A roll call was taken for the present 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 Public Comment	None.		
#4 Closed Session	Jason Epperson reported out of closed session. The report on closed session is that the commission discussed in closed session item 4A, conference legal counsel, anticipate litigation, significant exposure to litigation pursuant to government code section 54956.9, paragraphs two or three of subdivision D. The matter was discussed in closed session, direction was given to staff and negotiators. The commission took no other reportable action and recessed from closed session and adjourned the meeting at 2:29 p.m.		***No Motion***
#4. Adjourn	The meeting adjourned at 2:29 pm. The next Commission meeting is scheduled for September 17, 2026, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

May 21, 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		
✓	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 11:31 am, a quorum was present.		
#2 Finance Committee Minutes dated March 19, 2026 Attachment 2.A Action, D. Maychen, Chair	The minutes from March 19, 2026, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Neves / Soares)*
#3 Financials – as of March 31, 2026 Action D. Maychen, Chair	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		Motion: *Financials as March 31, 2026, were approved* *6 – 0 – 0 – 1* *(Frye / Rahn)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	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 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.		
#4 Annual Review of Finance Charter Action D. Maychen, Chair	No edits or revisions were recommended during the annual Charter review. This was approved to move to Commission for final approval.		Motion: *Approve annual review of Finance Charter to move to Commission for full approval* *6 – 0 – 0 – 1* *(Soares / Frye)*
#5 Announcements/Comments	The State released their 2026-2027 May revised budget confirming the CalViva Health budget assumption that the undocumented members will move out of Medi-Cal managed care and into a FFS delivery system effective 1/1/2027. This will affect approximately 52K CalViva members. The undocumented members moving in FFS delivery system will still receive full scope Medi-Cal benefits, with the exception of Community Supports and Enhanced Care Management.		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	In reference to the MCO taxes, when budgeting for FY 2027, the Plan budgeted MCO taxes to end this calendar year and not budget any additional MCO taxes after 2026 as it was unknown how any new MCO tax would be structured. With the State's May revised budget, the State is looking to submit an MCO tax proposal that 1) is not compliant with H.R 1 but is compliant with Prop 35 which the State projects to be rejected by CMS, and 2) that is compliant with H.R. 1 but not compliant with Prop 35, which they believe will be approved by CMS. More discussion to take place at the Commission meeting. CalViva Health is currently exploring a new TPA, and Retirement Plan Advisor for the retirement plans. Currently in the process of obtaining bids and will provide future updates.		
#6 Adjourn	Meeting was adjourned at 11:44 am		

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission
Dated: 7/16/26

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson
Dated: 7/16/2026

CalViva Health
Finance
Committee Meeting Minutes

July 16, 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		
✓	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 May 21, 2026 Attachment 2.A Action, D. Maychen, Chair	The minutes from May 21, 2026, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Frye / Neves)*
#3 Financials – as of May 31, 2026 Action D. Maychen, Chair	As of May 2026, total current assets were approximately $503.2M; total current liabilities were approximately $307.2M. Current ratio is approximately 1.64. TNE as of the end of May 2026 was approximately $205.6M which is approximately 690% above the minimum DMHC required TNE amount. For the DHCS standard, the minimum required TNE is approximately $197M, which the Plan is approximately $8.4M above the DHCS standard.		Motion: *Financials as May 31, 2026, were approved* *6 – 0 – 0 – 1* *(Soares / Neves)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	Interest income actual recorded was approximately $8.9M which is approximately $4.2M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $2.17B which is approximately $316.4M more than budgeted primarily due to rates and enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $1.4B which is approximately $306.1M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $51.4M which is approximately $3.4M more than budgeted due to enrollment being higher than projected. Labor expense actual recorded was approximately $4.3M which is approximately $621K less than projected mainly due to open positions during the current fiscal year. License expense actual recorded was approximately $1.2M, which is approximately $453K less than budgeted due to the DMHC license fee being less than projected. All other expenses are in line or below budgeted amounts. Total net income through May 2026 was approximately $21.5M, which is approximately $13.2M more than budgeted primarily due to interest income being approximately $4.2M more than budgeted and enrollment and rates being higher than projected.		
#4 Annual Review of Investment Policy Action D. Maychen, Chair	No edits or revisions were recommended for the annual review of the Investment Policy.		Motion: *Approve annual review of Investment Policy* *6 – 0 – 0 – 1* *(Frye / Soares)*
#5 Announcements/Comments	During the May Finance meeting it was discussed that as a part of the Plan's FY 2027 budget, the State was looking to change how they paid State directed payments which are supplemental payments that the State pays the Plan, and in turn, the Plan then pays the Providers, primarily hospitals, those supplemental payments. In the Plan's FY 2027 budget, a change was included relating to how the Plan accounted for the State directed payments from a balance sheet transaction to an income statement transaction, due to the State planning to pay State directed payments on a at risk, prospective basis beginning 1/1/27. However, DHCS has confirmed they will delay the implementation until 1/1/28. For the Plan's FY 2027 budget, a revised budget will not be presented until the Plan receives clarification on the MCO taxes which the governor signed as part of the State fiscal year 2026 - 2027 budget on 6/29/26, which has been sent to CMS		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	for federal review and approval. It has been confirmed the State is going to move forward in moving the UIS population out of Medi-Cal managed care into a Fee-For-Service (FFS) delivery system effective 1/1/27, which equates to approximately 50K CVH members as of July 2026.		
#6 Adjourn	Meeting was adjourned at 11:42 am		

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

Dated: Sept. 17, 2026

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 9/17/26

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
May 21st, 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)**	✓	**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 10:02 am. A quorum was present.	
#2 Approve Consent Agenda -Committee Minutes: March 19,	March 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 - A&G Inter-Rater Reliability Report (Q1 2026) - A&G Classification Audit Report (Q1 2026) - Quarterly A&G Member Letter Monitoring Report (Q1 2026) - CCC DMHC Expedited Grievance Report (Q1 2026) - A&G Validation Audit Summary (Q4 2025) - Concurrent Review IRR Report (Q1 2026) - Quarterly CA Operations Oversight Audit of Call Center Inquiry Calls (Q1 2026) - Medical Policies Provider Updates (Q1 2026) - Provider Office Wait Time Report (Q1 2026) - California Children's Services Report (Q1 2026) - TurningPoint Musculoskeletal Utilization Review (Q4 2025) - Access Workgroup Minutes: January 2026 - Access Workgroup Quarterly Report (Q1 2026) (Attachments A-N) **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.	(Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business/A&G: - A&G Dashboard and Turnaround Time Report (March 2026) - A&G Executive Summary (Q1 2026) - A&G Quarterly Member Report (Q1 2026) (Attachments O - Q) **Action** Patrick Marabella, M.D., Chair	The **Appeals & Grievances Dashboard through March 2026, Appeals & Grievances Executive Summary Q1 2026, and Appeals & Grievances Quarterly Member Report Q1 2026** were presented. Appeals and Grievances can be submitted via phone, fax, email, or online. Appeals and Grievances are categorized and reported on the dashboard, with supportive narratives in the separate quarterly reports. Monthly Excel files include the logs identifying each member who submitted a grievance during the monthly reporting period with a narrative description of the grievance and resolution (as applicable). • Appeals growth is concentrated in Fresno and Madera Counties, not systemwide. • Grievance increases are driven primarily by Fresno and Kings Counties. • A small number of issue types drive the majority of Appeals and Grievances. o 93.1% of Appeals fall into just two categories: Community Supports and Not Medically Necessary o 81.5% of Grievances are driven by five categories: Interpersonal, Transportation, Administrative Issues, Balance Billing, and Access to Care. • Balance Billing, transportation, and interpersonal issues continue as areas of opportunity. o Not Medically Necessary appeals o Quarter Over Quarter (QoQ) grievance increases: Balance Billing, transportation, and interpersonal issues o QoQ grievance decreases: Administrative Issues, Access to Care • Specific Appeal subcategories that present the strongest opportunities for intervention: o Under not medically necessary: ▪ Year Over Year (YoY) Appeal increases (top drivers): DME – Other, Diagnostic – MRI ▪ QoQ Appeals increases: DME – Other, Diagnostic – MRI o Under Community Supports: ▪ YoY Appeals increases (top drivers): Meals/Medically Tailored Meals, Housing Deposits ▪ QoQ Appeals increases: Meals/Medically Tailored Meals, Housing Deposits • Targeted actions can reduce Appeals and Grievances to improve the Member Experience: Provider education and vendor accountability offer the fastest relief. o Appeals/Not medically necessary – DME/Other/Diagnostic MRI ▪ Educate providers on the criteria for medical procedure coverage.	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (March 2026) - A&G Executive Summary (Q1 2026) - A&G Quarterly Member Report (Q1 2026) (Pascual/Ramirez) 4-0-0-4

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	▪ Ensure providers are submitting all needed information prior to medically necessary procedures. o Appeals/Community Supports – Medically tailored meals (14% overturned/86% upheld) ▪ Educate providers on qualification criteria. o Appeals/Community Supports – Housing Deposits (20% overturned/30% upheld/50% Partial) ▪ Educate providers/CBOs on the qualification and submission requirements. o Grievances/Prior Authorization Delay ▪ The provider should keep the member informed of the prior authorization timeline for approval. ▪ Continue providing routine live and recorded provider training webinars to address prior authorizations. o Grievances/Inappropriate Payment Demand (In-network providers) ▪ Coordinate with participating providers to reinforce billing guidelines and ensure members are not receiving inappropriate payment demands. ▪ Increase provider education on balance billing regulations and escalate repeat offenders through the vendor accountability process. o Grievances/General Complaint Vendor ▪ Implement a structured vendor performance review to identify recurring complaint patterns and establish corrective action plans. ▪ Enhance vendor CSR training on grievance resolution protocols and member communication standards. o Grievances/Transportation Missed Appointment ▪ Request feedback from the vendor on how they will address complaints related to no-show transportation. o Grievances/Provider ▪ Expand provider education on patient communication, empathy, and caring standards to address the increase in provider-related grievances. ▪ Develop targeted interventions for provider staff interactions, including office practice standards and member experience training.	
#3 **QI Business**	The **Potential Quality Issues (PQI) Report Q1 2026** provides a summary of Potential Quality Issues	**Motion:** *Approve*

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- Potential Quality Issues (Q1 2026) (Attachment R) **Action** Patrick Marabella, M.D., Chair	(PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, a non-member, or a Peer Review activity. Peer Review activities include cases with a severity code level of III or IV, or any case that the CVH CMO requests to be forwarded to Peer Review. The PQI report also includes behavioral health under SB 850 (parity regulations). Data for Q1 2026 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 18 at level zero (0), two (2) at level one (1), and nine (9) cases scored at level II; one (1) case at level IV.	- Potential Quality Issues (Q1 2026) (Pascual/Ramirez) 4-0-0-4
#4 Key Presentations - Health Equity Work Plan End of Year Evaluation & Executive Summary 2025 - Health Equity Program Description & Change Summary 2026 - Health Equity Work Plan & Executive Summary 2026 (Attachment S - U) **Action** Patrick Marabella, M.D., Chair	The **Health Equity 2025 Executive Summary and Annual Work Plan Evaluation, 2026 Program Description with Change Summary, and 2026 Executive Summary and Work Plan** were presented. 1. **2025 Health Equity Work Plan Annual Evaluation.** Summary of activities accomplished and improvements made over the last calendar year, and all 2025 work plan activities completed. Highlighted activities completed by category include: • Language Assistance Services o A member newsletter article on how to access language services was completed and disseminated. o One hundred and twenty-five (125) staff completed their bilingual assessment/re-assessment. o MY2024 Geo Access report completed in November. o Twenty-six (26) translation reviews were completed in 2025. o Attended quarterly CAHPS Action Plan meetings and provided feedback for health equity interventions. o Ten (10) health education materials were field-tested. • Compliance Monitoring o HEQ reviewed eight (8) interpreter complaints and 29 grievance cases (27 medical/physical and two (2) behavioral health) with three (3) interventions identified. o The 2024 grievance trending report was completed in Q2 2025. o Launched FindHelp and Cozeva integration in 2025. o Two (2) FindHelp trainings were completed for staff, with 245 attendees and two (2)	**Motion:** *Approve* - Heath Equity Work Plan End of Year Evaluation & Executive Summary 2025 - Health Equity Program Description & Change Summary 2026 - Health Equity Work Plan & Executive Summary 2026 (Waugh/Pascual) 4-0-0-4

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	provider trainings with 86 attendees. New programs (288) were added to the platform. • Communication, Training, and Education o One (1) A&G training was completed on coding and resolution of grievances. o Two (2) Call Center trainings were conducted for 47 new staff. o Providers were updated on cultural practices, Language Assistance Program (LAP) services, health literacy, and online cultural competency/Office of Minority Health (OMH) training. o Language identification posters for provider offices were remediated and posted in the provider library. • Health Literacy, Cultural Competency, and Health Equity o English material review completed for a total of 58 materials. o Conducted Plain Language training for nine (9) staff. o Implemented Diversity, Equity, and Inclusion (DEI) and Transgender, Gender-Diverse, and Intersex (TGI) trainings for providers to meet All Plan Letter (APL) 24-017 and APL 24-018. Cultural competency training has been extended to be completed by providers by 12/31/2026. o Completed cultural competency education through Culturally and Linguistically Appropriate Services (CLAS) Month. o Supported the completion of quality projects for Well Child Visits (W30-6+) for 0-15 months and Substance Use Disorder (SUD)/Metal Health (MH) follow-up after ED Visit. o Completed three (3) focus groups on perimenopause/menopause. Perimenopause and Menopause Awareness Campaign was completed in October 2025. 2. **2026 Health Equity Program Description**. Roadmap for structure, resources, and monitoring. Updated annually with changes noted below: o Pages 4 & 8. Updated NCQA Accreditation name. o Page 10. Due to DHCS APL 25-005, update the tagline term to Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (NOA). o Page 12. Removed list of topics from Cultural Competency Training and provided reference to the CVH Policy (CA.CLAS.10). o Page 14. Included information on training completed by providers, which can be found in the provider directory. o Page 15. Update the health literacy process to include "Content and Layout Review	

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	checklist to streamline EMRs". Updated the title of the section. o Page 16. Changed the checklist name from Cultural Competency and Plan Language checklist to Content and Layout Review checklist. o Page 17. Update Health Equity Interventions to new intervention strategies. o Page 22. Remove PNA from the Health Equity Program Description, as responsibility has moved to the Population Health Management team. o Page 26. Removed Director of Program and added VP of Quality Management. 3. **2026 Health Equity Work Plan.** The plan for Health Equity activities throughout the year. Updated annually with a mid-year evaluation of progress. The 2026 Work Plan is consistent with the 2025 Work Plan while incorporating enhancements into four (4) categories: • Language Assistance Services • Compliance Monitoring • Communication, Training, and Education • Health Literacy, Cultural Competency, and Health Equity o Key updates include: ▪ Removed Population Needs Assessment (PNA) from the workplan as the Health Equity Department now 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 three (3) targeted clinic sites from Clinica Sierra Vista in Fresno County. o Adding three (3) 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	

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	Council by Q3 2026. ▪ 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. *There were no additional questions or concerns from the Committee.*	
#4 Key Presentations - Health Equity Language Assistance Program Report 2025 (Attachment V) Action Patrick Marabella, M.D., Chair	The **Health Equity Language Assistance Program End-of-Year Report for 2025** was presented and reviewed for an annual comparative analysis of language service utilization. CVH Race/Ethnicity as of 12/31/25 is as follows: (n=427,003) • Latino/Hispanic 72%: 305,935 • White/Caucasian 9%: 39,946 • Asian/Pacific Islander 9%: 36,480 • Unknown/Blank 3%: 13,951 • African American/Black 4%: 18,673 • Other 2%: 10,268 • American Indian/Alaska Native 1%: 1,750 Spanish and Hmong are CVH's Threshold Languages. Spanish 99%: 59,592 consistently has the highest volume, and Hmong was .09%: 827 calls. Interpretation utilization was performed via the following: • 76% (2,935) telephonic interpreters down from 80% in 2024 • 21% (791) face-to-face – up from 18% in 2024 • 3% (130) Sign language – up from 2% in 2024 • 0.1% (2) Video Remote Interpretation – consistent with 2024 Behavioral Health interpretation was performed via the following: • 6% telephonic interpreters • 33% face-to-face • 40% Sign language • 20% Video Remote Interpretation Limited English (LEP) and non-English membership remain high for the CVH population, and therefore, interpreter services are integral to maintaining safe, high-quality care.	**Motion:** *Approve* - Health Equity Language Assistance Program Report 2025 (Waugh/Pascual) 4-0-0-4

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	Discussion: *Dr. Ramirez asked how much utilization there is of the interpretation services overall, not by modality?* *Dr. Marabella indicated that certified interpreters are supposed to be present in a clinic setting or hospital. However, it is not uncommon for a family member to interpret, which increases risk due to members not consenting to treatment or clearly understanding the situation. The risk increases outside of the threshold languages, as fewer people speak Russian, Arabic, or specific dialects, etc. Interpretation services are not being utilized as much as they should be. All members can call certified interpreter services available 24-7.* *Sia Xiong-Lopez added that Community Health Workers in the CalAIM program for enhanced case management routinely request interpreter services.* *Dr. Ramirez wondered how often providers are taking it upon themselves to offer interpretation services versus using CVH interpreters.* *Dr. Marabella indicated that there was no way to know, but utilizing certified interpreters would be the best option. It is probably easier for clinics to use their own staff, but that also brings up access issues if the in-house interpreter is busy or out of the office.* *Dr. Ramirez asked if CVH measures how many calls were performed by CVH interpreters.* *Dr. Marabella quoted the report stating that, "Member Services Department representatives handled a total of 161,035 calls across all languages. Of these, 60,419 (38%) were handled in Spanish and Hmong. A total of 3,858 interpreter requests (specific request for interpretation with a provider) were fulfilled for CVH members; 2,935 (76%) of these requests were fulfilled utilizing telephonic interpreter services, with 791 (21%) for in-person."* *There were no additional questions or concerns from the Committee.* *Maria McDivitt left the meeting at 10:52 am and returned at 10:53 am.* *Morgan Simpson left the meeting at 10:55 am and returned at 10:58 am.*	
#4 Key Presentations - PHM Strategy Description 2026 (Attachment W) Action Patrick Marabella, M.D., Chair	The **PHM Strategy Description & Change Summary 2026** was presented. The Population Health Management (PHM) Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Changes to the **2026 Strategy Description** include: • Population Needs Assessment (PNA) (pgs. 2, 3): Added reference to the renaming of Population Needs Assessment to "Local Planning". Added Local Planning requirements,	**Motion:** *Approve* - PHM Strategy Description 2026 (Waugh/Ramirez) 4-0-0-4

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	including participation in each LHJ's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process and data sharing. • Stakeholder Engagement (pg. 4): Removed the requirement for the PNA report to be available on the health plan's website. • Population Stratification (pgs. 4-7): 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 how SDoH needs are identified. • Basic Population Health Management (BPHM) (pg. 13): Added information on the First Year of Life program. Added statement on Care Management availability to members at any time and at any age to support with physical health, behavioral health, or SDoH needs. • Transitional Care Services (pg. 14) Changed "Conducting an initial outreach call within 72 hours of inpatient referral" to "... successfully connecting with the member within seven (7) days of discharge to complete an inpatient discharge risk assessment". Removed "A minimum of two (2) follow-up calls are made to the Member within fifteen (15) days of discharge". • PHM Programs and Services (pgs. 15-25) 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 Glycemic Status Assessment for Diabetes (GSD). Removed the value of directional improvement of 1-5% from the program goal. 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.	

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	○ Added Enhanced Care Management (ECM) to supplemental support for Members. ○ Updated details of the Diabetes Management Program goal to explain that a lower rate indicates better performance for GSD. Removed the value of directional improvement of 1-5% from the program goal. External Partnerships (pg. 28): Within Local Health Departments, COVID-19 information was removed, and community-based vaccination events were held. ○ Updated program name and eligibility criteria throughout. ○ Updated Program goal for Tobacco Cessation. ○ Updated eligibility criteria for Breast Cancer Screening (BCS) to 40-74 years. Added high-risk breast cancer screening e-project for appropriate member outreach, scheduling, and follow-up to program services. ○ 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 (pg. 28): Within Local Health Departments, removed COVID-19 information and added community-based vaccination events. • Data and information sharing with Practitioners (pg. 30): As the Behavioral Health Quality Improvement Program (BHQIP) ended, additional information was added on developing new partnerships and data exchange options to facilitate this type of bidirectional data exchange with organizations across California through the MOU process. *There were no additional questions or concerns from the Committee.*	
#4 Key Presentations - Continuity & Coordination of Care Improvement Plan (Attachment X) Action Patrick Marabella, M.D., Chair	The **Continuity & Coordination of Care Improvement Plan 2025** monitors aspects of continuity and effective coordination between medical and behavioral healthcare and CVH leaders and managers with the goal of improving patient safety by reducing miscommunication and addressing issues associated with Care Coordination. The purpose of this presentation is to review and discuss performance results from the activities selected for 2025 and to review and confirm activities selected for 2026. The committee will also discuss specific barriers to improvement, share information, and brainstorm applicable initiatives or potential actions that should be executed. Measures meeting goals and quality metrics: • Eye Exam for Patients with Diabetes (EED), Rating Score 4 • Prenatal and Postpartum Care (PPC) – Prenatal Rate, Rating Score 4 • Prenatal and Postpartum Care (PPC) – Postpartum Rate, Rating Score 3	**Motion:** *Approve* - Continuity & Coordination of Care Improvement Plan (Waugh/Ramirez) 4-0-0-4

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	• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Rating Score 2 • Follow-up After Emergency Department Visit for Mental Illness, seven (7) days Total Rate (FUM), Rating Score 2 • Follow-up After Emergency Department Visit for Substance Use, seven (7) days Total Rate (FUA), Rating Score 2 • Follow-up After Hospitalization for Mental Illness, seven (7) days Total Rate (FUH), N/A for CVH. • Follow-up After High-Intensity Care for Substance Use Disorder, seven (7) days Total Rate (FUI), N/A for CVH. • HEDIS® Diabetes Screening for Members diagnosed with Bipolar Disorder or Schizophrenia Prescribed Antipsychotic Medications (SSD), Rating Score 4 Opportunities for Improvement: HEDIS® HPR Measures • Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment Total Rate (IET). Rating Score 1 did not meet the performance goal, and therefore, an improvement plan is required. **Opportunities Recommended for 2026 with Potential Actions:** <u>#1 Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow-Up (IET).</u> Quantifiable Metric: HEDIS® Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow-Up (IET) Barriers: • The primary barrier is engaging members to continue treatment; members are successfully initiating treatment but are not consistently engaged in treatment following initiation, representing a gap in continuity of behavioral health care. Potential Actions: • Expand network to include alcohol treatment, medication-assisted treatment, and peer support services. • Create a resource directory that can be accessed and utilized by providers and members. • Create both a Provider Tip Sheet and Member Resource Sheet to include descriptions of the	

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	available resources and how they can be accessed and utilized via the Resource Directory of substance abuse providers and services. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® (Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment, Depression Screening & Follow Up (IET). <u>#2 Appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care.</u> Quantifiable Metric: • HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM) • HEDIS® Follow-Up After Emergency Department Visit for Substance Use (FUA) Barriers: • Timely provider notification of MH/SUD ED visits. • Lack of provider/member awareness of best practices for follow-up after MH ED visits • Limitations to relying on ADT reports for MH ED visits: too many notifications, difficulties when prioritizing outreach. • Member's resistance to BH or SUD treatment. Potential Actions: • Continue BH live member outreach calls after the MH ED visit. o Leverage internal MoCAT files to improve the member reach rate by offering additional phone numbers for outreach. • Implement Cozeva enhancements to increase and improve prioritized provider notifications about MH ED visits. • Embed staff (CHW, Substance Use Navigators, etc.) in high-volume EDs to conduct MH and SUD assessments and referrals that close HEDIS® gaps. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® Follow-Up After Emergency Department Visits for Mental Illness & Substance Use (FUM & FUA). *Discussion:* *Amy Schneider polled the Committee on whether the tip sheet and resource sheet are reasonable and helpful activities to pursue.*	

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	The Committee agreed. *Amy Schneider will forward a draft of both to the Committee for review before distribution.* *Amy also asked the Committee if there are any potential barriers to these activities.* *Dr. Ramirez said it would be easy to distribute a tip sheet internally for larger FQs.* *There were no questions or recommendations from the Committee.*	
#4 **Key Presentations** - CVH 2026 Long-Term Care Quality Assurance Performance Improvement Plan - Skilled Nursing Facility Quality Assurance and Performance Improvement Report (Q4 2025) (Attachment Y, Z) **Action** Patrick Marabella, M.D., Chair	The **CVH 2026 Long-Term Care Quality Assurance Performance Improvement Plan** was presented and reviewed. As part of CalAIM's benefit standardization and to move to a more seamless system, beginning January 1, 2023, DHCS initiated a transition of responsibility for Long-Term Care services from Fee-for-Service to Medi-Cal Managed Care Plans. • Starting with Skilled Nursing Facilities (SNF) • Followed by Subacute Care Facilities • Finally, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) The transition was completed in 2024. CalViva has a designated Long-Term Support Services (LTSS) Liaison. • With the 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. • Goal: Continuous, Data-Driven Improvement across the full long-term-care continuum. • Scope: Fresno, Kings, and Madera Counties in and out of network Skilled Nursing Facilities (SNF) Developed a Plan to Address Required Elements: • Ongoing, comprehensive program covering clinical care, quality of life, and resident autonomy. • Multi-source data integration: o Claims Data o Data from DHCS o CDPH Survey Data (Publicly available) o Critical Incident Data (*Never events*) o Appeal and Grievance Data o Satisfaction Data • Benchmark against Title 22/42, LTC MCAS measures, CMS quality metrics, others as indicated. • Oversight: QI/UM Committee and RHA Commission	**Motion:** *Approve* - CVH 2026 Long Term Care Quality Assurance Performance Improvement Plan - Skilled Nursing Facility Quality Assurance and Performance Improvement Report (Q4 2025) (Pascual/Ramirez) 4-0-0-4

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	Components of the Plan: • The main monitoring tool is a Quarterly QAPI Dashboard, which has been developed. • CalViva LTSS Liaison maintains the dashboard, leads SNF and stakeholder engagement, and ensures transparency. • A cross-functional team (LTSS, UM, Transitional Care, Contracting, Quality/Data Analytics, etc.) updates the dashboard every quarter by gathering and compiling data from the various sources. • QI/UM Committee reviews the Dashboard to identify trends and opportunities. • CVH collaborates with SNFs, the LTC Ombudsman, and CBOs for root-cause analysis and technical assistance. Through the LTC Dashboard, we will monitor: • 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 and investigating potential quality issues/critical incidents. Tied to Appeal and Grievance Data. • Adverse events: root-cause analysis, corrective action plans for prevention of recurrence (ensure CDPH has completed). • Active feedback loops with staff, residents, and families incorporated into the improvement cycle. Satisfaction/complaints. The **Skilled Nursing Facility (SNF) Quality Assurance and Performance Improvement Plan (QAPI) Dashboard (Q4 2025)** was presented and reviewed to provide a summary of key quality, regulatory, satisfaction, and performance measures for SNFs serving CVH members for oversight monitoring and identification of opportunities for improvement. The Dashboard will capture data from multiple sources, including but not limited to claims (ED and inpatient), DHCS Supplied WQIP data – scoring system that uses a combination of metrices across workforce, clinical quality and equity domains to determine incentive payments for SNFs, publicly available data (CMS and CDPH data including survey, complaint, critical incident), and MCAS/HEDIS® Long Term Care measures.	

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	Member Utilization and SNF Performance: • There are thirty-six (36) licensed SNFs in the CVH-designated service area. • In the last twelve (12) months, CVH members were admitted to ninety (90) different nursing homes statewide, averaging 1,080 patients monthly, with the majority in Fresno County. The Dashboard monitors eight (8) different issues/events, including preventable ED visits/hospital admissions/readmissions, healthcare-acquired infections, facility staffing issues, abuse/neglect, potential quality issues, adverse events, and member satisfaction/complaints. A weighted five (5) -point scale is used to evaluate each facility for quality of care and outcomes by assigning an overall score for quarterly comparisons and ranking over time. The Dashboard monitors the following Quality Categories: • Use of Anti-Psychotic Medications • Rate of Falls with Injury • Pneumococcal Vaccine Rate • Pressure Ulcers • UTI Rates • Staffing • Number of State Enforcement Actions • Infection Control Deficiencies • Quality of Care Deficiencies • Freedom from Abuse Deficiencies • Overall CMS Star Rating • Preventable Emergency Department Utilization • Preventable Inpatient Admission to Acute Care Charts presented provided the Q4 2025 results and identified the overall top-performing and bottom-performing SNFs in the CVH Region based on the weighted five (5)-point scale, including: • Top Ten (10) SNFs in CVH Service Region by Unique Member Utilization. • Overall Top and Bottom Performing SNFs in CVH Region. • Lowest and Highest Five (5) Performing SNFs serving CVH members. • Lowest and highest rates of preventable ED visits. • Lowest and highest rates of preventable acute inpatient admissions. Based upon these results, the following three (3) SNFs were selected as having the greatest	

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	opportunity to impact care and services provided to CVH members: 1. Manning Gardens Care Center (managed by Cambridge Health): Analysis of publicly available data shows a higher-than-state-average use of Antipsychotic Medications and Falls. They have shown improvement in their rate of UTIs. This facility is implementing the following to improve its quality outcomes: ▪ Hydration Rounds continue daily, all shifts. ▪ Pharmacy Education – Anti-Psychotic utilization education held in Q4 2025. In-service was conducted on 11/4/25 with all shifts. ▪ Management of BH: Psychiatrist-led in-service for all staff held in Q1 2026. 2. Kingsburg Center (managed by NewGen): Analysis of publicly available data shows a higher-than-state-average use of Falls, development of new wounds/ulcers, and UTIs. Member-level details are shared for additional investigation and targeted training. This facility is implementing the following to improve its quality outcomes: ▪ Hydration Rounds – Daily starting 3/1/26, dedicated staff will monitor availability and consumption of water – hydration rounds continue daily with all shifts. ▪ Repositioning Training and In-Services – Hosted during various shifts in March 2026, the Director of Staff Development and the Wound Care nurse provided training and education on repositioning, wound care, and techniques to relieve pressure. Arrangements will be made in Q2 2026 for a Wound Care Specialist physician to provide wound care and pressure sore in-service to the licensed and clinical staff at Kingsburg. ▪ Physical Therapy (PT) Team is making rounds to ensure all walkers are properly measured, starting 3/1/26. Rounds are conducted twice a month, and all new admits are assessed by PT within 48 hours of admission. 3. Community Subacute and Transitional: Analysis of publicly available data shows a better-than-average Fall rate and Antipsychotic Medication use. Rates of UTI and Pressure Ulcers are higher than the state averages, resulting in higher-than-expected ED utilization and inpatient admissions. This facility is implementing the following to improve its quality outcomes: ▪ Hydration Rounds - Daily, started on 9/1/25, dedicated staff will monitor availability and consumption of water. Hydration rounds to continue daily on all shifts. ▪ Physical Therapy Team Rounds to provide staff caregiver training on safe patient	

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	repositioning skills, starting 9/1/25 and conducted twice a month. ▪ All new admits are assessed by PT within 48 hours. Barrier Analysis: • Staffing Challenges in the Central Valley: Facilities report challenges with recruiting and retaining qualified Certified Nursing Assistants. 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. *Discussion:* *Dr. Ramirez asked when we would see results if changes were implemented in the fall of 2025.* *Dr. Marabella stated that we monitor trends quarterly to see if SNFs move out of the bottom five. There is a data lag.* *Dr. Ramirez asked if there was any sort of correlation made between the implementation of the activity and improvements in care.* *Dr. Marabella stated that the correlation is indirect. If the staff is doing physical therapy and wound care, then pressure ulcers should decrease. Hydrated members will have fewer UTIs.* *There were no additional questions or concerns from the Committee.* *Nicole Foss left the meeting at 11:00 am and returned at 11:02 am.*	
#5 UM/CM Business - Key Indicator Report & Turnaround Time Report (March 2026) - UM Concurrent Review (Q1 2026) (Attachments AA-BB) **Action**	The **Key Indicator Report & Turnaround Time Report March 2026 and the Utilization Management Concurrent Review (CCR) Report Q1 2026** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Acute Admissions: o MCE (Medicaid Expansion): Acute admissions and utilization remained consistent throughout Q1 2026, with figures closely aligned with 2025 averages. o TANF (Temporary Assistance for Needy Families): There was a minimal increase in admissions and utilization in Q1 2026 compared to 2025 levels. o SPD (Seniors and Persons with Disabilities): Q1 2026 utilization remained consistent.	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (March 2026) - UM Concurrent Review (Q1 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D., Chair	• Acute Bed Days: Have increased across all populations for Q1 2026. Monitoring will continue. • Average Length of Stay (ALOS): o ALOS remains within acceptable ranges across all populations, with slight increases that align with observed acuity trends. o Maintain current performance level. Length of stay will continue to be monitored through utilization reviews and quarterly reporting. o SPD to be monitored due to the increase in ALOS. • Readmissions: o MCE declined in Q1 2026. o TANF remained stable. o SPD improved. • Next Steps: o Maintain rigorous utilization review practices aligned with discharge planning. o Continue to support and monitor current performance levels. o Maintain robust collaboration between UM and CM teams to promote seamless care transitions and optimal member support. o Sustain and expand outreach with key hospital partners to strengthen onsite presence and foster coordinated transitions for members moving to lower levels of care. • Turnaround Time Compliance Goal 100%: o Routine Pre-Service Authorization w/Extension/Deferral TAT (non-BH) missed the goal of 100% in Q1 – Q3 2025 but returned to 100% compliance in Q4 2025 and Q1 2026. o Expedited Pre-Service Authorization w/Extension/Deferral TAT (non-BH) in March and April. ▪ TAT Non-Compliance issues were due to a change in the staffing model from LVNs to RNs, as the RNs were being onboarded, and have since been resolved. o The CCS rate remains stable.	
#5 UM/CM Business - PA Member Letter Monitoring Report (Q1 2026) (Attachment CC)	The **PA Member Letter Monitoring Report Q1 2026** 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 the correct anticipated decision date for deferral letters.	Motion: *Approve* - PA Member Letter Monitoring Report (Q1 2026)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	• 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 before 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.	(Pascual/Ramirez) 4-0-0-4
#5 UM/CM Business - Over/Under Utilization Report 2026 (Attachment DD) **Action** Patrick Marabella, M.D., Chair	The **Over Under Utilization Report 2026** was presented to review the impact of the UM Programs to detect and correct potential under and over-utilization through comprehensive monitoring efforts. Key Trends (PTMPY analysis was used to adjust for changes in membership): • **Inpatient Count:** The data reflects a steady 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. • **Emergency Room Utilization:** ER utilization continues to decline across all three (3) counties. • **Outpatient Utilization:** OP utilization remains highest in Fresno, intermediate in Madera, and lowest in Kings. • **Procedure Specific Trends:** • C-section rates are still an issue, but they are improving in Fresno, where the county is participating in DHCS-led Transforming Maternal Health (TMaH) discussion. • Bariatric surgery utilization continues to decline year-over-year across all counties. Obesity management has evolved in recent years with greater availability of medications. As of 1/1/2026, GLP-1 drugs are not a benefit for adult Medi-Cal members for weight loss or weight loss-related indications. Medi-Cal will review on a case-by-case basis requests for medical necessity indications (e.g., cardiovascular disease, sleep apnea, etc.) approved by the U.S. Food and Drug Administration (FDA). Implications for CM: • Strengthen post-discharge planning to reduce readmissions, especially for high-growth surgical and chronic condition cohorts. • Implement targeted complex CM for frequent utilizers.	Motion: *Approve* - Over/Under Utilization Report 2026 (Pascual/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Address social determinants impacting ER utilization through stronger community resource partnerships. *Discussion:* *Dr. Ramirez asked if the overall membership remained the same or increased.* *Dr. Marabella indicated that membership is declining. At the peak, it was close to 450,000, but with the changes in eligibility criteria, we may see it decline under 400,000.*	
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q1 2026) - Pharmacy Operations Metrics (Q1 2026) - Pharmacy Top 25 Prior Authorizations (Q1 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q1 2026) (Attachments EE-HH) **Action** Patrick Marabella, M.D., Chair	The **Pharmacy Executive Summary Q1 2026** 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 Q1 2026. o Overall, TAT for Q1 2026 was 100%. o PA volume was lower in Q1 2026 compared to Q4 2025 and there were some drug-specific differences. Volume was consistent in all months in Q1 2026. The **Pharmacy Operations Metrics Q1 2026** 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 100%. The **Pharmacy Top 25 Prior Authorizations Q1 2026** 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 Q1 2026 were mostly consistent with the top 25 drugs reviewed in Q4 2025, with a few placement variations. IVIG appears in the top 25, which had not previously been seen for several quarters. Pegfilgrastim continues to drive PA volume due to the existence of preferred products in the PA policies versus the branded products. Several drug requests in Q1 2026 had high denial rates based on the non-preferred status of the requests.	Motion: *Approve* - Pharmacy Executive Summary (Q1 2026) - Pharmacy Operations Metrics (Q1 2026) - Pharmacy Top 25 Prior Authorizations (Q1 2026) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q1 2026) (Ramirez/Pascual) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **Quality Assurance Reliability Results (IRR) for Pharmacy Q1 2026** 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 is 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 met. The overall score was 96%. • Three (3) sample cases had potential criteria application or documentation issues after plan review.	
#7 **Policy & Procedure Business** - A&G Annual Policy & Procedure Review (Attachment II) Action Patrick Marabella, M.D., Chair	The **A&G Annual Policy & Procedure Review** was presented to the committee. The following policy was presented for annual review with **no changes made:** AG-001 Member Grievance Process AG-002 Member Appeal Process AG-004 Handling DMHC Calls Regarding Urgent Grievances **The following policies were presented for annual review and were approved with the following changes:** AG-005 Managing DMHC Cases: Annual review. Minor grammatical edits. Committee members agreed with the policy changes as stated and voiced no questions or concerns.	Motion: *Approve* - A & G Annual Policy & Procedure Review (Ramirez/Pascual) 4-0-0-4
#8 **Oversight Audit Business** - UM/CM (Attachments JJ) Action Patrick Marabella, MD, Chair	The **2025 UM/CM Oversight Audit** was presented and reviewed. CVH Medical Management staff conducted an oversight audit of HN's Utilization Management (UM) and Case Management (CM) functions. A variety of documents were provided and reviewed, including the UM/CM Program Description, Workplan and Annual Evaluation, a number of policies and procedures, extensive reports and data analyses, logs, and other documentation as evidence of compliance with established standards and regulations. One-hundred and forty-four (144) standards were assessed, with one-hundred and forty (140) in compliance, a 97% overall compliance rating. A corrective action plan has been requested to address three (3) opportunities for improvement mostly related to policy/documentation issues.	Motion: Approve - UM/CM (Waugh/Pascual) 4-0-0-4
#9 **Compliance Update** -Compliance Regulatory Report	Morgan Simpson 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 KK)	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**: Annual audits in progress: Call Center, Q4 2025 Claims/PDR, 2026 Credentialing, 2026 Health Education, 2026 Health Equity, 2026 Marketing, and the 2026 Provider Network. Completed audits since the 3/19/26, report to the Commission: UMCM 2025 (CAP) **Fraud, Waste, and Abuse:** Since the 3/19/2026 Compliance Regulatory Report, there were eight (8) new MC609 filings relating to: Inappropriate Billing: two (2) cases, Phantom Provider: two (2) cases, Insufficient Documentation: two (2) cases, False Representation: one (1) case, and Services not rendered: one (1) case. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** No change in status: DHCS will issue forward-looking guidance at future CAP closure and allow 90 days to implement any required changes. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** CVH submitted its monthly CAP update on 4/15/26 and will continue to send updates until the CAP is closed. **2026 DMHC/DHCS Joint Medical Survey Audit:** CVH submitted all required DMHC pre-audit documentation on 2/20/26 and DHCS pre-audit requirements on 5/1/26. DHCS sent a Verification Study Sample request on 5/7/26, and the Plan will submit files by 5/19/26. DHCS and DMHC will be on-site from 6/16/26 through 6/26/26 to conduct audit interviews. **Memorandum of Understanding (MOU):** Since 3/19/26, the Plan has executed the following MOUs: DMC-ODS Madera County **Revised ASA and CPSA with HN:** The DHCS approved the Plan's revised ASA and CPSA on 4/29/26 and subsequently filed them with the DMHC on 5/5/26. Upon DMHC approval, the ASA and CPSA will be fully executed and retroactively effective 7/1/25. **(RY)2026 (MY)2025 Timely Access and Annual Network Submission (TAR):** CVH submitted its Annual TAR filing to DMHC on 5/1/26 and is awaiting a response. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026. **Public Policy Committee (PPC):** The next PPC meeting will be held on 6/3/26, from 11:30 a.m. - 1:30 p.m., CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#10 **Old Business** -Lead Levels in Children (Attachment LL)	*At the March 19th QIUM meeting,* Dr. Cardona asked what the positive Lead exposure rate was for the County. Dr. Marabella reported that Fresno County has one of the highest rates of childhood lead poisoning in California, with approximately **1,500 children** affected, particularly in older neighborhoods. Fresno, Alameda, Los Angeles, and Monterey counties have all been identified as having high rates. Approximately **4.09%** of children tested in Fresno County (2022 data) had **elevated blood lead levels ≥ 3.5** (mu/g/dL), which is higher than many other California counties. **Elevated Levels:** In **2023, 5.85%** of children under 6 in Fresno County had blood lead levels (BLL) at or above 3.5 (mu/g/dL). **High-Risk Areas:** Specific ZIP codes, particularly in downtown Fresno (e.g., 93701), show higher incidences due to older housing. **Childcare Facilities:** A 2023 report indicated that 66 out of 73 tested childcare centers in Fresno County had water with lead levels exceeding 5 ppb. There is no "safe level". **Common sources** are paint, soil, dust, ceramics, crystals, imported toys, and stained glass. Other sources of lead can come from remodeling older homes, shooting ranges, or welding. The **Childhood Lead Poisoning Prevention Program** (CLPPP) offers home visitation, education, and inspection. CLPPP participates in the National Lead Poisoning Prevention Week in October and the National Poison Prevention Week in March annually.	
#11 **Announcements**	The next meeting is on July 16th, 2026.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 11:45 a.m.	

NEXT MEETING: July 16th, 2026

Submitted this Day: July 16, 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

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
July 16th, 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,** Senior Medical Management Services Manager
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA **(Alternate)**	✓	**Norell Naoe,** Medical Management Administrative Coordinator
		✓	***Courtney Shapiro,** Director, Community Relations & Marketing, CVH
	Guests/Speakers		
	None.		

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

ATTENDANT/PRESENTER	MOTIONS/MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D., Chair	The meeting was called to order at 10:02 a.m. A quorum was present. Dr. Marabella introduced Courtney Shapiro, CVH Director of Community Relations and Marketing, to the QI/UM Committee. Ms. Shapiro presented Attachment R.	

AGENDA ITEM/PRESENTER	MOTION/MAJOR DISCUSSIONS	ACTION TAKEN
#2 Approve Consent Agenda Committee Minutes: May 21, 2026 - Initial Health Appointment (IHA) Quarterly Report (Q4 2025) - Provider Preventable Conditions (Q1 2026) - County Relations Quarterly Report (Q1 2026) - Specialty Referrals Report (Q1 2026) - Standing Referrals Report (Q1 2026) - Evolent (Q1 2026) - SPD HRA Outreach (Q1 2026) - TurningPoint Musculoskeletal Utilization Review (Q1 2026) - Facility Site & Medical Record & PARS Review Report (Q3 & Q4 2025) - Access Work Group Minutes from 3/19/26 - Accessibility of Service Report (Primary, BH, & Specialty Care) - Assessment of Network Adequacy (BH & Non-BH) (Attachments A-M) **Action** Patrick Marabella, M.D., Chair	The May 21st, 2026, QI/UM Committee minutes were reviewed, and highlights from the consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link to the Medi-Cal Rx Contract Drug List was available for reference.	**Motion:** *Approve* Consent Agenda (Quezada/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 QI Business/A&G: - A&G Dashboard (May 2026) (Attachment N) **Action** Patrick Marabella, M.D., Chair	**The Appeals & Grievances Dashboard Report through May 2026** was presented and reviewed. Monthly Excel files include the logs identifying each member who submitted a grievance during the reporting period (monthly), with a narrative description of the grievance and the resolution. • The May Appeals & Grievances dashboard was reviewed; activity remained generally consistent with prior months, with 212 grievances received and 234 resolved. • Access to care remained the highest grievance category, largely related to prior authorization and PCP scheduling issues. • Balance billing decreased and may reflect a baseline trend; education will continue as the primary intervention. • Community Supports complaints and appeals remained elevated, primarily related to meals, housing-related services, and quality-of-service concerns. • Transportation, interpersonal clinic issues, and provider no-show grievances continue to be monitored; quality-of-care grievances remained low. • Appeals remained higher at 87 in May, all pre-service. • DME appeals mainly involved wheelchairs, CPAP, oxygen, and braces; imaging appeals mainly involved CTs, and PET scans. • A new "Other" appeals trend was noted involving providers using the member appeal process instead of the provider dispute or appeal process; this will be monitored and addressed through education if needed. • The uphold/overturn rate was approximately 40/40.	**Motion:** *Approve* - A&G Dashboard (May 2026) (Ramirez/Waugh) 4-0-0-4
#3 QI Business/A&G: - Behavioral Health Performance Indicator Report (Q1 2026) (Attachment O) **Action** Patrick Marabella, M.D., Chair	**The Behavioral Health Performance Indicator Report Q1 2026** The committee reviewed a substantially revised Behavioral Health report developed by CVH Medical Management leadership, HN's new BH leadership, and the BH operational team to improve visibility for CVH, the QI/UM Committee, and the Board. The consolidated report covers behavioral health activities, performance data, county coordination, care management, access, grievances, satisfaction, MOU-related information, membership and utilization trends, turnaround time compliance, approval and denial rates, mental health parity, care coordination referrals, case management activity, access standards, transportation utilization, county behavioral health updates, and member/provider education efforts. • QI 2026 data indicated that: o Overall CVH membership declined from approximately 425,000 to 410,000; unique behavioral health patients decreased from about 35,000 to 32,000; and service	**Motion:** *Approve* - Behavioral Health Performance Indicator Report (Q1 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM/PRESENTER	MOTIONS/MAJOR DISCUSSION	ACTION TAKEN
	intensity declined from 780 to 650 units per thousand. o Turnaround time compliance was 100%, with average turnaround time increasing from 4.1 days in 2025 to 5.4 days in 2026. o Case management volume declined by 782 cases, or 52%, while engagement remained approximately 70% and case complexity increased. o Care coordination included 922 screenings; Fresno County had the highest volume, adults represented about 78% of activity, and youth volume remained stable at 65. o Access availability standards were 100% compliant. o Transportation totaled approximately 12,000 behavioral health-related trips; SUD trips accounted for about 8,500 trips, or 67%, and Fresno County represented 92% of utilization. Transportation and access to behavioral health services were noted as important areas to monitor, particularly for SUD-related services and rural access limitations. o Behavioral health grievances remained low at eleven (11) total; satisfaction results are pending, with ECHO survey results expected in November. • Behavioral Health Tip Sheets for members and providers were shared for feedback and are nearing deployment to support education on available services and levels of care. *Discussion:* *Dr. Marabella asked the Committee members to provide feedback on the format of the revised report.* *Committee members provided feedback that the narrative summary was helpful and that graphics should continue to be available for reference and trend review.*	
#3 QI Business/A&G: - Lead Screening Quarterly Report (Q4 2025) (Attachment P) Action Patrick Marabella, M.D., Chair	The **Blood Lead Screening Quarterly Report (Q4 2025)** was presented to monitor blood lead screening in children, assess CVH's quarterly performance, and review anticipatory guidance monitoring. Screening compliance reflects clinical guidelines and reporting requirements and helps ensure CVH members receive anticipatory guidance related to lead poisoning prevention, blood lead level testing, and follow-up services from providers. Overall results have not changed significantly, and documentation of anticipatory guidance remains inconsistent. • Facility site review data showed anticipatory guidance documentation increased only slightly, from approximately 2% to 2.5%. • Medical record audits showed higher screening rates at 12 months, lower screening rates at 24 months, and inconsistent documentation of anticipatory guidance.	**Motion:** *Approve* - Lead Screening Quarterly Report (Q4 2025) (Ramirez/Quezada) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTION / MAJOR DISCUSSION	ACTION TAKEN
	• Q4 2025 lead screening compliance was approximately 33.38% overall, with the older age group continuing to show lower performance. • A special audit was conducted with high-volume providers to better understand the barriers associated with documentation of the provision of anticipatory guidance. Audit findings showed significant variation by provider and based upon EMR use; clinics using available anticipatory guidance prompts had much higher documentation rates (over 90%), while clinics not using prompts showed very low rates (0-10%). • Provider education and technical support were identified as key interventions, including encouraging clinics to activate EMR prompts, improve documentation workflows, and use point-of-care lead testing equipment when available. • Fresno County was noted as a high-risk area for childhood lead exposure, reinforcing the importance of improving screening, parent education, and documentation. *Discussion:* *The committee discussed the need to support providers through multiple approaches, including member outreach, provider lists, EMR enhancements, potential pilot support, and continuing education.* *Dr. Quezada asked why rates are low for FHCN providers if they are prompted in EMR systems.* *Dr. Marabella indicated that providers may not be responding to prompts. FHCN accounts for approximately 36% of CVH pediatric membership in Kings County. Kings County is performing below the 25th percentile. Further investigation is needed into the root cause of the lack of documentation for this metric in Kings County.* *Dr. Ramirez stated that providers are doing the blood test, but it is difficult to correctly code the anticipatory guidance as there is no specific code for it. Would a global texting campaign suffice? This would only meet the standard if there was evidence in the child's record indicating that parents were educated.* *Amy Schneider stated that CVH is using multiple methods to communicate with families, such as sending education letters to parents, but they would need to be included in the child's record to meet DHCS standards. CVH Providers are also receiving lists of members to target to meet the MPL.*	
#3 QI Business/A&G: - Enhanced Care Management	**Enhanced Care Management and Community Supports Performance Report (Q1 2026)** summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the	**Motion:** *Approve* - Enhanced Care

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
and Community Supports Performance Report (Q1 2026) (Attachment Q) Action Patrick Marabella, M.D., Chair	quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system with program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) are responsible for administering both ECM and CS services. This report now includes DHCS audit findings and corrective action plan (CAP) updates. • Of the 22,782 members who were assigned to the three (3) CVH counties, 4,330 were successfully enrolled in ECM, representing a 19% enrollment rate below the 30% goal; Madera was closest at 25.8%, followed by Fresno at 19.6% and Kings County at 10.8%. Children and youth, including child welfare and CCS populations, remain key growth opportunities. • CS activity remained high, with approximately 64,000 authorizations and 700,000 claims; top paid claims were concentrated in Housing Transition/Housing Sustaining/Housing Deposits Services (36%), Assisted Living Facility Transition (25%), Personal Care and Homemaker Services (12%), and Medically Tailored Meals/Medically Supported Foods (11%). • CS referrals through Findhelp totaled 348 across 24 providers, while claims activity was concentrated in Fresno, with lower reported rates in recent months. • ECM in-person engagement averaged 44%, and focused provider audits showed progress, though audit completion rates remain an area for improvement. • The DHCS CAP addressed three (3) areas: documentation of the seven (7) ECM core components, timely written notices for discontinued ECM services, and standardization of ECM member-facing materials. • Discontinuation notice requirements were reported as fully compliant for February and March, while documentation of the seven (7) ECM core components remains a work in progress. • The committee reviewed ongoing barriers, provider engagement efforts, incentives, audit follow-up, and corrective action tracking to support improvement.	Management and Community Supports Performance Report (Q1 2026) (Waugh/Quezada) 4-0-0-4
#4 Key Presentations - DHCS Community Reinvestment (Attachment R)	DHCS All Plan Letter 25-004 established Community Reinvestment requirements for Medi-Cal Managed Care Plans. As part of these requirements, health plans must invest a portion of net income in activities that address community needs and improve health outcomes. Courtney Shapiro presented the **DHCS Community Reinvestment Plan** to review CVH's investments and goals, evaluate the potential impact on health outcomes, and provide the QI/UM Committee with an opportunity to provide feedback before submission to DHCS. • Community Reinvestment funds are divided into Base Community Reinvestment and Quality	**Motion:** *Approve* - DHCS Community Reinvestment (Quezada/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTION / MAJOR DISCUSSION:	ACTION TAKEN
Action Patrick Marabella, M.D., Chair	Community Reinvestment categories. Quality Community Reinvestment investments must measurably advance health outcomes, address a documented community need, support Community Health Improvement Plans (e.g., improving prevention, screening, care access), and reduce health disparities, all while demonstrating measurable success. • **CVH Quality Community Reinvestment Obligation** (Net income calculated on 2024 Medical Loss Ratio (MLR)): **Fresno County $1,306,583; Kings County $144,904; Madera County $183,702; Total $1,634,379.** o Planning Process 2025-2026 (including County engagement and DHCS review) o Implementation Period 2027-2029. • Quality investments were selected based on each county's Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), Behavioral Health priorities, stakeholder engagement, and CVH quality performance opportunities. Focus by CVH County: **Fresno's Behavioral Health Early Identification and Navigation Initiative** focuses on behavioral health screening, suicide prevention, warm handoffs, referral coordination, and post-crisis follow-up, with potential partners including county behavioral health and public health departments, community-based organizations, healthcare providers, and hospitals. **Kings County's Community Health Workers/Promotores Initiative** focuses on care navigation, PCP linkage, health literacy, behavioral health referrals, and workforce development, with expected outcomes including improved access to care, increased preventive care, and reduced health disparities. **Madera's Women's Preventive Health Initiative** focuses on breast and cervical cancer screening, mobile mammography, community outreach, navigation, and follow-up support, with potential partners including county public health and behavioral health departments and community-based organizations. • Success measures across the Reinvestment Plan include individuals screened and referred, connections to care, referral completion, follow-up after crisis, CHWs trained or certified, navigation encounters, PCP connections, behavioral health referrals, childhood vaccinations, FUA/FUM performance, screening completion, early detection, navigation assistance, appointments scheduled, and improvement in relevant preventive-care quality measures. • The proposed portfolio is intended to improve preventive care and behavioral health outcomes, reduce disparities, and advance county Community Health Improvement Plans with	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	funding expected to roll out in July of 2027. *Discussion:* *Dr. Ramirez asked if there are enough behavioral health providers in Kings County. Dr. Marabella indicated that Kings County met the MPL for FUA and FUM. Additional promotores can increase the number of referrals made (success metric), which improves access rates. The HEDIS® scores with the greatest opportunity for improvement are in the pediatric domain for Kings County. Courtney Shapiro mentioned that the promotores are there to help members overcome access barriers and navigate getting care.* *For Madera's screening focus, Dr. Ramirez indicated that the hospital's temporary closure impacted breast cancer screening access. They have tried mobile mammography units in the past, but these units do not have historical images available for the radiologists' review, which can affect quality. Dr. Marabella indicated that an ideal solution would be to create a local imaging center that has mammography and ultrasound equipment. Rates should improve now that the hospital has reopened.* *The Committee had no further questions or recommendations.* *Maria McDivitt left the meeting at 11:12 AM and returned at 11:15 AM.* *Morgan Simpson left the meeting at 11:17 AM and returned at 11:20 AM.* *Nicole Foss left the meeting at 11:18 AM and returned at 11:20 AM.* *Courtney Shapiro left the meeting at 11:21 AM.* *Mary Lourdes Leone left the meeting at 11:21 AM and returned at 11:25 AM.*	
II4 Key Presentations - Care Management Program Evaluation & Executive Summary 2025 (Attachment S) **Action** Patrick Marabella, M.D., Chair	The **Care Management Program Evaluation and Executive Summary for 2025** was presented and reviewed. The Care Management (CM) Program encompasses Physical Health (PH), Behavioral Health (BH), Perinatal Wellness, and Transitional Care Services (TCS). The program is designed to support member wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. Its goal is to provide quality health care along a continuum, decrease fragmentation of care across settings, enhance the member's quality of life, and support efficient utilization of patient care resources. The Goals for 2025 were both met: • The first goal was to increase the number of cases managed. In 2025, total cases increased to 8,816, compared to 3,649 in 2024, representing 2.03% of the total CVH population managed	**Motion:** *Approve* - Care Management Program Evaluation & Executive Summary 2025 (Quezada/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTION / MAJOR DISCUSSION	ACTION TAKEN
	through PH, BH, First Year of Life, perinatal case management, or TCS. • Maintain ≥90% compliance with the medical record documentation requirements: Each program achieved an overall file review score of 90% or greater in 2025. * Overall average was 94%. o *Physical Health and Transitional Care Services each fell below goal in one quarter during 2025; however, they were back above goal in the next quarter. CM Quarterly Audit Results of Complex & Non-complex File Reviews by Program in 2025 (Overall Average Scores: PH = 93%, BH = 95%, Perinatal = 98%, and TCS = 91%. For members enrolled in CM, readmissions decreased by 7.7%, ED visits decreased by 17.8% per 1,000 members per year, and inpatient, outpatient, and pharmacy claim volume decreased compared to the 90 days before CM enrollment. Clinical Outcomes for High-Risk OB: • First Prenatal Visit in 1st Trimester - improved 15.5% (Goal ≥8%) • Reduction in Pre-term Deliveries by 5.1% (Goal 2%) • Timely Post-partum Visit – improved 11.9% (Goal ≥10%) Member Satisfaction Survey results for 2025 included 75 respondents, with eleven of the thirteen (11/13) questions answered. • The goal of a 90% positive response (very satisfied – satisfied) was met (92%). • 59% are satisfied with the ability to reach their CM. • 84% reported CM helped them to reach their health goals. • 81% reported CM helped to organize care with their MD and other caregivers. • There were five (5) complaints in 2025. Key Accomplishments for 2025: • 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 and FYoL 55%, and TCS 45% increased) • Continue to enhance the TCS program to meet PHM requirements: o On-site staff at additional Hospitals (opened communication with Valley Children's)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Launched texting program with members Program Goals for 2026: • Enhancements in TCS program to meet updated PHM requirements. o Increase length of program for postpartum TCS cases. o Increase staffing. o Create a birthing checklist in portal and system. o Expand onsite staff presence at hospitals. • Launch enhanced Pregnancy Program o Utilize trimester-based assessments. o Ensure alignment with PHM policy update for postpartum member requirements. • Manage more members across CM programs. • Increase use of member texting programs. • Utilize texting platform to conduct timely satisfaction surveys. • Increase the ED visit reduction goal for members in CM. *The Committee had no further questions or recommendations.*	
#5 UM/CM Business - Key Indicator Report & Turnaround Time Report (May 2026) (Attachment T) **Action** Patrick Marabella, M.D., Chair	**The Key Indicator Report and Turnaround Time Report for May 2026** were presented to show inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness. • Acute admissions were slightly down overall, while the Expansion and SPD categories increased. Readmission rates followed a similar pattern. • Bed days increased overall; TANF bed days showed a recent increase after prior decreases, while SPD bed days remained relatively stable. • Average length of stay increased overall; however, Expansion and SPD length of stay decreased. • Utilization data for Q1 2026 initially appeared to demonstrate reductions in all categories; however, upon further analysis, some data errors were identified and when corrected showed no significant overall changes with trends remaining consistent with prior months; TANF readmissions remained stable, consistent with other categories which continued to demonstrate random variation. • Turnaround time compliance remained relatively stable, although Expedited Pre-service cases were out of compliance in April and May due to routing issues, holiday timing, and a system	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (May 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	breakdown. A formal corrective action plan will be requested if these trends continue in June. • Case management trends remained positive overall, with perinatal engagement staying strong, physical health engagement high, transitional care cases stabilizing around 600 per month, and behavioral health engagement also remaining strong. • First Year of Life engagement remains near 100%, although volume decreased again after the high volumes noted in March.	
#5 UM/CM Business - UM Report – Top 10 Inpatient Diagnoses MY2025 (Attachment U) **Action** Patrick Marabella, M.D., Chair	**The UM Top 10 Diagnoses Report 2025** provides an annual evaluation of the hospital admissions per one thousand (Adm/k), bed days per one thousand members (Days/k), and average length of stay (ALOS) for the top ten (10) diagnoses among the Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), and Medicaid Covered Expansion (MCE) populations. Identifying utilization trends helps establish opportunities for collaboration and outcome improvement. • Sepsis: Remained a leading diagnosis with a 4.23% increase in admissions, a 6.57% increase in bed days per thousand members, and a 2.25% increase in the average length of stay (ALOS) from 2024 to 2025. • Diabetes (Type 1 and Type 2 diabetes mellitus): Utilization decreased overall in 2025; admissions -5.7%, bed days -15.3%, and average length of stay - 10.2%. Type 2 diabetes ranked as the highest diagnosis in 2025. • Cardiac Diagnoses (Hypertensive heart and chronic kidney disease and Hypertensive heart disease): Showed a 17.3% reduction in admissions per thousand members and a 15.2% reduction in bed days per thousand members from 2024 to 2025. • Respiratory Diagnoses (Respiratory failure, not elsewhere classified, and Pneumonia, unspecified organism): Showed a 13.7% increase in admissions per thousand members and a 17.6% reduction in bed days per thousand members year over year. • Each population (SPD, TANF, MCE) exhibited minor variations in its top diagnoses for 2025.	Motion: *Approve* - UM Report – Top 10 Inpatient Diagnoses MY2025 (Ramirez/Waugh) 4-0-0-4
#5 UM/CM Business - Care Management & CCM Report (Q1 2026) (Attachment V) **Action**	**The Care Management and CCM Report Q1 2026** 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 Q4 2025 to Q1 2026, the referral volume for PH CM increased by 67%, while TCS referrals increased by 5%, and BH CM referral volume remained about the same. Referrals also	Motion: *Approve* - Care Management & CCM Report (Q1 2026) (Ramirez/Waugh) 4-0-0-4

AGENDA ITEM/PRESENTER	MOTIONS/MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D., Chair	Increased for PCM and FYOL programs in Q1. The volume of managed cases decreased across all programs in Q1, except Perinatal. • TCS has shown an increase in the volume of members referred in Q1 2026, and the engagement rate has increased this quarter to 90%, up from 82%. • Q3 to Q4 2025, referral volume decreased, which matched the IP trend in Q4. The percentage of PCP visits within 30 days increased from 38.1% in Q3 to 47.2% in Q4. • BH CM referrals have remained consistent in Q1 2026, and the engagement rate increased from 66% to 73%. • PCM's total referrals increased compared to the previous quarter, while the engagement rate varied from 71% to 68%. • The Pregnancy and Post-Delivery Mailings will no longer be sent as the Maternity Program has fully transitioned to the Enhanced Pregnancy Program. Members will be directed to the materials that are online. Materials can be mailed to members upon request. • FYOL referrals have increased in Q1 2026, but the engagement rate decreased slightly (95%). • The Readmission rate was 7.7% lower 90 days following CM enrollment compared to 90 days prior to CM. • ED claims per 1,000 members per year decreased by 651 (21.8% for Q4) after CM enrollment. • Survey participation in Q1 was low, limiting the ability to draw meaningful conclusions from satisfaction results this quarter. Survey content and methodology modifications are in progress to improve these results in the near future.	
#5 UM/CM Business - Clinical Practice Guidelines (Attachment W) **Action** Patrick Marabella, M.D., Chair	The **Clinical Practice Guidelines** were presented and reviewed by the Committee. HN adopts guidelines from Centene's National organization, and then CVH reviews, provides feedback, and asks questions as indicated about any new guidelines or changes to existing guidelines. The links to each guideline are listed in the attachment and are also available on the provider portal. After review, no concerns or questions were raised by committee members, and the clinical practice guidelines were adopted for CVH. *Maria McDivitt left the meeting at 11:41 AM.*	Motion: *Approve* - Clinical Practice Guidelines (Ramirez/Quezada) 4-0-0-4
#5 UM/CM Business - Medical Policies Provider Updates (Q2 2026)	The **Medical Policies (Q2 2026)** were presented to the committee. Dr. Marabella requested that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback. Medical	Motion: *Approve* - Medical Policies Provider Updates (Q2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment X) **Action** Patrick Marabella, M.D., Chair	Policies are compiled based on a national review by physicians and sent monthly to providers, featuring new, updated, or retired medical policies for the Plan. Updated policies for Q2 2026 include the following, but are not limited to these examples: CP.MP.185 Skin and Soft Tissue Substitutes CP.MP.244 Liposuction for Lipedema CP.MP.247 Transplant Service Documentation Requirements CP.MP.58 Intestinal and Multivisceral Transplant CP.MP.242 Pulmonary Function Testing CP.BH.500 Behavioral Health Treatment Documentation Requirements HNCA.CP.MP.55 Assisted Reproductive Technology Retired policies for Q2 2026 include the following, but are not limited to these examples: CP.MP.126 Sacroiliac joint fusion CP.MP.14 Cochlear implant replacements HNCA.CP.MP.127 Ambulance, Non-emergent HNCA.CP.MP.134 Voice Therapy HNCA.CP.MP.391 Refractive Surgery	2026) (Ramirez/Quezada) 4-0-0-4
#6 Policy & Procedure Business - Quality Improvement Policy & Procedure Annual Review (Attachment Y) Action Patrick Marabella, M.D., Chair	**The Quality Improvement Policy and Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with no changes: QI-006 Annual HEDIS® Production and Reporting QI-010 Medical Records Documentation Standards QI-011 Medi-Cal PCP Facility Site & Medical Record Review QI-012 Physical Accessibility Review Survey QI-013 Medical Record Confidentiality & Release of Information QI-014 Potential Quality Issues (PQI) Management Process QI-017 Provider Preventable Conditions Program The following policies were presented for annual review and approved with changes: **QI-005** Quality Improvement and Health Equity Transformation Program (QIHETP) Requirements: Revised and updated the organization's commitment to quality and health equity, performance monitoring and reporting, health equity tiers and domains, and quality and health equity initiatives, including the addition of Cancer Prevention. Updated the purpose, general requirements, MCAS performance measure requirements, consumer satisfaction survey requirements, health equity and quality data provisions, the Health Plan Level definition within the	Motion: *Approve* - Quality Improvement Annual Policy & Procedure Review (Quezada/Ramirez) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Quality Monitoring and Improvement Program, authority references, and attachments. **QI-007** Health Equity Quality Review and Engagement Strategies: Deleted the Population Needs Assessment section in the Engagement Strategy section. Minor edits throughout. **QI-008** Data Collection and Disparity Analysis: Added demographic categories for data segmentation in the Disparity Dashboard and Disparity Analysis, Identification, and Prioritization sections. **QI-018** Initial Health Appointment (IHA): Updated language throughout to align with DHCS APL 26-001 requirements. Updated the authority section. **QI-019** Childhood Blood Lead Screening: Added follow-up with providers who have agreed to contact members who have not been screened for lead in the Monitoring of Childhood Lead Testing Services. *Committee members agreed with the policy changes as stated and voiced no questions or concerns.*	
#7 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q2 2026) (Attachment Z) Action Patrick Marabella, M.D., Chair	The **Credentialing Subcommittee Quarterly Report Q2 2026** was presented. The Credentialing Subcommittee met on May 21, 2026, to review routine credentialing and re-credentialing reports for both Q4 2025 delegated and Q1 2026 non-delegated entities (Health Net (HN) and HN Behavioral Health (BH)). • The **Credentialing Adverse Actions Q1 2026** for CVH from the HN Credentialing Committee was presented, with no (0) cases presented for discussion for Q1 2026 for CVH. • The **Adverse Events Q1 2026** report was presented: o Credentialing submitted zero (0) cases to the Credentialing Committee in Q1 2026. There were no (0) incidents involving appointment availability issues resulting in substantial harm, zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner, and zero (0) cases required reporting for 805 in Q1 2026. • The **Access and Availability Substantial Harm Report Q1 2026** was presented to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked by severity level. o After reviewing 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	Motion: Approve - Credentialing Subcommittee Report (Q2 2026) (Ramirez/Quezada) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Code section 3428(b)(1). • The **NCQA Information Integrity Credentialing Oversight Report Q1 2026** was presented and reviewed. This report identifies 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. • The county-specific **Credentialing Subcommittee Reports** of significant subcommittee activities for January through March 2026 were presented. There were no (0) new cases identified in Fresno, Kings, or Madera Counties for Q1 2026.	
#7 Credentialing & Peer Review Subcommittee Business - Peer Review Subcommittee Report Q2 2026 (Attachment AA) Action Patrick Marabella, M.D., Chair	The **Peer Review Subcommittee Quarterly Report Q2 2026** was presented. The Peer Review Subcommittee met on May 21, 2026, to review Q1 2026 data provided in the following reports: • The county-specific **Peer Review Subcommittee Summary Reports for Q1 2026** were reviewed for approval. No (0) significant cases to report. • The **Q1 2026 Adverse Events Report** was presented to provide a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period. o There were eleven (11) Q1 2026 cases that met 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 potential quality issues,	Motion: Approve - Peer Review Subcommittee Report Q2 2026 (Ramirez/Quezada) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	and zero (0) were track and trend. ▪ Two (2) cases involved seniors and persons with disabilities. ▪ Zero (0) cases involved behavioral health. o The Investigations Team submitted six 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. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026. o 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. o Two (2) cases were placed on corrective action in Q1 2026. o Grievance data reviews for health equity, site review, chaperone, or medical records, completed in Q1, did not identify any providers/practitioners who met the Peer Review trended criteria for escalation. o There was one (1) new case and two (2) 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) in Q1 2026. o 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. o 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	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	escalation for presentation at the Peer Review Committee. o Zero (0) cases required reporting for 805.01 in Q1 2026. • The **Access & Availability Substantial Harm Report for Q1 2026** was also presented to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances, Quality of Care (QOC), and Potential Quality Issues (PQIs) related to identified appointment availability issues, and they are ranked by severity level. o Seventeen* (17) new 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. o There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2026. • The **Q1 2026 Peer Count Report** was presented with a total of seventeen (17) cases reviewed with the committee. 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.	
#8 Compliance Update - Compliance Regulatory Report (Attachment BB)	Mary Lourdes Leone presented the **Compliance Report.** **CalViva Health Oversight Activities: Health Net:** Since the last Committee report, CVH's oversight and audit activities included continued monthly and quarterly review of HN clinical and administrative performance indicators and joint work group meetings covering PPG-level financial viability, claims, provider disputes, access and availability, specialty referrals, UM data, grievances, and appeals. **Oversight Audits:** Annual audits in progress include: 2026 Health Education, 2026 Marketing, Call Center, Q4 2025 Claims/PDR, and 2026 Health Equity; the Provider Network (CAP) has been completed. **Fraud, Waste, and Abuse:** Since the last Committee report, there have been six (6) new MC609 filings: Inappropriate Billing: 2 cases; Phantom Provider & Possible Services Not Rendered: 3 cases; Impossible Days: 1 case. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** DHCS will issue forward-looking guidance for the 2023 Focused Audit for	-Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTION / MAJOR DISCUSSIONS	ACTION TAKEN
	Behavioral Health and Transportation after the final Transportation APL, after which DHCS will close the CAP and allow 90 days for implementation. **MY 2024 Health Equity and Quality Performance:** On 7/1/26, DMHC issued its Health Equity and Quality Performance Findings Report for Measurement Year 2024. CVH exceeded benchmarks for most quality measures and had no administrative deficiencies; however, four (4) aggregate measures and several health equity disparities require a CAP due to DMHC by 9/29/26. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** CVH has completed and submitted all 2025 Medical Audit CAP responses and is awaiting DHCS review, feedback, and final closure. **2026 DMHC/DHCS Joint Medical Survey Audit:** The DMHC/DHCS Joint Medical Survey Audit was conducted on-site from 6/16/26 to 6/18/26, with additional DHCS interviews held virtually from 6/22/26 to 6/25/26; CVH is awaiting the preliminary audit report. **2026 Network Adequacy Validation (NAV) Audit:** CVH received the HSAG Audit Document Request Packet on 5/11/26, submitted the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents on 6/18/26, and is scheduled for a virtual audit on 8/25/26. **Memorandum of Understanding (MOU): Annual Network Certifications:** Since the last QI/UM Committee Meeting, CVH has executed and submitted to DMHC & DHCS the following MOUs: • Correctional Facilities Fresno County **Revised ASA and CPSA with Health Net:** On 6/25/26, CVH received final DMHC/DHCS approval for the executed ASA and CPSA. The agreements are effectively retroactive to 7/1/25. **DMHC APL 25-019 & J-19 Compliance Grid:** To demonstrate full compliance with the DMHC updated network adequacy regulations under APL 25-019, CVH completed its required policy updates and successfully submitted all required policies and J-19 Compliance Grid by 7/1/26. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2026. **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 and other abortion clinics expired on 7/5/2026 when Congress failed to pass an extension. Plans can resume making payments to these clinics. **Public Policy Committee (PPC):** The PPC met on 6/3/26, with the following reports presented: • Health Ed 2025 Summary Work Plan Evaluation	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Health Ed 2026 Work Plan • Health Equity 2025 Summary and Work Plan Evaluation • Health Equity 2025 Summary and Language Assistance Program • Health Equity 2026 Summary and Program Description • Health Equity 2026 Summary and Work Plan • Appeal and Grievance Report • Review and Discussion of A&G Dashboard from Dr Marabella The next PPC meeting will be held on 9/2/26, from 11:30 a.m. to 1:30 p.m., in the CVH Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. *Patricia Gomez left the meeting at 11:47 AM.*	
#9 Old Business	None.	
#10 Announcements	Dr. Marabella announced that Mary Lourdes Leone will be retiring at the end of the month and thanked her for eleven (11) years of dedicated service to CVH. Morgan Simpson will assume the role of Chief Compliance Officer beginning August 1, 2026. The next QI/UM meeting is scheduled for September 17, 2026.	
#11 Public Comment	None.	
#12 Adjourn	The meeting adjourned at 11:59 a.m.	

NEXT MEETING: September 17th, 2026

Submitted this Day: 09/17/26

Submitted by: Amy Schneider

Amy Schneider, RN, Senior Director of Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, M.D., Committee Chair

Public Policy Committee
Meeting Minutes
June 3, 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
		✓	Jeff Nkansah, Chief Executive 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 11:31 am. Roll call was taken to establish a quorum.		
#2 Meeting Minutes from March 4, 2026 **Action** Joe Neves, Chair	The March 4, 2026, meeting minutes were reviewed and approved.		**Motion:** Approve March 4, 2026, Minutes 7-0-0-2 (R. Garcia / N. Mendoza)

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
			Miguel Rodriguez arrived at 11:38 am not included in vote
#3 Committee Membership Update **Information** Courtney Shapiro	Public Policy Committee membership has been updated as follows: Renewal: Miguel Rodriguez, Provider Representative – CAO for United Health Centers, renewed for a 3-year term through June 2029.		**No Motion**
#4 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 timeline for submission has changed. CVH will be submitted for the first round in September 2026. Items CVH is currently working on are the Community Supports Program, the "base", and the Quality part, proactive per se. CVH has been working with the different counties to learn what they are doing. One of the things in Fresno County that came out is Home Visitation Network. They have home visitors with 20+ nonprofits, and they go into the home to work with families with new infants. The first goal for Fresno County is to work with Home Visitation Network to get current home visitors trained as Community Health Workers. For Madera County, CVH is still in talks with nothing confirmed yet. For Kings County, CVH is going to bring a promotores group to Kings County. The PPC was polled to see if there are any additional non-profits that the committee would like for CVH 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.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#5 Enrollment Dashboard **Information** Maria McDivitt	Maria Sanchez presented the enrollment dashboard through March 2026. Membership as of March 31, 2026, was 419,209. CalViva Health maintains a 66.89% market share.		**No Motion**
#6 Health Education **Information** Steven Si	Steven Si presented the 2025 year-end evaluation summary for Health Education. Accomplishments consist of: • Member Incentive Programs o Enrolled 11,075 members across four incentive programs (Q1–Q4 2025). o Distributed $279,700 in gift cards (94% Fresno, 3% Madera, 1% Kings). o Achieved a 55% year-over-year increase in total awards compared to 2024. • Member Materials Management o Fulfilled orders for 22,627 pieces of educational materials. o Most ordered topics: Lead poisoning, diabetes, nutrition, and exercise. • Health Education Information Line o Logged 13 total inquiries: 9 welcome calls, 2 health assessment forms, and 2 asthma incentive programs. • Tobacco Cessation Promotion o Actively promoted the Kick It California program across member newsletters and stakeholder meetings. • New Program Launches & Promos o Received DHCS approval for the new Diabetes Prevention Program (DPP). o Launched 1 email campaign and 1 member mailing to promote the DPP. o Successfully transitioned from the myStrength program to Teladoc Mental Health. • Material & Library Enhancements o Developed 10 new in-house health education materials. o Audited member materials and fully converted content to Krames. o Expanded the Krames Online Library with interactive videos and tools. o Expanded Digital Health Resources to include dual-language support (English/Spanish). • Tracking & Community Referrals	*Miguel Rodriguez asked if there's any utilization information for the teledoc services medical and behavioral health. Are there any trends?* *Mary Lourdes confirmed the utilization is tracked for both medical and behavioral health. Members and Providers are both informed of the service.* *Melissa Carrillo with JSA added they can add information regarding teledoc/telehealth services vs going to the ED through CVHs social media pages.*	**No Motion** *R. Garcia left at 12:26 pm*

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	○ Updated the master tracker to include formal health education material reviews. ○ Referred 33 members to local organizations via FindHelp (24 received responses). <u>2026 Health Education Work Plan</u> Major health education initiatives include: • Digital & Vendor Care Programs ○ Diabetes Prevention Program (DPP): Continuing the partnership with Diabetes Care Partners. ○ Teladoc Mental Health: Continuation of Teladoc Mental Health (Digital Program). ○ Digital Resource Promotion: Expanding the use of QR codes and direct links to digital health education assets. • Clinical & Programmatic Outreach ○ Cancer Screenings: Continuing partnership with Every Woman Counts to promote Breast Cancer (BCS) and Cervical Cancer (CCS) screenings. ○ Tobacco Cessation: Continue promoting the Kick It California program. • Internal & Community Collaboration ○ Member Services Alignment: Work with Member Services Department to ensure customer service teams actively educate members on health resources. ○ Community Engagement: Continue partnership with Community Engagement to participate in health fairs and community events to promote health awareness to members and community.		
#7 Appeals, Grievances and Complaints **Information** Maria McDivitt	For Q1 2026 there were 72 Coverage Disputes (Appeals), 125 Disputes Involving Medical Necessity (Appeals), 35 Quality of Care, 186 Access to Care, and 433 Quality of Service, for a total of 851 appeals and grievances for the 1st quarter. The majority of which are from Fresno County. There were 149 appeal cases for Fresno County, 11 for Kings County, and 37 for Madera County, for a total of 197 for Q1 2026. There were 551 grievances cases		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	in Fresno County, 45 for Kings County, and 60 for Madera County for a total of 656 for Q1 2026. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for all categories with the exception of Expedited Appeals which was at 85.7% due to 1 out of 8 cases being non-compliant. There was a total of 479 Exempt Grievances received in Q1 2026. Of the total grievances and appeals received in Q1, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 136 • Appeals: 41 • Exempt: 71 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 Other, PCP Care, and Specialist Care. The top categories of appeal cases resolved were related to Advanced Imaging, Community Supports, and DME. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received. Dr. Marabella provided additional clarification/information on Appeals & Grievances for the 1st quarter of 2026.	*Miguel Rodriguez asked what the turnaround time is for expedited appeals.* *Dr. Marabella stated it's 72 hours.*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#8 Health Equity **Information** Pao Houa Lee	Pao Houa Lee presented the 2025 Annual Evaluation for Health Equity and Language Assistance Program, and the 2026 Health Equity Program Description and Work Plan. All 2025 work plan activities were completed. • Language Assistance Services o 125 staff completed a bilingual assessment/reassessment . o Distribute newsletter to members regarding our LAP services. o MY2024 Geo Access Report Completed in November. o 10 health education materials field tested. • Compliance Monitoring o Investigated and completed follow up on 29 cultural and linguistic grievances and 8 interpreter complaints. o Conducted 4 Findhelp trainings (2 for providers, 2 for staff) and added 288 overall new programs to Findhelp. • Communication, Training and Education o Completed coding and resolution training to A&G Department. o Completed 2 trainings to new CCC hires, training includes HEQ Core areas, LAP program, writing in plain language. • Health Literacy o Completed 58 English Materials Reviews. o Completed Plan Language Training for staff, one conducted live and another posted on demand. • Cultural Competency o Completed 4 provider trainings to 164 providers. Training includes (1) Special Needs and Cultural Competency, (1) Language Assistant Program and Plain Language for Health Literacy, and (2) Community Connect. o Completed a cultural competency training for staff; 2,246 staff completed the on-demand training. • Health Equity o Successfully co-led and supported the completion of quality projects. Projects target measures: W30-6+ and SUD/MH.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	○ Completed 3 focus groups for Perimenopause and Menopause Awareness Campaign in October. Highlights of Notable Changes for 2026 Health Equity Program Description: Vision, Mission, Goals and Objectives • Change and update new NCQA Accreditation name ○ Health Outcomes and Community-Focused Care Accreditation (formerly Health Equity and Health Equity Plus, respectively) Cultural Competency Education for Providers • Trainings completed by providers can be found in the provider directory. Health Literacy • Update health literacy process to include Content and Layout Review checklist to streamline English Material Reviews (EMRs). Population Needs Assessment • Remove PNA from the Health Equity's Program Description as responsibility has moved to the Population Health Management team. Health Equity Department Staff Roles and Responsibilities • Removed Director of Program and added VP of Quality Management. 2025 initiatives will continue in 2026 for the Health Equity Work Plan with enhancements: • Language Assistance Program ○ Add SOGI data collection as an activity, role includes maintaining Member Portal data collection and contributing to SOGI data collection planning. ○ Removed Population Needs Assessment (PNA) report as activity no longer applies to the Health Equity Department. • Compliance Monitoring ○ Added Cozeva integration as a new topic in Findhelp provider training guide. Health Equity ○ Update project goal for Phase 2 for the IHI/DHCS Child Equity Sprint project.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	○ Expand involvement in the community with new workgroups: CHIP workgroup, FCHIP Community Advisory Council, and Diabetes and Heart Health workgroup.		
#9 Marketing Update **Information** Melissa Carrillo	Melissa Carrillo with JSA shared a presentation referencing the CVH website and creative updates. • New website built to serve CalViva Health members with easier access to resources. • Navigation organized around member needs. The presentation included the following topics along with detailed information, examples, options, and open dialogue with PPC members: • Site Overview • Paid Ads Landing Page • New Commercials & Photography	*Martha Miranda asked if there was a pamphlet or something similar to assist those that are not tech savvy in order to navigate the website?* *Courtney shared that the CVH field team/CBOs that are out in the community have information available. And the information is also available in the Member Handbook.*	**No Motion**
#10 Audit Updates **Information** Morgan Simpson	• 2025 DHCS Audit update: CVH has submitted the final update as a result of the corrective action plan (CAP) by DHCS. DHCS has responded and stated no additional updates are required at this time. Pending approval and closure of the CAP. • 2026 DMHC/DHCS Joint Onsite Audit: Both regulatory agencies, Department of Managed Health Care and Department of Health Care Services will be onsite beginning June 16th to begin interviews with CVH staff and Health Net staff. All documents have been submitted in advance as required by both agencies. • Annual Network Validation Audit: Pre-audit documents are required to be submitted by June 18th. The first part of the virtual review will be August 25th.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#11 Final Comments from Committee Members and Staff	Aracelie Sanabria Gaona requested more information on the community Zumba classes that CVH sponsors; classes are put on by ENP. Maria Arreola, Martha Miranda, and Norma Mendoza shared recent events throughout their communities pertaining to CVH and its members. Miguel Rodriguez shared that UHC will break ground on a new imaging center in northwest Fresno in two weeks. In addition, UHC has broken ground on Clovis & Dakota for a new health center. The new PACE center in downtown Fresno is nearing completion. UHC has recruited 10 new internal medicine residents starting in June. UHC recently received approval for the first physical medicine and rehab program in the valley of which they are working on funding.	*CVH to talk with ENP to see how to get dance therapy classes in Fresno County.*	
#12 Announcements	Jeff Nkansah and Courtney Shapiro recently completed three full days of an emergency relief tour of approximately $803,000 to various organizations throughout the three CVH service counties. Courtney Shapiro announced CVH's current Chief Compliance Officer, Mary Lourdes Leone, will be retiring effective July 31, 2026. Jeff Nkansah reiterated that CVH is working on ways the Plan can improve the member experience. In addition, Jeff shared the Plan is continuing to track the changes occurring at the State and Federal levels.		
#13 Public Comment	None.		
#14 Adjourn	Meeting adjourned at 1:29 pm.		

NEXT MEETING September 2, 2026, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: September 2, 2026

Submitted By: C. Shapiro
Courtney Shapiro, Director Community Relations & Marketing

Approval Date: September 2, 2026

Approved By: Joe Neves
Joe Neves, Chairman

Fresno-Kings-Madera Regional Health Authority
2027 Commission Meeting Schedule

Meeting Location:

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

Date	Time	County	Meeting Location
January			**No Meeting**
February 18, 2027	1:30 to 3:30	Fresno	CalViva Health
March 18, 2027	1:30 to 3:30	Fresno	CalViva Health
April			**No Meeting**
May 20, 2027	1:30 to 3:30	Fresno	CalViva Health
June			**No Meeting**
July 15, 2027	1:30 to 3:30	Fresno	CalViva Health
August			**No Meeting**
September 16, 2027	1:30 to 3:30	Fresno	CalViva Health
October 21, 2027	1:30 to 3:30	Fresno	CalViva Health
November 18, 2027	1:30 to 3:30	Fresno	CalViva Health
December			**No Meeting**

Fresno-Kings-Madera Regional Health Authority

Finance Committee

2027 Meeting Schedule

Meeting Location:

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

Date	Time	County	Meeting Location
January			**No Meeting**
February 18, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
March 18, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
April 15, 2027	11:30 am to 12:00 pm ***TENTATIVE***	Fresno	CalViva Health
May 20, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
June			**No Meeting**
July 15, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
August			**No Meeting**
September 16, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
October 21, 2027	11:30 am to 12:00 pm * **Auditors presentation*	Fresno	CalViva Health
November 18, 2027	11:30 am to 12:00 pm	Fresno	CalViva Health
December			**No Meeting**

DRAFT

CalViva Health

Public Policy Committee
2027 Meeting Schedule

Date	Time	Meeting Location
January		**No Meeting**
February		**No Meeting**
March 3, 2027	11:30am – 1:30pm	Fresno County
April		**No Meeting**
May		**No Meeting**
June 2, 2027	11:30am – 1:30pm	Fresno County
July		**No Meeting**
August		**No Meeting**
September 1, 2027	11:30am – 1:30pm	Fresno County
October		**No Meeting**
November		**No Meeting**
December 1, 2027	11:30am – 1:30pm	Fresno County

Meeting Location:

Fresno County:

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

Fresno-Kings-Madera Regional Health Authority

Quality Improvement/Utilization Management

2027 Meeting Schedule

All Meetings Will Be Held At:

CalViva Health
7625 N. Palm Ave., Suite 109/Commission Room
Fresno, CA 93711

Date	Time
February 18, 2027	10:00 am – 12:00 pm
March 18, 2027	10:00 am – 12:00 pm
May 20, 2027	10:00 am – 12:00 pm
July 15, 2027	10:00 am – 12:00 pm
September 16, 2027	10:00 am – 12:00 pm
October 21, 2027	10:00 am – 12:00 pm
November 18, 2027	10:00 am – 12:00 pm

Please note that there are no QIUM Committee Meetings in the months of: January, April, June, August, or December.

Fresno-Kings-Madera Regional Health Authority

Credentialing Subcommittee

2027 Meeting Schedule

Meeting Location:

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

Date	Time	Meeting Location
February 18, 2027	12:00 pm – 12:30 pm	CalViva Health **1st Quarter**
May 20, 2027	12:00 pm – 12:30 pm	CalViva Health **2nd Quarter**
July 15, 2027	12:00 pm – 12:30 pm	CalViva Health **3rd Quarter**
October 21, 2027	12:00 pm – 12:30 pm	CalViva Health **4th Quarter**

Please note that the Credentialing Subcommittee meets once per quarter.

Fresno-Kings-Madera Regional Health Authority

Peer Review Subcommittee

2027 Meeting Schedule

Meeting Location:

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

Date	Time	Meeting Location
February 18, 2027	12:00 pm – 12:30 pm	CalViva Health **1st Quarter**
May 20, 2027	12:00 pm – 12:30 pm	CalViva Health **2nd Quarter**
July 15, 2027	12:00 pm – 12:30 pm	CalViva Health **3rd Quarter**
October 21, 2027	12:00 pm – 12:30 pm	CalViva Health **4th Quarter**

Please note that the Peer Review Subcommittee meets once per quarter.

Current Health Equity Project(s) and Initiative(s):	Objective	Status
Kings County CHIP	Priority 5: Maternal, Infant, and Child health Priority 6: CHW	5/26- CVH is coordinating with Kings County Public Health for a community baby shower. 6/26- Kick off meeting with CVH and HN Population Health team to start strategizing 7/26- Potential Community Baby Shower to be set for November 2026. Baby shower will be integrated into the CHIP Priority Goals. Strategy and coordination meeting to be scheduled with other MCPs and CBOs and also to finalize a venue to host the Community Baby Shower. July/ Aug 2026- CalViva Health is developing an Early Pregnancy Intervention Pilot that will take place in Kings County. The pilot will explore opportunities to increase awareness of doula services, strengthen local doula capacity, and better understand members' needs. A doula survey is currently under review and will be distributed before a planned Doula Convening in October.
Madera County- Live Well	Continue to collaborate with the **Madera County's Public Health team** on **Community Health Improvement Plan (CHIP) initiatives**.	Began discussions on prioritizing key activities in targeted areas of Madera County. The first partnership convening occurred in August to align MCP priorities and identify isolated rural communities that may benefit from a resource hub and stronger community support. As a next step, partners will form smaller workgroups focused on advancing projects in the identified priority areas.
FCHIP HOPE HUB	Central Valley Disabilities Service Provider (CVDSP) network to CVH's HE initiative in 2026	Update 09/17/2026 **July 2026:** The survey was completed and translated into English and Spanish and integrated into RaB's data system. The final survey shared with the workgroup. Survey distribution launched on August 1, with in-person distribution planned for RaB's Family Health Day on August 13. A second event is planned for November, with the date to be determined. An ASL interpreter was coordinated for the August event. **August 13, 2026:** RaB's Family Health Day reached 172 participants,

		representing 15 ZIP codes across Fresno and Madera Counties. **So far 80 families have responded to the survey.** The biggest barrier identified so far was difficulty navigating the developmental services system. **65%** of families did not have consistent guidance, **65%** felt there were not enough services or were unsure what services were available, **50%** felt their concerns were only somewhat taken seriously or not taken seriously, and **48%** waited at least six months for an evaluation or were still waiting. To increase survey participation among the target population, RaB will conduct targeted outreach through preschool and after-school programs, behavioral and social-emotional counselors, and Wellness Wednesday events. The Community Schools Coordinator is also distributing the survey across the other 39 community schools. Through this work, CVH was invited to join Help Me Grow Leadership team to expand the project to surrounding counties.

Health Equity Annual Activities	Status
NCQA Update	At this time, CalViva Health will not pursue NCQA Health Equity Accreditation because DHCS no longer requires health plans to obtain it. Instead, we will align our health equity efforts with current DHCS contractual requirements, many of which already overlap with NCQA standards. Whenever possible, we will continue implementing projects and maintaining documentation that can support both DHCS and NCQA requirements. This approach allows us to focus our resources on current obligations while remaining prepared to pivot if DHCS reinstates NCQA Health Equity Accreditation as a future requirement. We are not stepping away from our health equity work; we are strategically aligning it with current requirements while preserving our readiness for future changes.
Cultural Competency Training	Cultural Competency training for all staff scheduled for 12/4
Health Equity Annual Oversight Audit- HN	Oversight Audit Schedule to start- Completed 8/2026 no CAP issued

Health Equity Community Activities/ Updates	Who	Activity
June- Sept 2026	1. Disability Health Care Summit- hosted in LA	The summit, hosted at The California Endowment Center, brought together an influential group of policymakers, healthcare leaders, providers, families, advocates, and individuals with lived experience of disability. Participants included representatives from Disability Rights California, health policy and regulatory affairs leaders, senior health policy advisors, legislative advocates for health and human services, regional service executives, chief medical officers, and health plans. At the center of every conversation were the voices and experiences of people with disabilities and their families. Discussions examined the policies and systemic barriers that affect access to equitable, coordinated, and person-centered healthcare. Key issues included the transition from pediatric to adult care, preventive care, behavioral health, dental care, emergency services, care coordination, navigation, and the growing needs of individuals aging with disabilities. Families delivered a powerful and urgent message: the current system is too difficult to navigate and places an unfair burden on those who already face significant challenges. They described being required to complete too many repetitive assessments and encountering physicians who often lack the training, resources, or confidence needed to appropriately welcome, understand, and care for patients with disabilities. Participants also emphasized that existing data does not tell the full story. Data for people born with developmental or physical disabilities is

		frequently combined with data for older adults who acquire disabilities later in life, even though their experiences, needs, and care pathways may be very different. Relying primarily on diagnosis codes and healthcare utilization further obscures the true level of need. A primary diagnosis alone cannot capture the complexity of an individual's life, the barriers they face, or the support required by their family. The impact also extends far beyond the individual receiving services. Caregivers are often forced to reduce their work hours or leave employment entirely to coordinate appointments, locate resources, advocate for services, and provide daily care. This loss of stable income creates a ripple effect that affects housing, food security, transportation, health, and the overall well-being of the entire family. Most importantly, families called for greater transparency and accountability. Without a centralized, accurate, and comprehensive resource system, caregivers are forced to become full-time case managers simply to find and coordinate essential services. Families should not have to carry this burden alone. Their message was clear: meaningful change must begin by listening to people with disabilities and their caregivers, valuing their lived experiences, and building a system that is easier to access, better coordinated, and truly responsive to the needs of the whole family.
	2. DHCS, Chief Medical Officers and Chief Health Equity Officers' from Health Plans across CA, both commercial and	Scheduled 9/16 and 9/17/2026

	Medicaid plans	

Item #5

Closed Session

Item #6

Attachment 6.A

Financial Audit Report for FY 2026

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2026 Audit Results: The Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Report of Independent Auditors

Rianne Suico
Health Care Services Principal

Eleanor Garibaldi
Health Care Services Senior Manager

2026 Audit Objectives

- Opinion on whether the financial statements are reasonably stated and free of material misstatement in accordance with accounting principles generally accepted in the United States of America
- Consideration of internal controls
- Audit is required under the State of California Department of Managed Health Care

Report of Independent Auditors

Unmodified Opinion

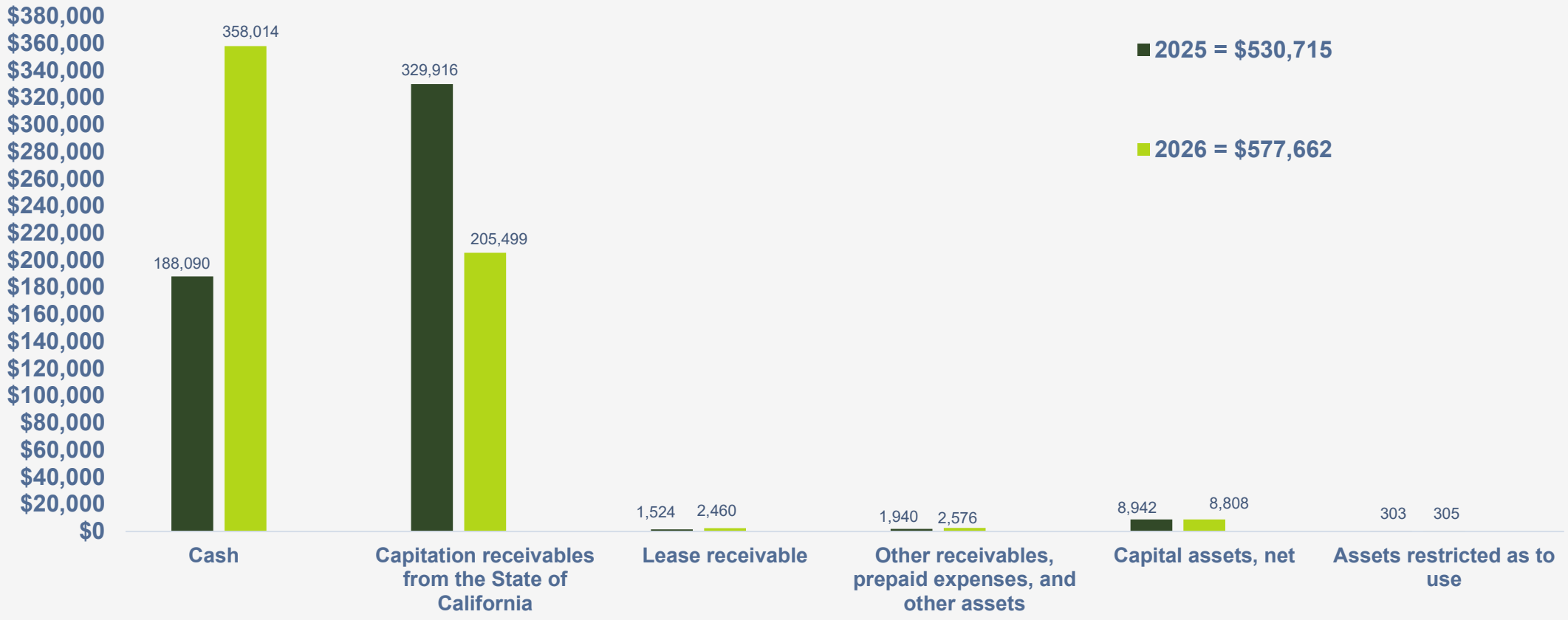
- Financial statements are fairly presented in accordance with accounting principles generally accepted in the United States of America

Statements of Net Position

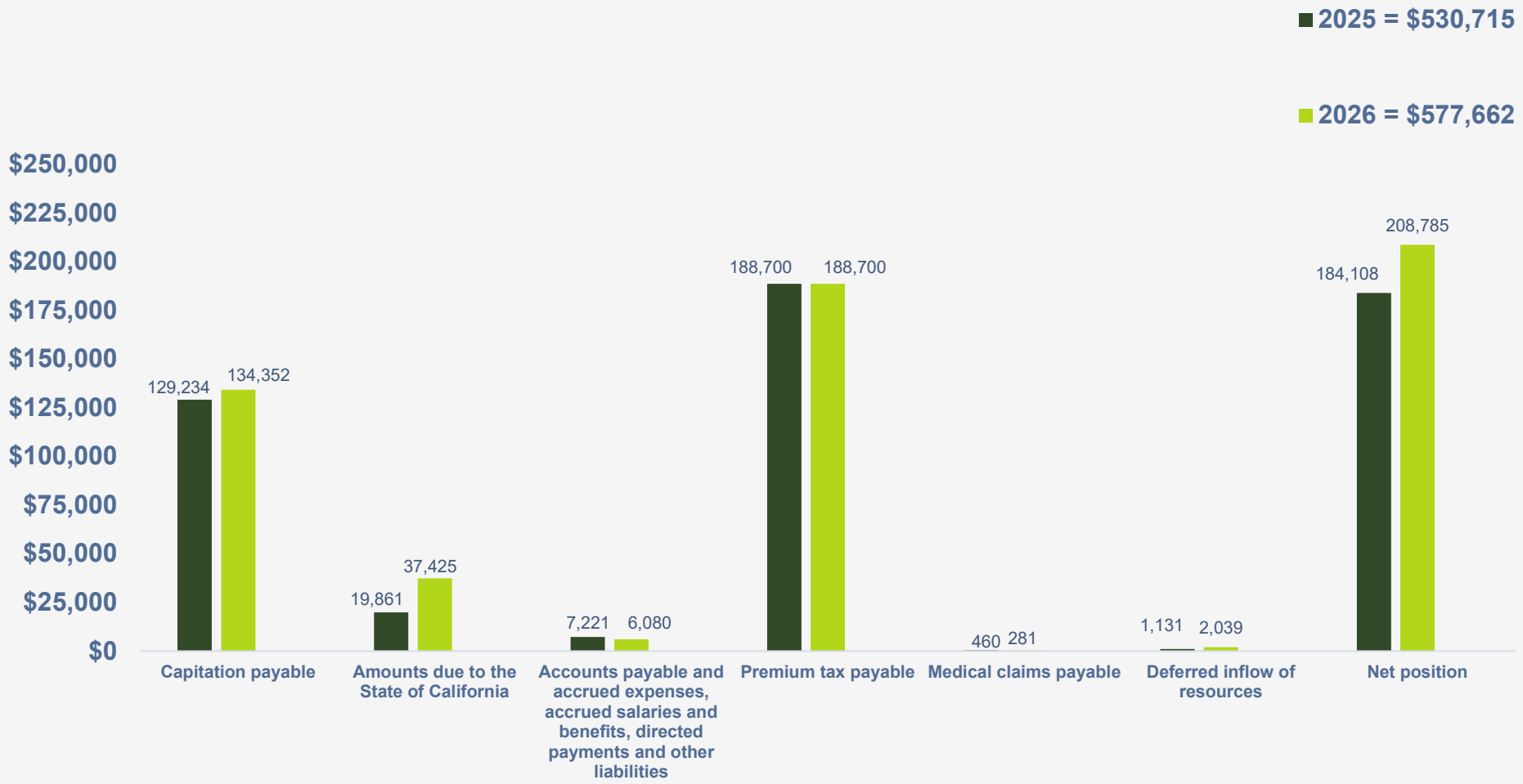


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Assets Composition (in thousands)



Liabilities, Deferred Inflows of Resources and Net Position (in thousands)

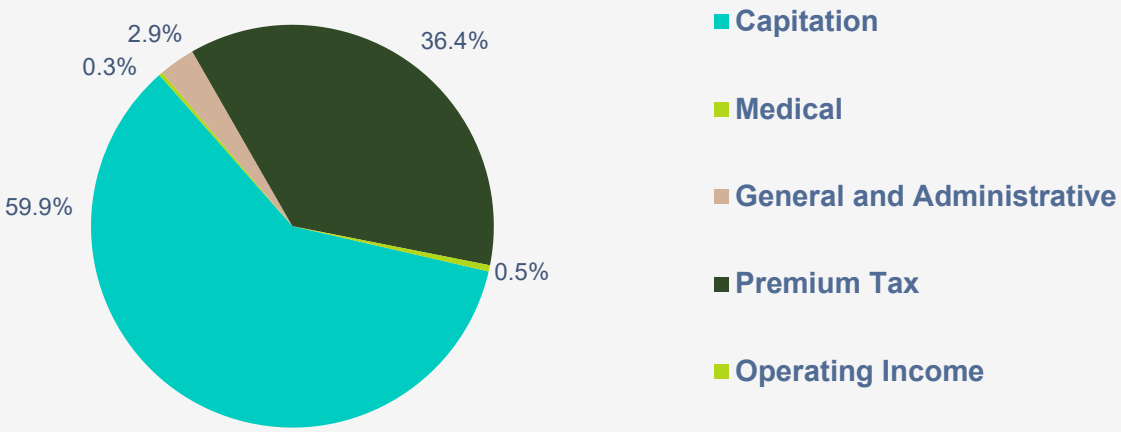


Operations

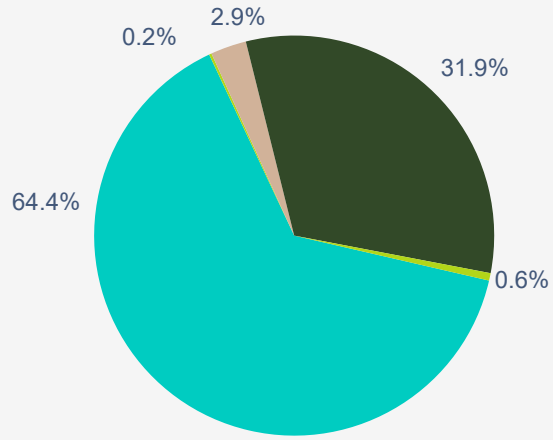
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Total Operating Expenses as a % of Total Operating Revenues (in thousands)

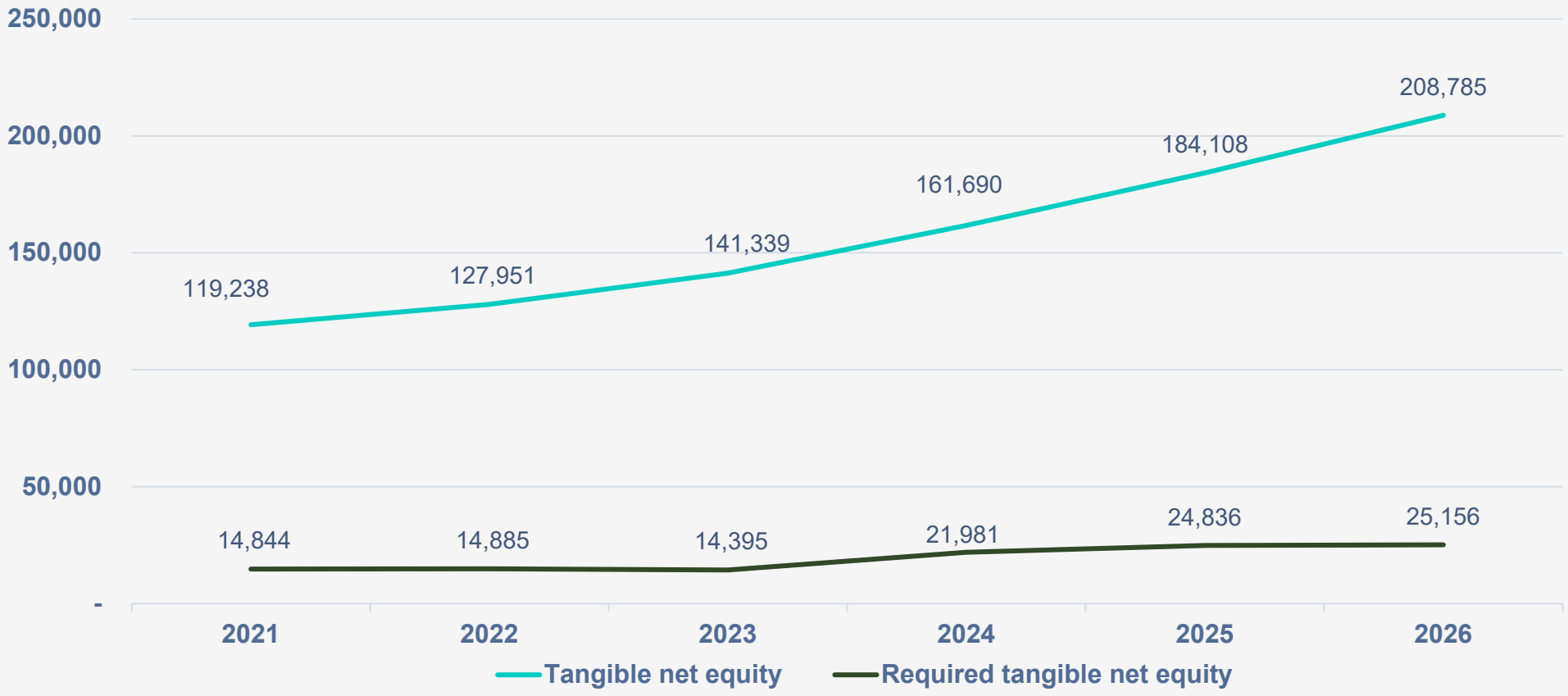
Year ended June 30, 2025
$2,333,594
(2025 Revenue)



Year ended June 30, 2026
$2,365,627
(2026 Revenue)



Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- Significant accounting policies
  - Adoption of GASB Statement No. 103, *Financial Reporting Model Improvements*
  - Adoption of GASB Statement No. 104, *Disclosure of Certain Capital Assets*
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of material fraud or noncompliance with laws and regulations

Questions?

Thank you.



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The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought. Tax information, if any, contained in this communication was not intended or written to be used by any person for the purpose of avoiding penalties, nor should such information be construed as an opinion upon which any person may rely. The intended recipients of this communication and any attachments are not subject to any limitation on the disclosure of the tax treatment or tax structure of any transaction or matter that is the subject of this communication and any attachments. Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, operate under an alternative practice structure and are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms. The name Baker Tilly and its associated logo is used under license from Baker Tilly International limited. ©2026 Baker Tilly Advisory Group, LP

Communications with the Commissioners

The Fresno-Kings-Madera Regional Health Authority dba CalViva Health

June 30, 2026

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Communications with the Commissioners

The Commissioners
The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

We have audited the financial statements of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva) as of and for the year ended June 30, 2026, and have issued our report thereon dated October __, 2026. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated April 17, 2025, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. As part of an audit conducted in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control over financial reporting. Accordingly, we considered The Fresno-Kings-Madera Regional Health Authority dba CalViva Health's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you, as stated in our engagement letter dated April 17, 2025.

Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by The Fresno-Kings-Madera Regional Health Authority dba CalViva Health are described in Note 2 to the financial statements. During fiscal year 2026, The Fresno-Kings-Madera Regional Health Authority dba CalViva Health adopted Governmental Accounting Standards Board Statement No. 103*, Financial Reporting Model Improvements* and Statement No. 104*, Disclosure of Certain Capital Assets*. The management's discussion and analysis and the financial statements were updated to apply these adoptions. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2026. We noted no transactions entered into by CalViva during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transactions occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management recorded estimated capitation receivables from the State of California. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosure affecting the financial statements was related to capitation revenue and is disclosed in Note 2 to the financial statements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of CalViva's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of CalViva's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS and the California Code of Regulations, Title 2 Section 113.2, State Controller's *Minimum Audit Requirements* for California Special Districts. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements the effects of which, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October __, 2026.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to CalViva's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health and management of the Commissioners of the Fresno-Kings-Madera Regional Health Authority dba CalViva Health, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October __, 2026

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Report of Independent Auditors and
Financial Statements

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health

June 30, 2026 and 2025

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Management's Discussion and Analysis

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2026, 2025 and 2024

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The Management's Discussion and Analysis of The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is intended to provide readers and interested parties with an overview of the Plan's financial activities for the fiscal years ended June 30, 2026 and 2025. It should be reviewed in conjunction with the Plan's financial statements and accompanying notes to enhance the reader's understanding of the Plan's financial performance.

Overview of CalViva's Financial Statements

CalViva's financial statements consist of three statements: Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows. CalViva's financial statements and related notes provide and report fiscal information about CalViva using Generally Accepted Accounting Principles (GAAP) as established by the Governmental Accounting Standards Board (GASB). CalViva utilizes the proprietary fund method of accounting under which the financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred, regardless of when cash is received or paid. The Statements of Net Position include all of CalViva's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to creditors (liabilities). All of the current period's revenues and expenses are accounted for in the Statements of Revenues, Expenses, and Changes in Net Position. The final required financial statements are the Statements of Cash Flows. These statements present cash receipts, cash payments, and net changes in cash resulting from operating, investing, noncapital financing, and capital financing activities.

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Financial Summary

Condensed Statements of Net Position

	June 30			2026 - 2025 Change	
	2026	2025	pre-GASB 103* 2024	Amount	% Change
Assets:					
Current assets	$ 566,619,847	$ 520,337,430	$ 480,634,924	$ 46,282,417	8.9%
Capital assets	8,808,411	8,942,322	9,097,783	(133,911)	-1.5%
Other assets	2,233,881	1,435,503	2,243,547	798,378	55.6%
Total assets	$ 577,662,139	$ 530,715,255	$ 491,976,254	$ 46,946,884	8.8%
Liabilities:					
Current liabilities	$ 366,793,749	$ 345,449,406	$ 328,084,199	$ 21,344,343	6.2%
Noncurrent liabilities	43,928	25,907	25,907	18,021	69.6%
Total liabilities	366,837,677	345,475,313	328,110,106	21,362,364	6.2%
Deferred inflow of resources	2,039,446	1,131,484	2,176,214	907,962	80.2%
Net position:					
Net investment in capital assets	8,808,411	8,942,322	9,097,783	(133,911)	-1.5%
Restricted	305,121	302,746	304,185	2,375	0.8%
Unrestricted	199,671,484	174,863,390	152,287,966	24,808,094	14.2%
Total net position	208,785,016	184,108,458	161,689,934	24,676,558	13.4%
Total liabilities, deferred inflow of resources, and net position	$ 577,662,139	$ 530,715,255	$ 491,976,254	$ 46,946,884	8.8%

***** Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026.

Condensed Statements of Revenues, Expenses, and Changes in Net Position

	Year Ended June 30, 2026	Year Ended June 30, 2025	pre-GASB 103* Year Ended June 30, 2024	Year Ended June 30, 2026 - 2025 Change Amount	% Change
Operating revenues	$ 2,365,626,696	$ 2,333,594,205	$ 2,048,060,849	$ 32,032,491	1.4%
Operating expenses	2,351,008,844	2,322,895,920	2,036,792,873	28,112,924	1.2%
Income from operations	14,617,852	10,698,285	11,267,976	3,919,567	36.6%
Nonoperating revenues	10,058,706	11,720,239	9,083,402	(1,661,533)	-14.2%
Changes in net position	24,676,558	22,418,524	20,351,378	2,258,034	10.1%
Net position, beginning of year	184,108,458	161,689,934	141,338,556	22,418,524	13.9%
Net position, end of year	$ 208,785,016	$ 184,108,458	$ 161,689,934	$ 24,676,558	13.4%

***** Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026.

Detailed Analyses

Net Position

On June 30, 2026, CalViva had assets of $577.6 million, liabilities of $366.8 million and deferred inflow of resources of $2.0 million. On June 30, 2025, CalViva had assets of $530.7 million, liabilities of $345.5 million and deferred inflow of resources of $1.1 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by $24.7 million to $208.8 million from $184.1 million at June 30, 2025, due to operating income of $14.6 million and non-operating income of $10.1 million.

On June 30, 2025, CalViva had assets of $530.7 million, liabilities of $345.5 million and deferred inflow of resources of $1.1 million. On June 30, 2024, CalViva had assets of $492.0 million, liabilities of $328.1 million and deferred inflow of resources of $2.2 million. The resulting net position, which represents the Plan's assets after the liabilities and deferred inflow of resources are deducted, increased by $22.4 million to $184.1 million from $161.7 million at June 30, 2024, due to operating income of $10.7 million and non-operating income of $11.7 million.

Liquidity

The Department of Managed Health Care (DMHC) requires a minimum current ratio (current assets divided by current liabilities) of 1.00.

As of June 30, 2026, CalViva maintained a current ratio of 1.54, which reflected an increase from 1.51 as of June 30, 2025. The increase is primarily due to the increase in cash and cash equivalents.

As of June 30, 2025, CalViva maintained a current ratio of 1.51, which reflected an increase from 1.46 as of June 30, 2024. The increase is primarily due to the increase in capitation receivables from the State of California.

Assets

Cash and cash equivalents – Cash and cash equivalents increased $169.9 million from $188.1 million at June 30, 2025, to $358.0 million at June 30, 2026. The increase is primarily due to net cash provided by operating activities and the timing of receipts of Managed Care Organization (MCO) tax payments from DHCS.

Cash and cash equivalents decreased $74.1 million from $262.2 million at June 30, 2024, to $188.1 million at June 30, 2025. The decrease is primarily due to net cash used in operating activities.

Capitation receivables from the State of California – Capitation receivables from the State of California decreased $124.4 million from $329.9 million at June 30, 2025, to $205.5 million at June 30, 2026. The decrease is primarily due to the decrease in accrued MCO tax revenue and the timing of receipts of MCO tax payments from DHCS, offset by an increase in capitation rates paid by DHCS.

Capitation receivables from the State of California increased $153.1 million from $176.8 million at June 30, 2024, to $329.9 million at June 30, 2025. The increase is primarily due to the increase in capitation rates and MCO tax revenue from DHCS, in addition to the timing of receipts of MCO tax payments from DHCS.

Other receivables – Other receivables increased $310,313 from $527,928 at June 30, 2025, to $838,241 at June 30, 2026. The increase is primarily due to the timing of receipts of interest payments from various investment accounts.

Other receivables decreased $348,949 from $876,877 at June 30, 2024, to $527,928 at June 30, 2025. The decrease is primarily due to the decrease of interest rates and the timing of receipts of interest payments from various investment accounts.

Prepaid expenses – Prepaid expenses increased $326,182 from $1,411,782 at June 30, 2025, to $1,737,964 at June 30, 2026. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2026.

Prepaid expenses increased $1,161,829 from $249,953 at June 30, 2024, to $1,411,782 at June 30, 2025. The increase is primarily due to the timing of payments for licenses, insurance, fringe benefits, and other costs that are to be charged to expense after June 30, 2025.

Capital assets, net of accumulated depreciation and amortization – Capital assets, net of accumulated depreciation and amortization, decreased $133,911 from $8.9 million at June 30, 2025, to $8.8 million at June 30, 2026. The decrease is primarily due to the depreciation and amortization expense of $348,442 recorded, offset by the purchase of $214,531 capital assets during the year ended June 30, 2026. See Note 4.

Capital assets, net of accumulated depreciation and amortization, decreased $155,461 from $9.1 million at June 30, 2024, to $8.9 million at June 30, 2025. The decrease is primarily due to the depreciation and amortization expense of $340,523 recorded, offset by the purchase of $186,144 capital assets during the year ended June 30, 2025. See Note 4.

Lease receivable – The Plan as a lessor, recognized a lease receivable, which represents the present value of future lease payments expected to be received by the Plan during the lease term.

The lease receivable balance increased $936,011 from $1.5 million at June 30, 2025, to $2.4 million at June 30, 2026. The increase is due to a new tenant entering into a lease agreement for a previously vacant office space during the fiscal year ended June 30, 2026, offset by collection of lease payments from tenants by the Plan during the year ended June 30, 2026.

The lease receivable balance decreased $1.1 million from $2.6 million at June 30, 2024, to $1.5 million at June 30, 2025. The decrease is due to collection of lease payments from tenants by the Plan during the year ended June 30, 2025.

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Assets restricted as to use – Restricted assets balance increased $2,375 from $302,746 at June 30, 2025, to $305,121 at June 30, 2026. The increase is due to accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2026 and 2025.

Restricted assets balance decreased $1,439 from $304,185 at June 30, 2024, to $302,746 at June 30, 2025. The decrease is due to distribution of accumulated interest earned on the restricted asset investment account. The balance consists of a deposit required by DMHC to pay for member claims in the event of insolvency and is held in an investment account as of June 30, 2025 and 2024.

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Liabilities and Deferred Inflow of Resources

Capitation payable – The capitation payable balance increased $5.1 million from $129.2 million at June 30, 2025, to $134.3 million at June 30, 2026. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in capitation rates paid by DHCS.

The capitation payable balance increased $9.6 million from $119.6 million at June 30, 2024, to $129.2 million at June 30, 2025. The increase is primarily due to the timing of capitation payments to the Plan's subcontracting entities for providing medical services to CalViva members. Furthermore, the increase in capitation payable is also attributable to the increase in capitation rates paid by DHCS.

Amounts due to the State of California – The amounts due to the State of California increased $17.5 million from $19.9 million at June 30, 2025, to $37.4 million at June 30, 2026. The increase is a result of the Plan accruing for DHCS' potential future recoupment of the MCO tax gain relating to the time period of January 2024 through June 2026.

The amounts due to the State of California decreased $20.6 million from $40.5 million at June 30, 2024, to $19.9 million at June 30, 2025. The decrease is attributable to full payment of $40.5 million payable balance to the State of California during the current fiscal year, as a result of DHCS' retroactive capitation rate recoupment covering the time period of January 2023 through December 2023, offset by the Plan accruing for $19.9 million payable balance to the State of California as a result of DHCS' potential future recoupment of the MCO tax gain relating to the time period of January 2024 through June 2025.

Accounts payable and accrued expenses – Accounts payable and accrued expenses consist of the cost of services received in the current period for which payment has yet to be made. The accounts payable and accrued expenses balance decreased by $1.3 million from $6.0 million at June 30, 2025, to $4.7 million at June 30, 2026. The decrease is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

The accounts payable and accrued expenses balance decreased by $31,773 from $6.0 million at June 30, 2024, to $6.0 million at June 30, 2025. The decrease is primarily due to the timing of payments to nonmedical vendors and to the Plan's subcontracting entity for administrative services.

Accrued salaries and benefits – The accrued salaries and benefits balance increased $65,385 from $492,256 at June 30, 2025, to $557,641 at June 30, 2026. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off (PTO). The increase is primarily due to additional PTO accrued by employees and an increase in payroll expenses during the fiscal year ended June 30, 2026.

The accrued salaries and benefits balance increased $88,542 from $403,714 at June 30, 2024, to $492,256 at June 30, 2025. The accrued salaries and benefits balance consists of accrued payroll and accrued paid-time-off (PTO). The increase is primarily due to additional PTO accrued by employees and an increase in payroll expenses during the fiscal year ended June 30, 2025.

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Premium tax payable – The premium tax payable remained at $188.7 million as of June 30, 2026 and 2025. The premium tax payable balance primarily represents the MCO tax as part of Assembly Bill (AB) 160 which imposes a per enrollee tax amount between specified taxing tiers and the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues.

The premium tax payable balance increased $32.0 million from $156.7 million at June 30, 2024, to $188.7 million at June 30, 2025. The premium tax payable balance primarily represents the MCO tax, as part of AB 160 which imposes a per enrollee tax amount between specified taxing tiers and the gross premium tax due to the State of California as part of SB 78, which imposes a 3.9375% assessment on the Plan's premium gross revenues. The increase is primarily due to the increase in the MCO taxes as a result of AB 160 which substantially increased the MCO tax amount during the fiscal year ended June 30, 2025.

Medical claims payable – The medical claims payable balance represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed and reported but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but not yet reported to the Plan.

The medical claims payable balance decreased $178,203 from $459,501 at June 30, 2025, to $281,298 at June 30, 2026. The balance at June 30, 2026, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2026.

The medical claims payable balance increased $387,618 from $71,883 at June 30, 2024, to $459,501 at June 30, 2025. The balance at June 30, 2025, is determined by factors such as cost of services, enrollment for providers paid on a fee-for-service basis, and the timing in the expected number of unpaid claims as of June 30, 2025.

Directed payment payable – The directed payment payable balance represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

The directed payment payable balance increased $81,641 from $742,751 at June 30, 2025, to $824,392 at June 30, 2026. The increase is primarily due to the timing of directed payments to the network hospitals and skilled nursing facilities.

The directed payment payable balance decreased $4.0 million from $4.8 million at June 30, 2024, to $742,751 at June 30, 2025. The decrease is primarily due to DHCS' recoupment of directed payments as a result of DHCS' retroactive directed payment rate reduction covering the time period of July 2019 through December 2021, and the timing of directed payments to the network hospitals and skilled nursing facilities.

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Other liabilities – Other liabilities increased $18,021 from $25,907 at June 30, 2025, to $43,928 at June 30, 2026. The increase is due to the Plan receiving a new tenant's security deposit related to a lease agreement entered into during the year ended June 30, 2026.

Other liabilities remained a balance of $25,907 during the years ended June 30, 2025 and 2024.

Deferred inflow of resources – The Plan, as a lessor, recognized a deferred inflow of resources corresponding to the lease receivable amount, and it is defined as an acquisition of net position by the Plan that is applicable to future reporting periods.

Deferred inflow of resources balance increased $907,962 from $1.1 million at June 30, 2025, to $2.0 million at June 30, 2026. The increase is due to a new tenant entering into a lease agreement for a previously vacant office space during the fiscal year ended June 30, 2026, offset by the recognition of lease revenue corresponding to the collection of lease payments from tenants by the Plan during the fiscal year ended June 30, 2026.

Deferred inflow of resources balance decreased $1.1 million from $2.2 million at June 30, 2024, to $1.1 million at June 30, 2025. The decrease is due to the recognition of lease revenue corresponding to the collection of lease payments from tenants by the Plan during the fiscal year ended June 30, 2025.

Membership

Membership months decreased 125,280 (-2.41%) from 5,209,085 for the fiscal year ended June 30, 2025 to 5,083,805 for the fiscal year ended June 30, 2026. The decrease is primarily due to the end of the COVID-19 eligibility redetermination flexibilities effective June 30, 2025, an enrollment freeze on the state-only full scope Medi-Cal expansion for adults aged 19 and older effective January 1, 2026, and the reinstatement of the Medi-Cal asset limit test for applicants or members whose eligibility is not based on modified adjusted gross income financial methods effective January 1, 2026.

Membership months decreased 16,451 (-0.31%) from 5,225,536 for the fiscal year ended June 30, 2024 to 5,209,085 for the fiscal year ended June 30, 2025. The slight decrease is primarily due to Medicaid disenrollment taking effect in July 2023 under the Consolidated Appropriations Act of 2023, and the loss of membership to Kaiser resulting from Kaiser's contract with DHCS effective January 1, 2024, partially offset by the expansion of full scope Medi-Cal managed care benefits to undocumented beneficiaries ages 26- 49 effective January 1, 2024, and additional dual Medi-Cal/Medicare members transitioning from voluntary to mandatory enrollment into Medi-Cal managed care in 2024.

Capitation revenue – The capitation revenue balance increased $32.0 million from $2,333.6 million at June 30, 2025, to $2,365.6 million at June 30, 2026. The increase is primarily due to the increase in capitation rates from DHCS, offset by the decrease in membership and the MCO tax revenue.

The capitation revenue balance increased $285.5 million from $2,048.1 million at June 30, 2024, to $2,333.6 million at June 30, 2025. The increase is primarily due to the increase in capitation rates from DHCS and the MCO tax revenue, offset by the decrease in membership.

Nonoperating revenue – The nonoperating revenue balance decreased $1.7 million from $11.7 million at June 30, 2025, to $10.0 million at June 30, 2026. The decrease is due to the decrease in investment income, offset by the increase in rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

The nonoperating revenue balance increased $2.6 million from $9.1 million at June 30, 2024, to $11.7 million at June 30, 2025. This increase is due to the increase in investment income, offset by the decrease in rental income generated from lease arrangements with tenants who occupy portions of the Plan's commercial building.

Health care expenses – Overall health care expenses consist of the capitation payment that the Plan pays to its subcontracting entities for health care services provided to CalViva members and for the direct payment of medical claims, including claims which have been incurred but not yet reported.

Overall health care expenses increased $123.6 million from $1,405.5 million at June 30, 2025, to $1,529.1 million at June 30, 2026. The increase is primarily due to the increase in capitation rates from DHCS which increases the capitation revenue and capitation expenses, offset by the decrease in membership.

Overall health care expenses increased $95.6 million from $1,309.9 million at June 30, 2024, to $1,405.5 million at June 30, 2025. The increase is primarily due to the increase in capitation rates from DHCS which increases the capitation revenue and capitation expenses, offset by the decrease in membership.

General and administrative expenses – Overall general and administrative expenses decreased $638,210 from $69.0 million at June 30, 2025, to $68.4 million at June 30, 2026. The decrease is primarily attributable to the decrease in expenditures related to license and administrative service agreement fees, offset by the increase in salaries and benefits, grants, and consulting fees. General and administrative expenses as a percentage of revenue totaled 2.9% for the fiscal years ended June 30, 2026 and 2025.

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Overall general and administrative expenses increased $447,874 from $68.6 million at June 30, 2024, to $69.0 million at June 30, 2025. The increase is primarily attributable to the increase in expenditures related to license, and salary and benefits, offset by the decrease in administrative service agreement fees and consulting fees. General and administrative expenses as a percentage of revenue totaled 2.9% and 3.3% for the fiscal years ended June 30, 2025 and 2024, respectively.

Premium tax – In 2009, AB 1422 was passed by the legislature and signed by Governor Schwarzenegger. The bill provided that Medi-Cal managed care plans would be subject to a gross premium tax (GPT). CalViva is required to pay 2.35% on gross Medi-Cal capitation revenues to the State of California. The GPT program concluded on June 30, 2012. In June 2013, SB 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. The collected taxes are matched by federal dollars and are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. The State of California calculates the gross premium tax amount in CalViva's capitation rates; as such, the premium tax has no financial impact on the Plan.

On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined.

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On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare and Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. A modification to the Managed Care Organization (MCO) tax, authorized by Assembly Bill (AB) 160 (Chapter 39, Statutes of 2024) with an effective period of January 1, 2024, through December 31, 2026, was approved by the Centers for Medicare and Medicaid Services (CMS) on December 20, 2024. This modification establishes tax amounts in addition to the MCO tax originally authorized by AB 119 (Chapter 13, Statutes of 2023) approved by CMS on December 15, 2023. Under the Tax Uniformity Requirements enacted July 4, 2025, health care related taxes, including MCO taxes, must apply a uniform 1:1 rate and cannot tax Medicaid business at a higher rate than non-Medicaid business. As a result, the current MCO tax ceases as of the enactment date, however, there is a discretionary allowance of up to a three-year transition period which the State of California is applying for with the federal government. On November 14, 2025, CMS approved to provide a limited transition period in accordance with Section 71117(c) of Working Families Tax Cuts Legislation (WFTCL), for health care related taxes, including MCO taxes, until the end of the applicable state's fiscal year ending in calendar year 2026. On February 2, 2026, CMS finalized a rule that changes federal requirements for health care related taxes used to finance Medicaid programs. Under the policies finalized in this rule, these taxes, including MCO taxes, will have a transition period that ends December 31, 2026. The premium tax recorded was $753.5 million and $848.4 million for the fiscal years ended June 30, 2026 and 2025, respectively.

Significant Capital Asset and Long-Term Financing Activity

There was no significant capital asset or long-term financing activity during the fiscal years ended June 30, 2026 and 2025.

Currently Known Facts, Decisions, or Conditions

Legislative changes to Medi-Cal directly affect the Plan's operations, membership, and revenue. As part of the State of California (State) budget for fiscal year 2026-2027, the State made a policy shift to move Medi-Cal beneficiaries with Unsatisfactory Immigration Status (UIS) out of Medi-Cal managed care and into the State's Fee-For-Service (FFS) delivery system effective January 1, 2027, which will result in a decline in membership and revenues during fiscal year 2027.

On July 4, 2025, President Donald Trump signed H.R.1, the "One Big Beautiful Bill Act" which introduced broad federal reductions in Medicaid and Affordable Care Act (ACA)-related funding, significantly affecting Medi-Cal coverage levels. These changes reflect provisions that tighten eligibility verification, impose work requirements, modify renewal rules, and reduce federal matching rates for the Medicaid expansion population. The expected impacts include enrollment reductions and increased acuity due to adverse risk selection. The Plan estimates a decline in enrollment and revenues during fiscal year 2027 as a result of the various policy changes related to H.R.1.

In addition, H.R.1 prohibits any new Medicaid provider tax or increases to existing tax rates. Furthermore, H.R.1 prohibits any provider taxes that would impose a lower rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes or taxes Medicaid units of service (e.g., member months) at a higher rate than non-Medicaid units of service. In response to these federal changes, the State and Plan's MCO tax during fiscal year 2027 will likely be materially lower than prior year amounts.

The Plan is projecting enrollment at the end of the next fiscal year ending June 30, 2027 to be 312,141 which represents approximately a 23.6% decline, primarily due to the State policy shift of moving UIS members into the State's FFS delivery system in addition to federal policy changes related to H.R.1.

Overall, Plan management anticipates, based on current and forecasted operating trends and projected cash flows from operations, that the Plan will continue to be financially viable, meet its obligations, and meet the minimum financial regulatory requirements for the fiscal year ending June 30, 2027.

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Report of Independent Auditors

The Commissioners
The Fresno-Kings-Madera Regional Authority
dba CalViva Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of The Fresno-Kings-Madera Regional Authority dba CalViva Health, which comprise the statements of net position as of June 30, 2026 and 2025, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of The Fresno-Kings-Madera Regional Authority dba CalViva Health as of June 30, 2026 and 2025, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor’s Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of The Fresno-Kings-Madera Regional Authority dba CalViva Health and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health’s ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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In performing an audit in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The Fresno-Kings-Madera Regional Authority dba CalViva Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about The Fresno-Kings-Madera Regional Authority dba CalViva Health's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 11 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of The Fresno-Kings-Madera Regional Authority dba CalViva Health's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

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San Francisco, California
October __, 2026

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Financial Statements

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position
June 30, 2026 and 2025

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	2026	2025
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 358,014,370	$ 188,090,716
Capitation receivables from the State of California	205,498,343	329,916,083
Other receivables	838,241	527,928
Prepaid expenses	1,737,964	1,411,782
Lease receivable - current portion	530,929	390,921
Total current assets	566,619,847	520,337,430
CAPITAL ASSETS		
Nondepreciable	3,161,419	3,161,419
Depreciable, net of accumulated depreciation and amortization	5,646,992	5,780,903
Total capital assets	8,808,411	8,942,322
LEASE RECEIVABLE - NONCURRENT PORTION	1,928,760	1,132,757
ASSETS RESTRICTED AS TO USE	305,121	302,746
Total assets	$ 577,662,139	$ 530,715,255

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Net Position
June 30, 2026 and 2025

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	2026	2025
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Capitation payable	$ 134,350,539	$ 129,234,051
Amounts due to the State of California	37,425,290	19,860,831
Accounts payable and accrued expenses	4,654,185	5,959,612
Accrued salaries and benefits	557,641	492,256
Premium tax payable	188,700,404	188,700,404
Medical claims payable	281,298	459,501
Directed payment payable	824,392	742,751
Total current liabilities	366,793,749	345,449,406
OTHER LIABILITIES	43,928	25,907
Total liabilities	366,837,677	345,475,313
DEFERRED INFLOWS OF RESOURCES	2,039,446	1,131,484
Total liabilities and deferred inflow of resources	$ 368,877,123	$ 346,606,797
NET POSITION		
Net investment in capital assets	$ 8,808,411	$ 8,942,322
Restricted by legislative authority	305,121	302,746
Unrestricted	199,671,484	174,863,390
Total net position	208,785,016	184,108,458
Total liabilities, deferred inflow of resources, and net position	$ 577,662,139	$ 530,715,255

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2026 and 2025

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	2026	2025
OPERATING REVENUES		
Capitation revenue	$ 2,365,626,696	$ 2,333,594,205
OPERATING EXPENSES		
Health care expenses:		
Capitation expense	1,524,022,357	1,398,230,816
Medical expense	5,088,137	7,253,544
Total health care expenses	1,529,110,494	1,405,484,360
General and administrative expenses:		
Administrative service fees	55,945,648	57,403,720
Other expense	5,422,740	5,319,319
Salaries and benefits	4,629,456	4,209,448
Marketing and promotion	1,488,907	1,393,717
Depreciation and amortization	348,442	340,523
Legal and professional	563,157	369,833
Total general and administrative expenses	68,398,350	69,036,560
Premium tax	753,500,000	848,375,000
Total operating expenses	2,351,008,844	2,322,895,920
Income from operations	14,617,852	10,698,285
NONOPERATING REVENUE		
Other income	584,693	471,252
Interest income	9,474,013	11,248,987
Total nonoperating revenue	10,058,706	11,720,239
CHANGES IN NET POSITION	24,676,558	22,418,524
NET POSITION, beginning of year	184,108,458	161,689,934
NET POSITION, end of year	$ 208,785,016	$ 184,108,458

See accompanying notes.

The Fresno-Kings-Madera Regional Health Authority
dba CalViva Health
Statements of Cash Flows
Years Ended June 30, 2026 and 2025

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	2026	2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	$ 2,490,044,436	$ 2,220,358,364
Health care expenses paid	(1,506,526,109)	(1,420,144,672)
Administrative expenses paid	(823,408,424)	(885,858,398)
Net cash provided by (used in) operating activities	160,109,903	(85,644,706)
CASH FLOWS FROM NONCAPITAL FINANCING AND RELATED ACTIVITY		
Proceeds from lease receivable	505,520	536,604
Net cash provided by noncapital financing and related activity	505,520	536,604
CASH FLOWS FROM CAPITAL FINANCING AND RELATED ACTIVITY		
Payments for purchase of capital assets	(214,531)	(186,144)
Net cash used in capital financing and related activity	(214,531)	(186,144)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest income, net	9,522,762	11,232,516
Net cash provided by investing activity	9,522,762	11,232,516
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	169,923,654	(74,061,730)
CASH AND CASH EQUIVALENTS, beginning of year	188,090,716	262,152,446
CASH AND CASH EQUIVALENTS, end of year	$ 358,014,370	$ 188,090,716
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
Income from operations	$ 14,617,852	$ 10,698,285
Adjustments to reconcile income from operations to net cash provided by (used in) operating activities:		
Depreciation and amortization	348,442	340,523
Changes in operating assets and liabilities:		
Capitation receivables from the State of California	124,417,740	(153,128,341)
Receivable from Health Net	-	39,892,500
Other receivables	(310,313)	348,949
Prepaid expenses	(326,182)	(1,161,829)
Capitation payable	5,116,488	9,603,107
Amounts due to the State of California	17,564,459	(20,639,169)
Accounts payable and accrued expenses	(1,305,427)	(31,773)
Accrued salaries and benefits	65,385	88,542
Premium tax payable	-	31,968,750
Medical claims payable	(178,203)	387,618
Directed payment payable	81,641	(4,011,868)
Other liabilities	18,021	-
Net cash provided by (used in) operating activities	$ 160,109,903	$ (85,644,706)

See accompanying notes.

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Note 1 – Organization

The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (CalViva or the Plan) is a local governmental health insuring organization that operates in the counties of Fresno, Kings, and Madera (Tri-Counties). The Boards of Supervisors for the Tri-Counties established The Fresno-Kings-Madera Regional Health Authority (the Authority) in March 2009, in accordance with the State of California Welfare and Institutions Code (the Code) Section 14087.38. Through the provisions of the "Joint Exercise of Powers Agreement between the counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs" agreement, dated March 2009, and pursuant to the Code, CalViva became financially independent of Fresno, Kings, and Madera counties. In addition, the Code provides that CalViva is a public entity, separate and apart from the counties of Fresno, Kings, and Madera. CalViva received its Knox-Keene license from the California Department of Managed Health Care (DMHC) on December 30, 2010, and commenced operations on March 1, 2011.

The mission and purpose of CalViva is to improve access to care and provide quality health care to families in the Fresno, Kings, and Madera County areas at the right place and the right time.

CalViva has contracted with the California Department of Health Care Services (DHCS) to receive funding to provide health care services to the Medi-Cal eligible Tri-County area residents who are enrolled as members of CalViva under the two-plan model. The DHCS contract is effective March 1, 2011, through December 31, 2027. The DHCS contract specifies capitation rates based on a per-member, per-month basis, which may be adjusted annually. DHCS revenue is paid monthly and is based upon the contracted capitation rates and actual Medi-Cal enrollment. In addition, DHCS pays CalViva supplemental capitation rates such as a fixed maternity case rate for each eligible birth incurred by a CalViva Medi-Cal member. CalViva, in turn, provides services to Medi-Cal beneficiaries through a contract with Health Net Community Solutions, Inc. (Health Net), a wholly owned subsidiary of Centene Corporation. Further, CalViva has an administrative service agreement with Health Net in which Health Net performs specific administrative functions for CalViva.

On September 2, 2009, the California State Legislature ratified Assembly Bill (AB) No. 1422 (AB 1422), which levies a 2.35% gross premium tax (GPT) on all Medi-Cal capitated revenue received. The proceeds from the tax are appropriated from the Children's Health and Human Services Special Fund to the State Department of Health Care Services and the Managed Risk Medical Insurance Board for specified purposes. This provision was effective retroactively to January 1, 2009. The GPT program was concluded on June 30, 2012. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statutes 2023) enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115 (Chapter 348, Statutes 2019). The new MCO tax was approved by the CMS on December 15, 2023, with an effective date range of April 1, 2023, through December 31, 2026. A modification to the Managed Care Organization (MCO) tax, authorized by Assembly Bill (AB) 160 (Chapter 39, Statutes of 2024) with an effective period of January 1, 2024, through December 31, 2026, was approved by the Centers for Medicare and Medicaid Services (CMS) on December 20, 2024. This modification establishes tax amounts in addition to the MCO tax originally authorized by AB 119 (Chapter 13, Statutes of 2023) approved by CMS on December 15, 2023. Under the Tax Uniformity Requirements enacted July 4, 2025, health care related taxes, including MCO taxes, must apply a uniform 1:1 rate and cannot tax Medicaid business at a higher rate than non-Medicaid business. As a result, the current MCO tax ceases as of the enactment date, however, there is a discretionary allowance of up to a three-year transition period which the State of California applied for with the federal government. On November 14, 2025, CMS approved to provide a limited transition period in accordance with Section 71117(c) of Working Families Tax Cuts Legislation (WFTCL), for health care related taxes, including MCO taxes, until the end of the applicable state's fiscal year ending in calendar year 2026. In addition, on February 2, 2026, CMS finalized a rule that changes federal requirements for health care related taxes used to finance Medicaid programs. Under the policies finalized in this rule, these taxes, including MCO taxes, will have a transition period that ends December 31, 2026.

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On September 8, 2010, the California State Legislature ratified Assembly Bill No. 1653 (AB 1653), which established a Quality Assurance Fee (QAF) program allowing additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the California Welfare and Institutions (W&I) Code Section 14167.6 (a), DHCS shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with QAF funding: Section 14167.6 (h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services," and Section 14167.10 (a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner prescribed as a pass-through to revenue. The payments did have an effect on the overall AB 1422 gross premium tax paid. In April of 2011, California approved SB 90, which extended the QAF program through June 30, 2011. SB 335, signed into law in September of 2011, extended the QAF portion of SB 90 for an additional 30 months through December 31, 2013. In October of 2013, California approved SB 239, which extended the QAF program for an additional 36 months from January 1, 2014, through December 31, 2016. In November of 2016, the voters of California passed Proposition 52, which permanently extended the QAF program.

Beginning with the July 1, 2017, rating period, DHCS implemented the following managed care Directed Payment programs: (1) Private Hospital Directed Payment (PHDP), (2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP), and (3) Designated Public Hospital Quality Incentive Pool (QIP). (1) For PHDP, this program provides supplemental reimbursement to participating Network Provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The PHDP program was created to maintain access and improve the quality of care for Medi-Cal beneficiaries. (2) For EPP-FFS and EPP-CAP, this program provides supplemental reimbursement to Network Provider designated public hospitals through either a uniform dollar or percentage increase based on actual utilization of network contracted qualifying services. (3) For QIP, DHCS has directed the Medi-Cal managed care health plans (MCPs) to make QIP payments to designated public hospitals and University of California hospitals that are tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP payments will be linked to delivery of services and increase the amount of funding tied to quality outcomes.

Beginning with the calendar year 2023 rating period, DHCS implemented the District and Municipal Public Hospital Directed Payment (DHDP) program which directed MCPs to reimburse California's District and Municipal Public Hospitals for network contracted services, based on actual utilization of contracted services. The goal of this program is to improve preventative care for children, maternity care, and birth equity through increasing access to care. The payments will be enhanced by either a uniform percentage or dollar increment.

Beginning with dates of service on January 1, 2023, DHCS implemented the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) to provide performance-based directed payments to eligible network provider SNFs to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP is authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB)186 (Chapter 46, Statutes of 2022)) for dates of service from January 1, 2023, through December 31, 2026. DHCS has directed Medi-Cal managed care plans to make SNF WQIP payments to eligible SNFs according to utilization and performance on designated WQIP metrics. Based on the State of California's Enacted Budget for State fiscal year 2025-2026, the SNF WQIP ended on December 31, 2025.

CalAIM implementation – Beginning January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. This requires managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. Components that began on January 1, 2022, include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. In addition, institutional Long-Term Care (LTC) benefit including skilled nursing facilities transitioned to Medi-Cal managed care plans effective January 1, 2023. Effective January 1, 2024, all Medi-Cal managed care plans became responsible for the full LTC benefit at facility types such as Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, Pediatric Subacute Care Facility and Subacute Care Facility.

Note 2 – Summary of Significant Accounting Policies

Accounting standards – Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements, as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts, and the State Controller's Office prescribed reporting guidelines.

Proprietary fund accounting – The Plan utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Use of estimates – The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates used in preparing the financial statements include capitation receivables from the State of California, medical claims payable such as liability for incurred but not reported claims expense, useful lives of capital assets, lease receivable, and deferred inflow of resources.

Risks and uncertainties – The Plan's business could be impacted by external price pressure on new and renewal business; additional competitors entering the Plan's markets; federal and state legislation; and governmental licensing regulations of Health Maintenance Organizations (HMOs) and insurance companies. External influences in these areas could have the potential to adversely impact the Plan's operations in the future.

Income taxes – The Plan operates under the purview of the Internal Revenue Code (IRC) Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, the Plan is not subject to federal or state income taxes.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits and other short-term, highly liquid securities with original maturities of three months or less.

Concentration of risk – Financial instruments potentially subjecting the Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (FDIC) insurance thresholds. If any of the financial institutions with whom the Plan does business were placed into receivership, the Plan may be unable to access the cash on deposit with such institutions in order to operate its business without adverse effect. As of June 30, 2026 and 2025, the Plan's uninsured cash and cash equivalent balance totaled $357,661,732 and $187,711,364, respectively. The uninsured balances are collateralized in accordance with state law, which requires qualifying securities to be pledged at 110% of the uninsured balances. To date, the Plan has not experienced any losses on these accounts.

The Plan is highly dependent upon the State of California for its revenues. All capitation receivable and capitation revenues are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Plan.

The Plan has a contract with Health Net whereby Health Net provides virtually all administrative services vital to the Plan's successful daily operation. In addition, the Plan has a capitation agreement with Health Net whereby the Plan utilizes Health Net's network of contracted providers to furnish care for most of the Plan's members. The inability of Health Net to meet its obligations under these contracts could significantly impact the Plan's ability to operate in the short term until alternative arrangements could be made.

Capital assets – Capital assets are recorded at cost. The capitalization threshold of such assets is $10,000. Depreciation of capital assets is based on the straight-line method over the estimated useful lives of three to 30 years. Expenditures for maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized.

The Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

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Lease receivable and deferred inflow of resources – Pursuant to GASB Statement No. 87, *Leases*, the Plan as a lessor recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Plan during the lease term. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Plan that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Plan recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative future receipts on the contract exceed $100,000 that meet the definition of an other than short-term lease. The Plan uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Assets restricted as to use – The Plan is required by the DMHC to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amount recorded was $305,121 and $302,746 at June 30, 2026 and 2025, respectively. Restricted cash comprises certificates of deposit and is stated at fair value.

Medical claims payable – Medical claims payable balance of $281,298 and $459,501 at June 30, 2026 and 2025, respectively, represents the estimated liability for health care expenses payable on a fee-for-service basis for which services have been performed but have not yet been paid by the Plan. Medical claims payable also includes the estimated value of claims that have been incurred but are not yet reported to the Plan. The balances at June 30, 2026 and 2025, were determined by factors such as cost of services and enrollment for providers paid on a fee-for-service basis.

Net position – Net position is classified as invested in capital assets and restricted or unrestricted net position. Invested in capital assets represents investments in land, building, furniture and fixtures, and computer equipment and software, net of depreciation and amortization. Restricted net position is noncapital assets that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Plan. Unrestricted net position consists of net position that does not meet the definition of invested in capital assets or restricted net position.

Operating revenues and expenses – The Plan's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. The primary operating revenue is derived from capitation in support of providing health care services to its members. Operating expenses are all expenses incurred to provide such healthcare services. Nonoperating revenues and expenses include subsidies received and provided, contributions to permanent and term endowments, revenues and expenses related to financing, resources from the disposal of capital assets and inventory, and investment income and expenses. Noncapital subsidies, if any, are presented separately from other nonoperating revenues and expenses.

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Capitation revenue – Capitation revenue is recognized as revenue in the month the beneficiary is eligible for Medi-Cal services. The State of California pays the Plan capitation revenue on a monthly basis based on initial membership, which is adjusted monthly for retroactivity. These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by the Fresno County Department of Social Services, the Madera County Department of Social Services, and the Kings County Human Services Agency, and validated by the State of California. The State of California provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

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Premium deficiencies – The Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2026 and 2025.

Capitation expense and medical expenses – CalViva contracts with providers to furnish health care services to enrolled members. The expenses related to these provisions for covered services to enrolled CalViva members are recognized on an accrual basis.

Premium tax – The Plan paid the State of California a gross premium tax (AB 1422), which was levied in September 2009 pursuant to Section 28 of Article XIII of the California Constitution and is effective retroactively from January 1, 2009, to June 30, 2012. The payment amount is determined by multiplying the Plan's capitation revenue by 2.35%. In June 2013, Senate Bill (SB) 78 extended the imposition of taxes retroactively from July 1, 2012, to June 30, 2013, and increased the tax rate to 3.9375% effective July 1, 2013, through June 30, 2016. On March 1, 2016, SB X2-2 established a new managed care organization provider tax, to be administered by DHCS, effective July 1, 2016, through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans, as defined, except as excluded by SB 78. SB 78 would establish applicable taxing tiers and per enrollee amounts for the 2016--2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. On September 27, 2019, Assembly Bill 115 authorized DHCS to implement a modified Managed Care Organization (MCO) tax model on specified health plans. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 enacted a new MCO tax with the tax structure similar to the prior version pursuant to Assembly Bill 115. The new MCO tax was effective retroactively from April 1, 2023, through December 31, 2026. Assembly Bill 160 authorized a modification to the MCO tax, and established tax amounts in addition to the MCO tax originally authorized by AB 119, with an effective period of January 1, 2024, through December 31, 2026. The premium tax equaled $753,500,000 and $848,375,000 for the years ended June 30, 2026 and 2025, respectively. Premium tax is recognized in the period the related capitation revenue is recognized.

Insurance coverage – The Plan maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the "claims-made" policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the term of the "claims-made" policies but reported subsequent to the termination of the insurance contract may be uninsured.

New accounting pronouncements – In May 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements*. This statement modifies the basic financial statements and MD&A to enhance governmental financial reports. Changes include revisions to MD&A, modifications to proprietary fund statements, elimination of separate extraordinary and special item presentations, and changes to budgetary comparison information. This statement is effective for fiscal years beginning after June 15, 2025. The Plan adopted the Statement effective July 1, 2025, and the adoption resulted in changes to certain financial statement presentation and disclosures but did not have a material impact on the amounts reported in the financial statements.

In September 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*. This statement requires separate disclosure of certain capital assets in the notes, such as lease, intangible right-to-use, and subscription assets, each by major class. It also establishes new disclosure requirements for capital assets that a government has decided to sell and for which a sale is probable within one year. This statement is effective for fiscal years beginning after June 15, 2025, with retroactive application required upon adoption. The Plan adopted the statement effective July 1, 2025, and the adoption had no material impact on the financial statements.

In December 2025, the GASB issued Statement No. 105, *Subsequent Events*. This statement defines subsequent events as transactions or other events that occur after the date of the financial statements but before the date the financial statements are available to be issued. This statement describes the date the financial statements are available to be issued as the date at which (1) the financial statements are complete in a form and format that complies with generally accepted accounting principles and (2) approvals necessary for issuance have been obtained. That definition modifies the subsequent events time frame throughout the GASB literature. This statement also requires the date through which subsequent events have been evaluated to be disclosed. This statement clarifies the subsequent events that constitute recognized and nonrecognized events and establishes specific note disclosure requirements for nonrecognized events. This statement is effective for fiscal years beginning after June 15, 2026. The Plan is currently evaluating the impact of the adoption of this statement on its financial statements.

Note 3 – Investments

The Plan held investments as of June 30 as follows:

	2026	2025
Assets restricted as to use	$ 305,121	$ 302,746
	$ 305,121	$ 302,746

Investments authorized by the Plan's investment policy – Investments may only be made as authorized by the Plan's investment policy. The objectives of the policy are to ensure the Plan's funds are prudently invested to preserve capital, meet the liquidity needs of the Plan and lastly, to achieve a return on the funds.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, an entity will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, an entity will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit).

As of June 30, 2026 and 2025, none of the Plan's deposits with financial institutions in excess of federal depository insurance limits were held in uncollateralized accounts and none of the Plan's investments were subject to custodial credit risk.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Plan did not have any investments that were considered highly sensitive to changes in interest rates as of June 30, 2026 and 2025.

Information about the sensitivity of the fair values of the Plan's investments to market interest rate fluctuations is provided by the following table that shows the distribution of the Plan's investments by maturity:

	Remaining Maturity (in Months) as of June 30, 2026			
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	$ 305,121	$ 305,121	$ -	$ -
Total	$ 305,121	$ 305,121	$ -	$ -

	Remaining Maturity (in Months) as of June 30, 2025			
	Total	12 months or less	13 to 24 months	25 to 60 months
Certificates of deposit - restricted	$ 302,746	$ -	$ 302,746	$ -
Total	$ 302,746	$ -	$ 302,746	$ -

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Investments made by the Plan are not rated by Standard & Poor's, but are fully FDIC insured.

Concentration of credit risk – The investment policy of the Plan contains no limitation on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code. More than 5% of the Plan's investments are in certificates of deposit issued by the Community West Bank and the South State Bank as of June 30, 2026. These investments were 83.38% and 16.62%, respectively, of the Plan's total investments as of June 30, 2026. More than 5% of the Plan's investments are in certificates of deposit issued by the Community West Bank and the South State Bank as of June 30, 2025. These investments were 83.31% and 16.69%, respectively, of the Plan's total investments as of June 30, 2025.

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Note 4 – Capital Assets, Net

A summary of changes in capital assets, net for the years ended June 30, 2026 and 2025, is as follows:

	Balance at July 1, 2025	Additions	Retirements	Transfers	Balance at June 30, 2026
Land	$ 3,161,419				$ 3,161,419
Construction in progress	-	188,923		(188,923)	-
Building	8,229,895			188,923	8,418,818
Furniture and fixtures	286,152	25,608	(3,750)		308,010
Computer equipment and software	56,000		(56,000)		-
Total assets	11,733,466	214,531	(59,750)	-	11,888,247
Less: depreciation expense and accumulated depreciation related to retirements	(2,791,144)	(348,442)	59,750		(3,079,836)
Capital assets, net	$ 8,942,322	$ (133,911)	$ -	$ -	$ 8,808,411

	Balance at July 1, 2024	Additions	Retirements	Transfers	Balance at June 30, 2025
Land	$ 3,161,419	$ -	$ -	$ -	$ 3,161,419
Construction in progress	111,670	-	-	(111,670)	-
Building	7,993,729	124,496	-	111,670	8,229,895
Furniture and fixtures	238,934	61,648	(14,430)	-	286,152
Computer equipment and software	71,723	-	(15,723)	-	56,000
Total assets	11,577,475	186,144	(30,153)	-	11,733,466
Less: depreciation expense and accumulated depreciation related to retirements	(2,479,692)	(340,523)	29,071	-	(2,791,144)
Capital assets, net	$ 9,097,783	$ (154,379)	$ (1,082)	$ -	$ 8,942,322

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Note 5 – Capitation Receivables from the State of California

CalViva receives capitation from the State of California based upon the monthly capitation rate of each aid code (Medi-Cal category of eligibility). The State of California makes monthly payments based on actual members for the current month and retroactive adjustments related to prior months. The capitation receivable represents amounts due from the State of California under the Medi-Cal program. CalViva had capitation receivable of $205,498,343 and $329,916,083 due from the State of California as of June 30, 2026 and 2025, respectively.

Note 6 – Capitation Payable

CalViva contracts with providers to furnish certain health care services to enrolled members. The cost of health care services provided or contracted for is accrued in the period in which it is provided to an enrolled member. The Plan recorded capitation payable of $134,350,539 and $129,234,051 as of June 30, 2026 and 2025, respectively.

Note 7 – Amounts Due to the State of California

During the fiscal year ended June 30, 2026, CalViva recorded amounts due to the State of California of $37,425,290, which relates to the period of January 1, 2024 through June 30, 2026. This amount is related to DHCS' potential future recoupment of the MCO tax gain recognized by the Plan.

During the fiscal year ended June 30, 2025, CalViva recorded amounts due to the State of California of $19,860,831, which relates to the period of January 1, 2024 through June 30, 2025. This amount is related to DHCS' potential future recoupment of the MCO tax gain recognized by the Plan.

Note 8 – Directed Payment Payable

CalViva is under the direction of the DHCS to implement the directed payment program for enhanced reimbursements to eligible and participating network hospitals and skilled nursing facilities for qualifying contracted services. Directed payment payable balance of $824,392 and $742,751 as of June 30, 2026 and 2025, respectively, represents the liability for directed payments approved and paid by the DHCS for disbursements but have not yet been paid by the Plan to the network hospitals and skilled nursing facilities.

Note 9 – Retirement and Deferred Compensation Plans

Retirement plan – Effective January 1, 2010, the Plan established a defined contribution money purchase pension plan, 401(a), for its executive employees. The contribution requirement is established by the Plan. Employees do not make contributions to the Plan. Furthermore, employer contributions are immediately vested. The amounts are not available to employees until termination, retirement, death, disability, and other specific conditions. The Plan's contributions to the retirement plan totaled $247,435 and $242,379 for the years ended June 30, 2026 and 2025, respectively.

Deferred compensation plan – The Plan offers its employees a deferred compensation plan created in accordance with IRC Section 457. The 457b deferred compensation plan is available to all employees and permits them to defer a portion of their salary. An employer match is also provided and is vested at the rate of 33% per year. The amounts are not available to employees until termination, retirement, death, or unforeseeable emergency. The Plan's contributions to the deferred compensation plan totaled $134,971 and $117,911 for the years ended June 30, 2026 and 2025, respectively.

The market value of the investments held equals the amounts due to plan participants under both deferred compensation plans. The assets in both deferred compensation plans referenced above are not available to pay the liabilities of CalViva. CalViva is not controlling the assets in both deferred compensation plans, and employees who participate in these plans are responsible for the direction, use, exchange, or employment of the assets. Therefore, the respective assets and liabilities are not reflected in the statements of net position.

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Note 10 – Lessor Lease Arrangements

The Plan is a lessor for noncancelable leases of office space with lease terms through 2032. Lease revenue from the lease arrangements was $584,693 and $471,252 for the years ended June 30, 2026 and 2025, and is included in other income in the statements of revenues, expenses, and changes in net position. Interest revenue from the lease arrangements was $199,678 and $148,495 for the years ended June 30, 2026 and 2025, respectively, and is included in interest income in the statements of revenues, expenses, and changes in net position.

Note 11 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity was $25,156,267 and $24,835,942 at June 30, 2026 and 2025, respectively. The Plan's tangible net equity was $208,785,016 and $184,108,458 at June 30, 2026 and 2025, respectively.

Note 12 – Risk Management

The Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Plan's commercial coverage.

Note 13 – Commitments and Contingencies

Litigation – In the ordinary course of business, the Plan is a party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the Plan's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Plan.

Note 14 – Federal and State Health Care Policy and Budget Cuts

The health care industry is subject to extensive federal, state, and local laws and regulations. Noncompliance with these laws and regulations could result in sanctions, fines, penalties, exclusion from government-sponsored health care programs, or other adverse actions. Management believes the Plan is in compliance with applicable laws and regulations, including those related to fraud, waste, and abuse. However, health care laws and regulations are subject to ongoing interpretation, regulatory review, and change, and the outcome of any future regulatory actions cannot be predicted.

The Plan is also subject to risks and uncertainties arising from changes in federal and state health care policies, funding mechanisms, and Medi-Cal program requirements. Recent legislative and regulatory changes affecting Medi-Cal eligibility, enrollment, reimbursement methodologies, and supplemental funding programs could affect the Plan's future enrollment, revenues, expenses, operations, and financial condition.

Management continues to monitor these developments and evaluate their potential impact on the Plan's operations, financial position, and cash flows.

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Item #7

Attachment 7.A

Member Experience

POSITION TITLE: Member Experience & Retention Specialist I	EXEMPT STATUS: Exempt	SALARY RANGE:
DEPARTMENT: Administration	REPORTS TO: Chief Executive Officer	

JOB SUMMARY:
The Member Experience and Retention Specialist reports directly to the Chief Executive Officer. The position is responsible for improving the member experience by building trusted relationships with members, identifying and resolving barriers to care and services, connecting members to available resources, and ensuring the member voice is heard throughout the Health Plan. The position will use member feedback and experience The position will use member feedback and experience to identify opportunities for improvement and support member satisfaction, engagement, and retention. The position is responsible for navigating complex member escalations, assessing detractors from member satisfaction, and raising those trends and issues to management leadership. The primary focus of the position will be to address member satisfaction and loyalty with the health plan.

The position is an at-will position and will be primarily remote and field based and will travel through the plan's service area of Fresno, Kings, and Madera Counties during company office hours.

ESSENTIAL DUTIES & RESPONSIBILITIES:

- Apply active listening and a localized connection to concerns and offer solutions to improve the member concern and retention of membership.

- Assist members in resolution to healthcare questions, services, concerns, etc. Establish a personal trusted relationship through one-on-one relationships with members and assist with identifying the entry ways to medical, physical, behavioral, and social care and registering/connecting to available resources. Provide follow-up to confirm issues raised were successfully resolved.

- Conduct proactive outbound calls to active and/or inactive members to gauge member experience and also understand why an inactive member may have left the health plan, and if they left encourage re-enrollment with the health plan. Conduct new member orientations and quarterly focus group interviews of Medi-Cal beneficiaries in the service area to assess member satisfaction, concerns, etc.

- Actively engage with members to enhance satisfaction and overall experience with the Health Plan.

- Serve as a member advocate to push through barriers and conflicts by working with Community Based Organizations, High Volume Providers, etc. with the goal to reduce health plan friction b/w the applicable parties and resolve issues hindering the member experience promptly.

- Collaborate with internal teams, including providers, administrative staff, etc., to ensure consistent member service.

- Maintain up-to-date knowledge of health plan services, programs, and resources. Connect members to available resources. Support presence at community events.

- Ensure detailed documentation of all interactions and if applicable escalate complex issues to the appropriate channels when necessary.

- Deliver a monthly report of activities to the Health Plan's Management Oversight Meeting.

- Ensure member interactions and activities follow the privacy and security of PHI (Protected Health Information) as outlined in RHA's policies and procedures relating to HIPAA compliance.

- Other duties as required.

MINIMUM QUALIFICATIONS:

EDUCATION:

- Bachelor's degree required
- Related fields: Healthcare or Public Administration, Health, Social Work/Sociology, Psychology, communications, or a related field preferred. Relevant professional experience may substitute for education
- Verbal bilingual fluency & must successfully complete required Medi-Cal certification upon hire and maintain certification every two years thereafter.

EXPERIENCE:

- Experience in healthcare, insurance, or managed care is highly desirable
- Minimum 2 years of experience in members service, patient experience, or customer service.

KNOWLEDGE, SKILLS & ABILITIES:

- Strong interpersonal and communication skills in both English and Spanish. Mastery of de-escalation techniques and customer service. Demonstrates prominent levels of emotional intelligence and empathy.
- Ability to build and maintain effective working relationships with members, colleagues, providers, and the community.
- Strong problem-solving and conflict-resolution skills and ability to prioritize tasks, multitask, and work independently
- Proficiency with computers, electronic health records, and standard office software
- Detail-oriented with the ability to accurately document interactions and track outcomes
- Ability to adapt to changing conditions and maintain composure in a fast-paced environment
- Commitment to member confidentiality and adherence to HIPAA regulations and rules, regulations, policies, and standards related to managed care.

PHYSICAL REQUIREMENTS:

- Frequent verbal and written communication with staff and other business associates by telephone, correspondence, or in person
- Must have reliable transportation. Will be required to travel between Kings, Madera, and Fresno counties as well as between offices for meetings

NOTE: The information in this description indicates the general nature and level of work performed by employees within this classification. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job.

Item #8
Attachment 8.A-B

Health Equity

A. Executive Summary
B. Work Plan Evaluation

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist Sia Xiong-Lopez, MA, Health Equity Officer
COMMITTEE DATE:	October 15, 2026
SUBJECT:	Health Equity 2026 Work Plan Mid-Year Evaluation – Summary Report

Summary:

This report provides information on the Health Equity Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The Health Equity Work Plan is broken down into the following four sections: 1) Language Assistance Program (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of June 30, 2026, all work plan activities are on target to be completed by the end of the year with some already completed.

Purpose of Activity:

To evaluate the mid-year progress against the work plan activities and identify changes to be made to meet end of year goals. CalViva Health (CVH) has delegated all language services to Health Net's Health Equity Department.

Data/Results (include applicable benchmarks/thresholds):

Below is a high-level summary of the activities completed during the first six months of 2026. For complete report and details per activity, please refer to the attached 2026 Health Equity Work Plan Mid-Year Evaluation Report.

a. Language Assistance Services

a. Provided documents for internal audit.
b. Amended 5 language vendors' contracts and completed 6 vendors' risk assessments.
c. Produced 3 nondiscrimination notices in large print.
d. Fifty-four staff completed their bilingual assessment or were re-assessed.
e. Twenty-nine translation reviews were completed.
f. Attended 2 CAHPS meetings and provided insights on how to improve member experience.
g. Assisted 7 staff with gaining access to translation portal (Vu).

b. Compliance Monitoring

a. Health Equity reviewed 29 grievance cases with 6 interventions identified, and responded to 2 interpreter complaints.

b. Completed, presented and received approval for the 2025 End of Year Language Assistant Program, 2025 End of Year Work Plan reports, the 2026 Program Description, and 2026 Work Plan.
c. Attended all Public Policy Committee meetings.
d. One staff training course was completed in Q2 with 45 attendees. One provider training on track to be completed later in the year.
e. 1,164 referrals were made in findhelp with 308 closed loop referrals, 119 members got help, and 318 new programs were added to the platform.

c. Communication, Training and Education

a. Annual coding and resolution of grievance to new hires and current A&G staff completed in February.
b. Ongoing support for other departments regarding LAP services.
c. Provider's newsletter on track to complete in Q3.

d. Health Literacy, Cultural Competency and Health Equity

a. English material review completed for a total of 29 materials.
b. Hosted two Readability and EMR Database trainings, no attendees in Q1 and 5 attendees in Q2.
c. Plain language training for staff is on track to be completed in Q4.
d. National Health Literacy Month on track to complete in Q4.
e. LAP and the use of plain language training for providers on track to be completed by the end of the year.
f. Cultural Competency training for providers and staff is on track to be completed in Q3.
g. Provided necessary data for clinical (W30-6+) and non-clinical (SUD/MH) PIP project submissions in August.
h. Produced community referral process for IHI Sprint Project.

e. CalViva Health Equity

a. Annual CLAS Month event is on track to be completed in December.
b. Co-leading the Kings County CHIP Priority #5: Maternal, Infant and Child Health Workgroup to host an upcoming community baby shower, doula and CHW Convening.
c. Partnered with other manage care plans and public health to expand doula service.
d. Actively working on community assessment with Reading and Beyond to better understand community members living with a disability. Initial pilot event to be completed in August 2026.
e. Partnered with Madera County Public Health to develop a comprehensive resource list to identify Policy, Systems, and Environmental (PSE) in Madera County.

Analysis/Findings/Outcomes:

All activities are on target to be completed by the end of the year with some already completed. The Health Equity Department will continue to implement, monitor, and track C&L related services and activities.

Next Steps:

Continue to implement the remaining six months of the Health Equity 2026 CalViva Health Work Plan and report to the QI/UM Committee.

2026
Health Equity
Mid-Year Work Plan Evaluation

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

Mission:

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

Goals:

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:
1. To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
2. To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
3. To advance and sustain cultural and linguistic innovations.

Objectives:

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

Selection of the Cultural and Linguistics Activities and Projects:

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

Strategies:

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

^

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

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

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- Cultural Competency Training Program 16
- Health Equity 19

^ revision
* new

	Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/26 - 6/30/26)	Year-End Update (7/1/26 - 12/31/26)
	Language Assistance Program Activities					
1	**Rationale**	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2	**Responsible Staff:**	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3	Audit	Assure Health Equity/C&L audit readiness to support DMHC and DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: review of TAG to identify risk areas, collecting requested documentation, submitting documents to regulator as requested, preparing all supporting documents for on-site visit by regulator, fill out DHCS C&L questionnaire Conduct internal audit to ensure compliance with Medi-Cal and LAP requirements (ensure systems are capturing provider and office language capabilities per SB137)	Vary by year	Completed 1 internal audit by CalViva Health. Provided documents related to language vendors contracts and bilingual assessments for audits.	
4	Contracted Vendors	Conduct language assistance vendor management oversight. Review and update vendor contracts to ensure alignment with requirements; participate in vendor oversight calls; align and submit reports as needed. Ensure risk assessments are completed, annually.	Number of vendor contracts updated or amended; date of JOC meetings; number of risk assessment completed	Ongoing	Amended and renewed 5 language vendors' contracts. Completed 1 JOC meeting on 6/24. Completed 6 vendor's risk assessments.	
5	Data	Collect and conduct analysis of language utilization and demographic data to identify emerging language needs and threshold languages.	Updated LAP utilization report to contain monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log. Production of report showing emerging language need and threshold languages.	Semi-annual	Ongoing. Received monthly and updated monthly on internal dashboard.	

6	Operational	Document emerging and threshold language for fiscal year and deploy process and timeline for incorporation of languages into member materials. Specifically identify whether new languages meet threshold criteria and write on document that threshold analysis was completed.	Documentation of notification to impacted departments; documented process and timeline for incorporation of emerging and threshold languages	March	Annual threshold language analysis prepared in January with NCQA update in March. Distributed across the enterprise.	
7	Data	Facilitate alignment and collection of demographic data for reports. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly	Ongoing. Received and reviewed January through June data.	
8	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing	Four criteria were reviewed with the following providers who were audited and their respective compliance rate 34 audits at 100% (Office Mgmt. D_1), 27 audits at 100% (Office Mgmt. D_2), 22 audits at 96% (Format F), and 9 audits at 50% (Format G).	
9	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials.	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint. Also maintain inventory and organization of public and working files.	June and December	3 CVH NDN updated	

10	Member Communication	Coordinate, write/review articles for LAP, findhelp, Privacy, and other content as needed to assure Cultural and Linguistic appropriateness and to meet NCQA Health Outcomes Accreditation and Community-Focused Care Accreditation Standards requirements for members' newsletter Annual LAP mailing to survey REAL and SOGI.	The member newsletters are mailed to members once a year.	Annual	The newsletter will be mailed to members in Q4.		^
11	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified or recertified annually	Annual	54 staff were certified or recertified		
12	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis. Report to summarize utilization of LAP services, number of bilingual staff and provide year-over-year trends for the utilization of LAP services.	Reports submitted to committees	Q2 & Q3	2025 EOY LAP and 2025 Work Plan completed and accepted by committee in Q1.		^
13	Operational	Coordinate Health Net LAP Oversight operational meetings with Centralized Unit and Behavioral Health.	Quarterly meetings and review of metrics, interpreter and translation issues, grievances discussion, billing and invoice changes and system upgrades	Quarterly	Completed quarterly meetings on 3/23/2026, 5/7/2026 (ad hoc), and 6/30/2026.		
14	Operational	Request interpreter service complaint/exempt grievance logs from call center and conduct trend analysis. Provide complaint information to impacted areas for resolution, e.g., vendor, internal process.	Monitor interpreter service vendors through service complaints.	Biannual (trend)	Ongoing collection of logs. On track for trend analysis.		
15	Operational	Coordinate and facilitate quarterly Health Equity Department/LAP meetings to review requirements and department procedures for language and health literacy services.	Minutes of meetings	Quarterly	Completed quarterly meetings on 3/19/2026 and 6/25/2026.		
16	Operational	Support Population Health Management (PHM) with Population Analysis Report with demographic and social needs data for presentation.	Data provided to PHM.	Annual, as needed	Provided demographic data for PNA in April.		^

	17	Access and Availability	Implement activities to meet the 2027-Geo Access action plans	Report on Geo Access action plan activities and metrics	May	N/A for 2026.	
	18	Member Experience	Provide consultation and support on reasonable accommodation requests.	Number of reasonable accommodation requests supported	Ongoing	No reasonable accommodation requests have been received during this reporting period.	
^	**19**	Operational	Develop, update and maintain Health Equity P&Ps including LAP, translation, alternate formats, interpreter services, bilingual assessment, and others.	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual and as needed	Annual P&P revisions completed in March. Minor revisions for some P&Ps completed in May and June.	
	20	Operational	Complete Health Equity Geo Access report including cultural analysis to meet NCQA requirements. To be completed every two years.	Data collection and data analysis for Health Equity GeoAccess report.	Q3 2025	Report is on track to be completed in 2027.	
	21	Operational	Attend workgroup meetings and contribute to solutions for improving Access and Availability, produce annual or quarterly (as needed) and annual TAR reports.	Annual TAR report completed and Access and Availability meetings attended	Quarterly/Annually	Attended Access and Availability meeting on 3/31 and 5/36	
*	**22**	Operational	Provide subject matter guidance to other departments on LAP content and review of materials.	Materials reviewed and consultation provided	Ongoing	Ongoing	
*	**23**	Operational	Oversee SOGI data collection tracking; Maintain Member Portal data collection expertise; Contribute to SOGI data collection planning throughout the Enterprise.	Update P&P (CA.CLAS.14) with SOGI collection information, as needed; Track SOGI data by line of business		Monthly review of data files. Ongoing subject matter expert feedback throughout enterprise. Revisions to P&P in June.	
^	**24**	Operational	Manage the translation review process and resources.	Number of translation reviews completed annually	Ongoing	Completed 29 translation reviews	

25	Operational	Lead IT projects related to language assistance services such as standing requests and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories.	Successful implementation of IT projects	Ongoing	Ongoing	
26	Operational	Participate in CAHPS Action Plan Meeting with Health Equity to identify potential actions to improve member experience.	CAHPS Action Plan Meetings attended, and action plan/activities implemented	Quarterly	CAHPS action plan meetings attended on April 9 and May 14, 2026.	
27	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Monitor strategic partners and specialty plans for compliance with LAP program. Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing	Strategic partnership checklists received from specialty plans.	
28	Translation and Alternate Format Management	Vital documents management is inclusive of annual reminders to dept. managers, confirm placement of vital docs info on TAFT master spreadsheet, request annually from departments which vital documents they produce (including adverse benefit determination notices) and request desktop/policy from departments (when appropriate) on vital document process. Use information obtained from business unit to update the vital document spreadsheet and glossary. Oversee implementation and management of TAFT master spreadsheet.	Master spreadsheet of Vital Documents	Ongoing	Requested document updates from dept. managers in Q2. Ongoing collection of spreadsheets.	
29	Compliance and Accreditation	Manage the Health Education material field testing process and resources for the Field Testing Workgroup.	Number of materials field tested completed annually	Ongoing	No field testing requests received during this time frame.	

30	Compliance and Accreditation	Provide oversight to translation projects and coordinate ad hoc multi department requests and provide overall coordination support between the vendor and internal departments	Number of materials translated	Ongoing	3 translations coordinated and support with 7 Vu (translation portal) accounts created	
	Compliance Monitoring					
31	**Rationale**	**Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.**				
32	**Responsible Staff:**	**Primary: P. Lee, A. Johnson**	**Secondary: M. Quan**			
33	Complaints and Grievances	Oversight of complaints received on LAP or C&L services, including monitoring and responding to C&L grievances. Develop and maintain desktop for grievance resolution process. Collect grievance and call center reports. Maintain quarterly contact with the call center to ensure they monitor C&L complaints. Conduct monthly reconciliation meetings with A&G.	Number of grievances, complaints, and interventions.	Quarterly	A total of 29 cases were referred. 6 required corrective actions. Investigated 2 interpeter complaints (2 medical, 0 BH)	
34	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers to gauge the effectiveness of the LAP program	Production of trend analysis report	August	Trend analysis completed and submitted to committee in Q2.	
35	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December	No updates made to the desktop procedures in Q1 or Q2. Updates and reviews will be conducted in Q4.	

^	**36**	Oversight	Participate in CalViva required workgroups and committees. Attend weekly QI/UM meetings. Write and present annual work plan and program description, mid-year work plan evaluation, LAP report, end of year work plan evaluation, and end of year LAP report. Support PNA report and updates. Assist with DHCS and DMHC Cultural and Linguistic Services audits.	Dates documents were submitted and approved by Committee. Number and dates of QI/UM Committee and ACCESS Workgroup meetings attended.	Ongoing	Attended QI/UM weekly meetings and completed 2025 EOY LAP and 2025 EOY Work Plan reports in April. Supported with providing documents for audits and participated in audits in June.	
*	**37**	Liaison to Plan Partner	Attend community events and providers meetings as needed to sustain local relationships and develop partnership with CVH staff.	Document and provide details of meetings and community events, number and dates of meetings.		Attended community meetings: Keeping Our Families Safe Coalition and Perinatal Wellness Taskforce. Attended CVH's annual provider visits in Q1.	
	38	Member Support	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings with presentations and/or materials as needed.	Quarterly	Attended PPC meetings on 3/4 and 6/3. Presented 2025 EOY Work Plan and 2025 EOY LAP report in June.	

39	SDoH/Community Resources	Work with Marketing to develop new/rebrand findhelp materials for members and findhelp website, as needed. Update provider training guide to include the latest Cozeva integration.	Rebranding findhelp materials and websites	Ongoing	The 2026 update of the Provider and Community Partner How-to Guides is in progress, incorporating enhancements related to the findhelp–Cozeva integration, updated terminology, screenshots, and provider resources took place in Q1 and Q2. Health Equity and Provider Communications collaborated to review and apply revisions with final items in Q3.	
40	Operational	Collaborate with community and health plan partners on SDoH and social needs support programs, including biweekly meetings with findhelp.	Attend meetings, conduct presentations and support activities	Biweekly As needed	Attended meetings for monthly reports with findhelp.	

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41	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal departments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Update training to align with Cozeva integration by creating an online findhelp course for staff and an on-demand recording for providers. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within findhelp to address social risks within each month.	Ongoing	Training was provided in March (Q2), where 45 staff members attended. No provider trainings in Q1 and Q2, on track for Q3 and Q4. Staff 63 referrals 2 closed loops 2 members got help Community Partners 20 SNAs Completed 10,259 Searches 1,101 referrals 306 closed loops 117 members got help 318 new programs added	

42	Collaboration-External	HN collaboration and consultation to external forums such as DHCS HECL workgroup, AHIP health equity workgroup, NCQA expert workgroup on health equity and other SDoH collaborative forums, as needed.	Minutes of meetings that reflect HN consultation and shared learning	Quarterly	Attended meetings with other MCP (San Joaquin and LA Care) workgroups on DEI training in Q1 and Q2. Collaborated with California-based community organizations, health plans, and healthcare partners to learn and share best practices for advancing health equity and improving access to care. Topics included community-informed approaches to health assessments, transportation resources, housing support, and other social determinants of health. Discussed and contributed insights and strategies to support equitable maternal and child health outcomes.	
	Communication, Training and Education					
43	**Rationale**	**To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.**				
44	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, N. Buller**			
45	Training and Support	Train and provide support to A&G on coding and resolution of grievances related to C&L codes; re-align coding per 1557 non-discrimination reporting	Development of scripted responses and/or training for A&G associates regarding grievance responses, coding, when to send to Health Equity	Annually	Completed training in Q1 on 2/17/26	

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46	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations). Update training deck with specific data slides at mid-year and EOY. Update interpreter and translation quick reference guides with any system updates or process changes and collect the reference guides from the call center.	Create and post to share drive: curriculum, power point, list of participants from Call Center and Provider Relations who attended the in-service. Ensure material is shared with attendees and post trainings. Update and collect interpreter and translation quick reference guides with any system updates or process changes	Ongoing	Ongoing. No trainings presented in Q1 and Q2.	
47	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing	Ongoing and on track for Q4	
48	Provider Communication	Provider Update to cover the following required topics: 1. LAP services 2. Race/ethnicity and language diversity of members 3. Culture and health care topic 4. Promote on-line cultural competence/OMH training 5. Health literacy	Provider Updates distributed and fax/email distribution proof from Marketing	Ongoing	Redlines prepared in May/June. On track for final distribution for July.	
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
49	**Rationale**	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**				
50	**Responsible Staff:**	**Primary: A. Kelechian**	**Secondary: A. Said, M. Quan**			
51	English Material Review	Conduct English Material Review (EMR). Include: review content and layout of materials for reading grade level and cultural and linguistic appropriateness.	All EMRs are completed within a 5 business day turnaround as tracked through Workfront. Exception: Content heavy and high-volume requests are completed within 7 business days.	Ongoing	19 EMRs were completed in Q1 and 10 completed in Q2.	

^	**52**	Operational	Review and update Health Literacy materials and toolkit as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials.	Update and post materials on Health Literacy SharePoint	Ongoing	On track for Q3.	
^	**53**	Training	Training and resources for staff on how to use the C&L database and write in plain language. Update online training as needed.	Quarterly training and resources production.	Quarterly	In Q1, training was offered with no attendees. In Q2, 5 staff attended the training. Plain training for staff is on track to be completed in Q4.	
	54	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities completed.	October	On track for Q4.	
		Cultural Competency Training Program					
	55	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**				
^	**56**	**Responsible Staff:**	**Primary: A. Said, L. Espinoza**	**Secondary: D. Fang, A. Kelechian**			
	57	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) external workgroup. Attend ad hoc/subgroups on training requirements and shared resources (where applicable) per APLs (SB923; DEI)	Minutes of meetings that reflect consultation and shared learning	Ongoing	HICE meeting participation on 3/9/2026 and 5/11/2026.	

^	**58**	Provider Training	A. Conduct cultural competency training for contracted providers. B. Trainings to address required cultural competency topics per regulations and contracts. C. Update trainings as warranted. D. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	A. Cultural Competency Core meeting minutes B. Training curricula, training tracker regulations and contracts met, P&P updates C. Updated training curricula D. Relias provider training lists	Annual	A. On track for Q3 and Q4. B. Trainings have been updated per regulations no changes in Q1 of 2026. C. No changes will be made in 2026 D. On track to work on in Q3 and Q4.	
*	**59**	Provider Training Program Oversight	A. Work with provider engagement to publish invites for trainings and as warranted create OnDemand trainings. B. Work with provider communication to implement available computer-based trainings through provider update(s) and/or provider newsletters and medical directors. C. Promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates (to be included in annual provider LAP update).	A. Training invites B. Provider updates, newsletters, and communications C. Provider update, operational manual		A. No provider trainings were conducted in Q1 and Q2. B. Worked with provider training to update DEI training deadline to communicate to provider the new due date of 12/2026. On track to be completed early Q3.	
*	**60**	Staff Training Program Oversight	A. Coordinate and conduct cultural competency training series for staff. B. Trainings to address required cultural competency topics per regulations and contracts (APL 24-018 training and SB923 DMHC training). C. Update trainings as warranted. D. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required departments are represented.	Cultural Competency Core meeting minutes A. Training schedule for the year along with attendance # B. Cultural competency/DEI training deck C. Any changes/updates that were made to training D. Attendance for Bridging and DEI trainings from WDL		A. Training to be deployed Q3 2026; No trainings deployed Q1/Q2 B. Training deck to be deployed on WDL in Q3 C. No changes will be made to the trainingin2026 D. Attendance to be collected Q3 2026	

*	**61**	Provider Training	Implement *Cultural Humility, Competency, and Equity in Healthcare* (DEI APL 24-016 training) for all LOB providers annually to include downstream sub-contractor and vendor.	Number of attendees/participants and training evaluation		Implement Cultural Humility, Competency, and Equity in Healthcare (DEI APL training) 7/14/2026 Medi-Cal = 6.2% DHCS extended provider completion deadline on 12/2025 to 12/31/2026 so provider have more time now to complete it.	
*	**62**	Provider Training	Implement *Transgender, Gender Diverse, & Intersex Affirming Care & Equity* (TGI/SB923) training to downstream PPG and Vendor STAFF with delegated HN functions that are member facing.	Number of attendees/participants and training evaluation		No trainings took place in Q1 and Q2 of 2026	
	63	Provider Training	Implementation of Language Assistance Programs and the Use of Plain Language for Health Literacy training for providers. Topics: Language Assistance Program, health literacy, plain language communication, health literacy/plan language resources	Number of attendees/participants and training evaluation	Q4	Annual provider training planning began in May. Meetings with Provider Training department in June. Training slide updates completed in June. Recording and live session planned for July and August.	
^	**64**	Accreditation	Obtain NCQA Health Outcomes Accreditation and Community-Focused Care Accreditation	Procurement of NCQA Health Outcome Accreditation and Community-Focused Care Accreditation (renewal) and lead collection and preparation of materials during non-renewal years	Ongoing	Ongoing document preparation and bi-weekly document reviews with internal team.	

65	Report	Complete reports for NCQA Health Equity Accreditation and HEA Plus. Reports include Defining the Community, Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis.	Timely completion of reports. Submitted to NCQA HEA Plus.	Q1	Defining the Community report is on track to be completed in October. Provided data for Annual Referral Disparity Tracking, Social Risk and Social Needs Analysis and Prioritization, and Social Risk and Social Needs Resource Assessment Analysis in Q1.	
	Health Equity					
66	**Rationale**	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				
67	**Responsible Staff:**	**Primary: P. Lee**	**Secondary: N. Chand**			
68	Operational	Lead quarterly Health Equity Collaborative Workgroup. Workgroup aligns QI, population health, SDoH, cultural competency and disparity initiatives across departments. It is inclusive of reporting out and supporting disparity reduction projects, Health Equity updates and reporting to support NCQA and other regulatory requirements.	Facilitate at a minimum quarterly meetings, take minutes and attendance and share out workgroup presentation decks.	Quarterly	Q1 meeting- presented health disparity project findings for HEDIS measures. Q2 meeting- met individually with Pediatric, Health Education, Behavioral, Chronic Conditions PODS to expand current intervention efforts to support low compliance populations identified in the service counties.	

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

71	Operational	Provide support for Madera Lean FUA/FUM QMIP project. Partner with local hospitals to improve rates among members' follow up care after 30 days of an emergency visit. During the measurement period, CalViva Health will carry out targeted interventions that will result in improvement in the percentage (from MY2023 9.84% to 24.51% for FUA and 40.59% for FUM) of members who receive follow up services after an ED Visit for SUD/MH diagnoses following or within 7 days of an emergency department visit for Madera County members.	Support with barrier analysis and interventions such as cultural competency training. Development of modules; meet health disparity reduction targets. Attend bi-weekly meetings.	Ongoing	Attend meetings as needed. Provide data regarding the number of provider staff who completed the cultural competency training and reviewed HSAG submission for completeness.	
72	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project to improve W30-6+ rates. By September 2026, we will increase the W30-6+ WCV rate for non-Spanish-speaking children aged 0–15 months at CSV-Elm Clinics (2) & CSV-RMC Clinic in Fresno County from 61% to 78% and the W30-2+ WCV rate for non-Spanish-speaking 15–30 months from 71% to 88%, in alignment with the overall collaborative goal.	Disparity reduction project work plan; evaluation, documentation of process outcomes. Attend internal meetings and IHI/DHCS learner monthly calls.	Ongoing	Attend bi-weekly meetings. Support with submitted intervention #3 in June which details how Fresno County families navigate and is referred to social services.	
73	Report	Conduct annual disparities analysis for each county.	Conduct disparities analysis for NCQA and DHCS measures by REL and share with internal stakeholders.	Q4	Completed in Q1, presented findings to stakeholders.	
74	Report	Complete Disparity Project Report. Report is inclusive of disparity reduction projects annual write ups. Report is completed annually or bi-annually.	Report for NCQA including annual disparity gap analysis and prioritized opportunities for intervention. Disparity reduction project write-ups demonstrating implementation of member, community and provider level initiatives and evaluation.	Q3	On track to be completed in July.	
75	**Responsible Staff:**	**Primary: S. Xiong-Lopez**	**Secondary: J. Nkansah**			

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*	**76**	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles/webinars that educate staff on culture, linguistics, and the needs of special populations	Attendance record and tracking. Event summary and activity specific participation totals	Annually	Annual Training scheduled for 12/4	
*	**77**	HEQ Project/ Activity	Partner with Kings County Department of Public Health to advance Community Health Improvement Plan (CHIP) priorities within the Access to Care, Maternal and Child Health, and Community Health Worker (CHW) workgroups by implementing community-driven, culturally responsive interventions that improve preventive care access and outcomes.	Measure success through consistent monthly participation in CHIP workgroup meetings to identify and advance collaborative opportunities, increased engagement of priority populations, and demonstrated improvements in access and maternal and child health outcomes.	Ongoing	Co-led the Maternal and Infant Health Workgroup. In process of coordinating a Kings County community baby shower with MCPs and CBOs. Developing a pilot with Public Health to expand doula capacity and benefit utilization. Doula and CHW convening scheduled to take place in October.	

*	**78**	HEQ Project/ Activity	Participate in FCHIP to support development and administration of a provider-facing survey to identify system-level health gaps in developmental services and convene a Community Advisory Council by Q3 to elevate community voice and inform improvement strategies.	By Q2, develop a Needs Survey for providers and/or their member participants to assist in identifying health or service gaps.	Ongoing	April 2026: Proposed community survey based on developmental disabilities data. June 2026: Reading and Beyond (R&B) selected to administer surveys and provide referrals. July 2026: Survey completed in English and Spanish. August 2026: Survey launched at R&B's Health Fair with ASL support. October 2026: Second survey event planned.	
*	**79**	HEQ Project/ Activity	Co-lead the Diabetes and Heart Health workgroup within the Madera County Department of Public Health Live Well Madera initiative to design and implement community-driven strategies that improve prevention, early detection, and management of chronic conditions among priority populations.	Consistent monthly participation, active co-leadership of workgroup initiatives and activities that result in direct community impact and demonstrated increases in engagement and access to diabetes and cardiovascular health services.	Q3	Actively participate in the quarterly steering committee and co-lead the initiative alongside Madera County Public Health. Currently lead the asset-mapping strategy to identify existing work, developing a comprehensive resource list, and identify existing PSEs and initiatives.	

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

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

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

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

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

^ **Indicates revision.**

* **Indicates new.**

Fresno-Kings-Madera Regional Health Authority Commission Approval

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

_____ _____

David Hodge, MD — Date

Regional Health Authority Commission Chairperson

_____ _____

Patrick Marabella, MD, Chief Medical Officer — Date

Chair, CalViva Health QI/UM Committee

Item #9
Attachment 9.A-B

2026 Quality Improvement, Health Education, and Wellness Work Plan Mid-Year Evaluation

A. Executive Summary
B. Work Plan Evaluation

(For 9.B - due to the size of the document ~151 pgs~ 9.B has not been printed. It is accessible in the packet link emailed to you on Friday,10/23/26. A hard copy will be provided upon request)

REPORT SUMMARY TO COMMITTEE

TO:	CalViva QI/UM Committee Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick Marabella, MD Chief Medical Officer Amy Schneider, RN Senior Director Medical Management
COMMITTEE DATE:	September 17, 2026
SUBJECT:	Quality Improvement and Health Education (QIHEd) Mid-Year Work Plan Evaluation Executive Summary 2026

Summary:

CalViva Health's (CalViva) 2026 QIHEd Program monitors improvement in clinical care, service and satisfaction, and health education intervention outcomes using a range of indicators. These key performance indicators are found in service, clinical, and utilization reports from QI and Health Education, and various other departments. Based on these reports, areas of improvement are identified, and interventions are implemented and monitored.

In 2026, quality improvement initiatives focus on (but not limited to) improving preventive care, disease management outcomes, continuity and coordination of patient care, hospital and patient safety metrics, member access to care, and provider support initiatives. These activities are expected to impact Measurement Year (MY) 2026 quality metrics, which will be reported during Reporting Year (RY) 2027.

Health education programs and services are also being implemented across a variety of topics to promote healthy lifestyles and improve health outcomes for CalViva members. Primary areas of focus include member engagement, weight control, pregnancy, smoking cessation, preventive health care services, and chronic disease education.

The 2026 QIHEd Work Plan Mid-Year Evaluation summarizes progress on nine programs, each with measurable goals and supporting activities designed to monitor and improve quality performance and health education outcomes. HEDIS results for MY 2025 were reported in June 2026. Work plan goals achieved for MY 2025 are shown in Table 1. Activities planned and implemented in 2026, are expected to influence outcomes reported in RY 2027 and activity progress are shown in Table 2.

A. **Goals:** There were 95 total measurable goals for MY 2025/RY 2026:

- 79 goals were completed as of the mid-year mark.
  - 70 goals were met.
  - 9 goals were not met.
- 16 goals are scheduled for Q3-Q4 and are on-track as of the mid-year mark.

Programs that did not meet their MY 2025 goals included Access and Availability, Member Experience, Pediatric/Dental, and Preventive Health. Planned and ongoing

activities for MY 2026 will continue through completion, with ongoing monitoring and evaluation through year-end.

B. **Activities:** There were 98 total activities planned for the year to support program goals for MY 2026/RY 2027.

- 22/22 mid-year activities planned were completed.
- 76 activities are planned for year-end. Of those, two activities were cancelled.

Purpose of Activity:

The QIHEd Mid-Year Work Plan Evaluation Executive Report provides evidence of monitoring the overall effectiveness of the QIHEd activities and processes and identifies barriers and opportunities for improvement.

Work Plan Initiatives:

For MY 2025/RY 2026, CalViva implemented a comprehensive set of quality improvement and health education initiatives designed to improve clinical performance, member experience, access to care, and overall health outcomes. These efforts combined data-driven analysis, targeted member outreach and support services, provider engagement strategies, and ongoing performance monitoring to advance established quality goals. As a result, 70 of 79 measurable goals (88.61%) reported for RY 2026 were achieved, while remaining goals continue to progress according to established timelines. The following tables summarize goal attainment and activity completion across each QIHEd Work Plan program.

Table 1. QIHEd and Wellness Mid-Year Performance Progress for MY 2025/RY 2026.

Work Plan Programs	MY 2025 Goals Met
1. Access and Availability	5/7, 71.43%
2. Behavioral Health	6/6, 100%
3. Care Coordination/Member Engagement	There are two goals that are N/A at Mid-Year.
4. Chronic Conditions	6/6, 100%
5. Maternal Health/Hospital/Patient Safety	12/12, 100%. There are 11 remaining hospital goals that are N/A at Mid-Year.
6. Member Experience	8/12, 66.67% There are three remaining CAHPS goals that are N/A at Mid-Year.
7. Pediatric/Dental	23/24, 95.83%
8. Pharmacy	3/3, 100%
9. Preventive Health	7/9, 77.79%
Total	70/79, 88.61% of goals met at mid-year. 16 goals are remaining until year-end.

-- Note shaded elements excluded from mid-year numerator and denominator.

Table 2. QIHEd and Wellness Mid-Year Work Plan Activities for MY 2026/RY 2027.

Work Plan Programs	Mid-Year Activities Completed	Year-End Activities Planned
1. Access and Availability	1/1, 100%	7
2. Behavioral Health	2/2, 100%	6
3. Care Coordination/Member Engagement	0/0, 0%	5
4. Chronic Conditions	6/6, 100%	8
5. Maternal Health/Hospital/Patient Safety	0/0, 0%	13
6. Member Experience	2/2, 100%	9 (1 activity is cancelled)
7. Pediatric/Dental	6/6, 100%	19 (1 activity is cancelled)
8. Pharmacy	N/A	N/A
9. Preventive Health	5/5, 100%	9
Total	22/22, 100%	76

Note: Activities may support multiple programs. Counts are based on activities planned by the programs listed in Table 2.

Details for the outcomes are included in the 2026 QIHEd Mid-Year Work Plan Evaluation. Key program highlights include:

1. Access, Availability, and Service

1.1 Improve Access to Care:

Provider Appointment Availability Survey (PAAS)

CalViva adopted the Department of Managed Health Care's (DMHC) regulatory compliance goal of 70% for Urgent and Non-Urgent Appointment Availability to align with industry standards. To ensure consistency in provider performance expectations, CalViva established a 70% performance goal across all appointment access measures. Results are reported by county within the health plan's service area, as well as adjacent counties where network providers are located.

To monitor compliance with DMHC timely access standards, CalViva implemented the Provider Appointment Availability Survey (PAAS) methodology developed by DMHC for MY 2025. CalViva contracted with an external survey vendor, QMetrics, to administer the survey in accordance with the Department of Managed Health Care Provider Appointment Availability Survey Methodology. DMHC developed four standardized PAAS survey tools containing the required survey scripts. QMetrics surveyed a census of applicable in-network providers based on DMHC methodology requirements. The survey was conducted via fax, email, and telephone from July 2025 through December 2025.

Pursuant to DMHC Rule 1300.67.2.2, patterns of non-compliance are determined as defined in subsection (b)(12)(A). For PAAS, a pattern of non-compliance exists when

fewer than 70% of network providers, as calculated on the PAAS Results Form, have urgent or non-urgent appointments available within the required access standards. DMHC evaluates patterns of non-compliance using the Summary of Rate of Compliance tab within the Results Report Form for the following measures:

- Rate of Compliance – Urgent Care Appointments (All Provider Survey Types)
- Rate of Compliance – Non-Urgent Appointments (All Provider Survey Types)

Expanded Appointment Set (EAS) Survey:
For improved monitoring of CalViva providers, a separate PCP and Specialist PAAS was administered. In addition to the specialty types which were surveyed as part of the DMHC PAAS methodology (Cardiologists, Dermatologist, Endocrinologists, Gastroenterologists, Neurologist, Oncologist, Ophthalmologist, Otolaryngologist, Pulmonologist, and Urologist), a random sample of CalViva providers were surveyed separately to capture timely access measures for a wider sample of the specialty types in the plan. Health Net on behalf of CalViva included the following specialties in the survey sample: Family Practice, General Practice, General Surgery, Gynecology, Infectious Disease, Internal Medicine, Nephrology, Obstetrics/Gynecology, Orthopedic Surgery, Orthopedics, Pediatrics and Physical Medicine. The same survey questionnaire from the DMHC PAAS was included in the PCP and specialist PAAS. QMetrics conducted the survey by telephone, from October 2025 through November 2025.

Data/Results:

Provider Appointment Availability Survey (PAAS)

Measure	Final Rate (MY 2024)	MY 2024 Goal Rate	Final Rate (MY 2025)	MY 2025 Goal Rate
Ancillary Non-Urgent	91.00%	70.00%	**81.00%**	70.00%
PCP Non-Urgent	86.00%	70.00%	**84.00%**	70.00%
PCP Urgent	77.00%	70.00%	**76.00%**	70.00%
Specialists (All) Non-Urgent	67.00%	70.00%	63.00%	70.00%
Specialists (All) Urgent	53.00%	70.00%	58.00%	70.00%

Note: Rates in bold met the goal.

Provider After-Hours Accessibility Survey (PAHAS)

Measure	Final Rate (MY 2024)	MY 2024 Goal Rate	Final Rate (MY 2025)	MY 2025 Goal Rate
Ability to Contact On-Call Physicians	90.02%	90.00%	86.90%	90.00%
Appropriate Emergency Instructions	93.10%	90.00%	**93.70%**	90.00%

Note: Rates in bold met the goal.

For MY 2025, measures that met goal or demonstrated improvement include:

PAAS:

- Met goal (≥70%)
  - Ancillary Non-Urgent: 81%
  - PCP Non-Urgent: 84%
  - PCP Urgent: 76%
- Measures that showed year-over-year improvement
  - Specialist Urgent: 53% → 58%

PAHAS:

- Met goal (≥90%)
  - Appropriate Emergency Instructions: 93.7%
- Measures that showed year-over-year improvement
  - Appropriate Emergency Instructions: 93.1% → 93.7%

MY 2025 results demonstrate strong performance in PCP access, ancillary appointment availability, and after-hours emergency guidance, while showing progress in specialist urgent care access despite remaining below the established goal.

Opportunities:

Specialist appointment availability remains the primary area of concern, with both Urgent and Non-Urgent measures falling below the 70% goal. In addition, several measures experienced year-over-year declines, most notably Ancillary Non-Urgent Appointments, which decreased by ten percentage points. These results suggest ongoing challenges related to provider capacity, specialist availability, and appointment access that may require targeted network improvement efforts.

PAAS:

- Below goal (<70%)
  - Specialist Non-Urgent: 63%
  - Specialist Urgent: 58%
- Year-over-year declines
  - Ancillary Non-Urgent: 91% → 81%
  - PCP Non-Urgent: 86% → 84%
  - PCP Urgent: 77% → 76%
  - Specialist Non-Urgent: 67% → 63%

Barriers:

MY 2025 performance barriers include:

- Limited availability of specialists and psychiatrists, particularly in rural areas.
- High demand for specialty services exceeding provider capacity.
- Provider staffing and scheduling constraints impacting appointment availability.
- Difficulty meeting timely access standards and urgent care appointment requirements.
- Need for increased provider engagement, support, and operational readiness to improve access and member experience.

Actions Taken:

The analysis and aggregation of MY 2025 PAAS and PAHAS survey results have been completed. Providers identified as non-compliant with applicable access standards will receive Corrective Action Plans (CAPs) in September 2026. CAPs will require providers to implement corrective measures and demonstrate improvement in appointment accessibility and after-hours availability.

To support provider compliance and performance improvement, the Access & Availability team has scheduled 18 provider education webinars between July and December 2026. Training topics include timely access standards, after-hours requirements, best practices for compliance, survey readiness, and CAP response expectations. Webinar participation and completion certificates will be tracked. In addition, a self-paced training option is available to providers and includes a certificate of completion upon successful completion of the training.

Next Steps:

MY 2025 results indicate continued strong performance in primary care, ancillary services, and after-hours accessibility. However, specialist urgent and non-urgent appointment availability remain below the established compliance goals. CalViva will continue targeted provider outreach, corrective action monitoring, and educational interventions to improve specialist access and ensure compliance with DMHC, DHCS, and NCQA access standards. Particular focus will be placed on provider education, appointment scheduling processes, network adequacy monitoring, and timely implementation of corrective actions to improve member access to specialty care.

<u>DMHC TAR Filing Findings:</u>

In February 2026, DMHC issued a finding related to CalViva's DMHC TAR Filing Report for MY 2024/RY 2025 PAAS results due to unmet sample size requirements for certain County/Network combinations. Although the required sample sizes were not achieved, the PAAS was conducted as a census survey, and sampling error for Urgent, Non-Urgent, and Non-Urgent Follow-Up Appointments remained below DMHC thresholds, supporting the validity and reliability of the results.

Root Causes:

- Provider information changed during the multi-month survey period, resulting in ineligible providers and lower response rates.

- Small County/Network provider populations require near-complete participation to meet sample size requirements, making compliance difficult when providers become ineligible or do not respond.

Actions Taken to Improve Sample Size Compliance:

- Continued use of a census approach for all CalViva network providers.
- Increased provider outreach and education on timely access requirements and survey participation.
- Improved provider data validation and contact information accuracy before survey fielding.
- Collaborated closely with providers responsible for multiple surveys to encourage completion.

1.2 Improve Member Satisfaction:

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey:

In 2026, CalViva participated in the regulatory Adult and Child CAHPS survey administered by Press Ganey, with data collection concluding on May 15, 2026. Additionally, the Health Services Advisory Group (HSAG) conducted the Adult and Child CAHPS surveys on behalf of the California Department of Health Care Services (DHCS) as part of its regulatory survey activities. Final comprehensive survey reports are expected in August 2026. Results were submitted to the National Committee for Quality Assurance (NCQA), and the AHRQ CAHPS Health Plan Survey Database in June 2026, with submission to the Culturally and Linguistically Appropriate Services (CLAS) expected in the upcoming months.

Successes:

The CAHPS Team has demonstrated strong operational performance through consistent execution of key initiatives. Quarterly root cause analyses (RCA) leveraging resolved appeals and grievances data have strengthened the organization's ability to identify trends and inform targeted improvements. Findings are regularly reviewed by the CalViva A&G Workgroup and shared across internal stakeholders, supporting cross-functional alignment. Additionally, provider engagement efforts have been a notable success, with 117 CalViva providers participating in SullivanLuallin webinars in Q1 2026, covering seven CAHPS-focused topics aimed at improving patient experience and service excellence.

Barriers:

Sustaining provider engagement and consistent implementation of improvement strategies across provider groups remain challenges. Variations in operational practices and competing priorities may impact the pace and effectiveness of CAHPS improvement efforts.

Opportunities:

Ongoing RCA findings continue to highlight opportunities to further improve CAHPS performance, particularly through targeted interventions addressing key experience drivers. There is an opportunity to expand and reinforce provider education and engagement strategies to ensure sustained behavior change and broader adoption of best practices. The upcoming 2026 CAHPS results will provide additional insights to refine priorities, enhance targeting of interventions, and strengthen data-driven decision-making.

Next Steps:

The CAHPS Team continues to collaborate closely with cross-functional stakeholders to monitor progress, address emerging issues, and implement initiatives aimed at improving CAHPS performance and overall member satisfaction. A key focus remains strengthening partnerships with the Provider Engagement and Medical Affairs teams to support sustained improvements in CAHPS performance and member experience.

Outpatient Mental Health (OPMH) Survey (formerly Experience of Care and Health Outcomes (ECHO) survey):

In 2026, CalViva participated in the regulatory BH CAHPS survey administered by Press Ganey. The surveys were initially mailed July 2, 2026, and results will be available at the end of September 2026. The purpose of this activity is to improve provider and member satisfaction by expanding access to clear, practical behavioral health information and resources. This work supports referral guidance, awareness of treatment options, and more consistent communication with members. It also establishes a structured process for monitoring progress and identifying opportunities for continued quality improvement.

Successes:

The ME.7 report for 2024 ECHO survey results yielded access to care and attitude and service as areas of opportunity for improvement. Findings indicate that planned interventions are progressing as expected and that key foundational tools are being established to support provider and member satisfaction. Completion of the substance use resource directory is an important milestone for improving awareness of treatment options. In addition, development of provider and member materials supports a more standardized approach to communication and access

Barriers:

Key barriers include the time required for cross-functional review and approval of educational materials, which may delay implementation. In addition, measurable improvement in satisfaction and engagement may lag because several interventions are still being finalized and distributed. Provider awareness, consistency of use, and the time needed for members to access and respond to new resources may also affect the pace of improvement.

Actions Taken/Next Steps:

Actions completed to date include development of the countywide substance use resource directory and draft provider and member resource materials for leadership review. Next steps are to finalize the provider and member tip sheets, complete the depression and anxiety educational materials, and distribute approved resources to providers and members as appropriate. Monitoring will continue through monthly implementation review, quarterly trend analysis, and ongoing discussion by the Behavioral Health Team and QIUM Committee. If improvement is not observed, additional root cause analysis will be completed, and interventions will be revised as needed.

2. Quality and Safety of Care: Meet or Exceed the MCAS Minimum Performance Levels (MPLs)

Each year, the Department of Health Care Services (DHCS) requires CalViva to meet or exceed the 50th percentile performance benchmark for the Managed Care Accountability Set (MCAS) measures. Final RY 2026 rates are presented in Table 3.

Table 3. MCAS HEDIS® Measure Reported Rates and Benchmarks for RY 2026 (Fresno, Kings, Madera).

HEDIS Measure	Fresno	Kings	Madera	MPL	HPL
Asthma Medication Ratio (AMR)	73.52	**83.87**	**80.18**	63.66	76.25
Breast Cancer Screening (BCS)	55.05	57.83	50.25	55.87	66.31
Cervical Cancer Screening (CCS)	62.60	62.38	**67.13**	52.32	64.21
Chlamydia Screening (CHL)	62.80	59.63	67.60	56.30	70.67
Childhood Immunizations - Combo 10 (CIS-10)	27.69	17.08	**44.77**	23.89	34.79
Controlling High Blood Pressure (CBP)	72.26	73.24	73.24	67.88	75.43
Developmental Screening in the First Three Years of Life	53.04	36.74	**73.48**	35.70	63.22
Follow-Up After ED Visit for Mental Health Illness-30 days (FUM)	47.12	63.97	55.42	57.13	74.67
Follow-Up After ED Visit for Substance Abuse-30 days (FUA)	38.06	42.50	35.43	39.10	53.27
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%) (**inverted rate**) (HBD >9%)	24.82	**18.98**	25.55	30.41	23.60
Immunizations for Adolescents: Combination 2 (IMA)	43.20	43.87	**51.07**	34.14	47.16
Lead Screening in Children (LSC)	74.99	57.67	**89.39**	69.96	82.86
Prenatal Care (PPC-Pre)	90.02	**93.67**	**92.46**	86.37	91.97
Postpartum Care (PPC-Post)	**88.32**	88.08	**91.97**	82.48	88.32
Topical Fluoride for Children	**26.28**	22.83	**36.12**	19.00	25.08

HEDIS Measure	Fresno	Kings	Madera	MPL	HPL
Child and Adolescent Well-Care Visits (WCV)	56.80	51.46	63.20	55.41	67.63
Well-Child Visits in the First 15 Months of Life- Six or more Well-Child Visits (W30-6+)	63.35	69.01	**73.05**	63.38	71.71
Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits (W30-W30-2+)	73.34	64.27	**82.77**	72.32	82.12

LEGEND	
NONBOLD	Result below DHCS MPL for that RY (IP)
NONBOLD	Result met the DHCS MPL for that RY but below the High Performance Level (HPL)
BOLD	Result met the DHCS HPL for that RY

In RY 2026, CalViva did not meet the MPL and needs improvement for the following measures:

Fresno	Kings	Madera
• Breast Cancer Screening (BCS-E) • Follow Up After ED Visit for Mental Health Illness- 30 Days (FUM) • Follow Up After ED Visit for Substance Abuse – 30 Days (FUA) • Well-Child Visits in the First 15 Months of Life – Six or more Well-Child Visits (W30-6+)	• Childhood Immunizations - Combo 10 (CIS-10) • Lead Screening in Children (LSC) • Child and Adolescent Well-Care Visits (WCV) • Well-Child Visits for age 15 Months to 30 Months- Two or more Well-Child Visits (W30-2+)	• Breast Cancer Screening (BCS-E) • Follow-Up After ED Visit for Mental Health Illness-30 Days (FUM) • Follow-Up After ED Visit for Substance Abuse-30 Days (FUA)

CalViva met the MPL and achieved compliance in all counties for the following measures:

- Asthma Medication Ratio
- Cervical Cancer Screening
- Chlamydia Screening
- Controlling Blood Pressure
- Developmental Screening in the First Three Years of Life
- Diabetes – HbA1c Poor Control
- Immunizations for Adolescents: Combination 2
- Prenatal and Postpartum Care, and
- Topical Fluoride in Children

CalViva demonstrated strong quality performance by achieving countywide MPL compliance across nine key measures, reflecting sustained focus on preventive care, chronic disease management, maternal health, and pediatric services. CalViva will continue to advance quality outcomes through participation in DHCS quality collaboratives, implementation of targeted improvement strategies for underperforming measures, and collaboration with the Institute for Healthcare Improvement (IHI) to enhance well-child visit performance and drive continued improvement in member health outcomes.

3. Quality Improvement Projects (QIPs)

3.1 MCAS Performance Improvement Projects (PIPs)

3.1a Non-Clinical PIP-focused on Provider Notification after ED Visit for Substance Use or Mental Health Issue in Fresno and Madera Counties.
The California Department of Health Care Services (DHCS) assigned CalViva the 2023-2026 non-clinical Performance Improvement Project (PIP), which focuses on improving provider notifications and timely follow-up care for members with substance use disorder (SUD) or mental health diagnoses within seven days of an emergency department (ED) visit in Fresno and Madera Counties. The project tracks performance on two HEDIS measures: Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Substance Use (FUA).

CalViva submitted Steps 1-8 of the PIP process and three Intervention Worksheets to HSAG and DHCS on October 28, 2025, and achieved a 100% validation score on December 5, 2025. Project data collection ended on December 31, 2025, with final submission of the non-clinical PIP to HSAG on August 6, 2026. HSAG will provide validation findings no later than October 1, 2026. Throughout the project, CalViva has maintained a partnership with a local Fresno County hospital serving the population of focus to support intervention activities and improve follow-up care for members with mental health and substance use disorder diagnoses.

For the non-clinical PIP, CalViva is leveraging dedicated hospital staff to notify providers when eligible members present to the emergency department (ED) with a substance use disorder (SUD) or mental health (MH) diagnosis. Timely provider notifications could support follow-up care for members following an ED visit for mental illness or substance use. CalViva is currently implementing the following three interventions:

- Educate providers on the use of Smart Phrases to support complete and accurate documentation of services rendered, referrals made, and follow-up care provided, ensuring compliance with FUA and FUM HEDIS specifications and appropriate capture of qualifying follow-up services.
- Develop and implement culturally and linguistically appropriate outreach, education, and engagement strategies to increase awareness of the importance of timely follow-up care after an ED visit for mental illness or substance use disorder. Efforts are focused on the Hispanic population, which represents approximately 62% of the target population, and aim to reduce barriers to care, improve member engagement, and increase completion of follow-up visits for the FUA and FUM HEDIS measures.

- Utilization of the Resiliency Center to Increase Provider Notifications. The Resiliency Center intervention was initially designed to facilitate provider notifications and support follow-up care for members with mental health and substance use disorder needs. However, due to insufficient referral volume, this intervention was discontinued as part of the PIP. Despite its removal from the PIP, the Resiliency Center will continue to operate as an Enhanced Care Management (ECM) provider, supporting care coordination and member engagement for eligible populations.

Data/Results:

- CalViva did not meet the MPL for the FUA and FUM measures in Fresno and Madera Counties for RY 2026.
- Madera County did not meet the FUM MPL in MY 2025, performance improved significantly from 22.47% in MY 2024 to 55.42% in MY 2025. Similar improvement is noted for the FUA measure (39.10% MPL) in MY 2024 with Fresno County improving from 15.01% to 38.06%.
- Hispanic members make up the majority of the FUA/FUM target population in both Madera County (61.3%) and Fresno County (54.9%). Cultural factors may contribute to lower follow-up care rates within this population.
- The Behavioral Health team conducted telephonic outreach for FUA and FUM members in 2025, but only 19% of members were reached. Key barriers included inaccurate contact information and member reluctance to discuss mental health and substance use follow-up care.
- Outreach efforts were limited by privacy and data-sharing restrictions related to Admission, Discharge, and Transfer (ADT) data, resulting in only about 35% of behavioral health emergency department visits being identified through the ADT report.
- CalViva partnered with Binational of Central California to provide cultural competency training focused on working with the Hispanic population. The training equipped staff with strategies to support members and encourage follow-up treatment. This training will now be included in the onboarding process for all new hires.

CalViva continues to identify and address barriers that impact the timely receipt of emergency department visit notifications and related data.

3.1b. Clinical PIP – focused on Well-Child Visits in the First 30 Months of Life – 0 – 15 Months (W30-6+) for Black or African American members in Fresno County

CalViva successfully completed the Clinical Performance Improvement Project (PIP) focused on improving Well-Child Visits in the First 30 Months of Life (W30-6+) among Black or African American (B/AA) members in Fresno County. The project received a final validation score of 94% and achieved a High Confidence rating for overall adherence to PIP methodology.

The project demonstrated sustained improvement in well-child visit performance over the three-year intervention period. Fresno County's overall W30-6+ rate increased from 56.55% in MY 2023 to 63.35% in MY 2025, exceeding the benchmark of 60.38%. The targeted B/AA population experienced even greater improvement, with performance increasing from 31.3% at baseline to 50.9% by MY 2025, reflecting meaningful progress toward reducing disparities in preventive pediatric care.

A key component of the project was CalViva's partnership with Fresno County Black Infant Health (BIH), which provided culturally responsive outreach, education, care coordination, and incentive-based engagement strategies for pregnant and postpartum B/AA members. During the intervention period, hundreds of members were referred for supportive services, members participated in educational programming and incentive opportunities, and providers received education on available community resources and developmental screening tools. These efforts helped strengthen member engagement and support timely completion of well-child visits.

Although the formal PIP concluded on December 31, 2025, CalViva continues to collaborate with Black Infant Health to support pregnant and postpartum B/AA members through culturally relevant education, care coordination, and community-based services. Ongoing efforts are intended to sustain improvements in well-child visit utilization and advance health equity for Black or African American children and families in Fresno County

3.2 Lean – Madera

3.2a. CalViva 2025 FUM/FUA BH Lean Project Madera County

CalViva Health completed and submitted to DHCS a Lean Performance Improvement Project to Improve Follow-up After ED Visits for MH/SUD Issues in Madera County. The purpose of the Lean Project in Madera County is to improve FUM/FUA HEDIS® measures above the MPL. Throughout the project, CalViva has maintained a partnership with a dedicated clinic in Madera County serving the population of focus to support intervention activities and improve follow-up care for members with mental health and substance use disorder diagnoses.

CalViva is currently implementing the following Interventions:

- Community Health Worker (CHW) Training.
- Implemented LANES, an Admission, Discharge, and Transfer (ADT) reporting system that provides real-time data for members seen in the emergency department for FUA/FUM through secure file transfer. The system supports timely member identification, outreach, and follow-up to support timely member identification, outreach, and follow-up by providers and community health workers.
- The CHW will be accessing the LANES database (which is a Daily ADT Report) to follow up in a timely manner with patients seen in the ED to facilitate referrals and access treatment.
- Culturally Appropriate Education Strategies for Mental Health/Substance Use Disorder to Increase Follow-up Care.
- An SUD Directory was developed for Fresno and Madera and shared with relevant stakeholders.
  Developed a SUD Provider Tip Sheet, and Member Tip Sheet including information about types of treatment and resources Madera County.

Due to the limited access to Behavioral Health services in Madera County, it is particularly important to identify all available resources and communicate these to providers and members. Additional CHW or provider resources will be explored/considered based upon analysis of data regarding the referral process to ensure adequate resources to support this population.

3.3 Institute for Healthcare Improvement (IHI) Collaborative

IHI Child Health Equity Collaborative (CHEC) Sprint – Phase 2

CalViva continued participation in the Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative (CHEC) Sprint – Phase 2, in partnership with Clinica Sierra Vista (CSV), to improve well-child visit (WCV) utilization and advance health equity for children and families served in Fresno County. The collaborative uses a structured quality improvement approach to test and implement interventions designed to increase access to preventive pediatric care and strengthen connections to community resources.

Through mid-year 2026, CalViva and CSV successfully implemented four Plan-Do-Study-Act (PDSA) cycles focused on member outreach and appointment scheduling, newborn enrollment and care linkage, community-based resource engagement, and patient navigation support. These efforts improved access to well-child visits, increased newborn enrollment and early engagement in care, and strengthened connections between families, providers, and community-based organizations. Outreach activities resulted in high appointment scheduling rates among members reached, while newborn enrollment initiatives expanded opportunities for early preventive care engagement.

The collaborative also enhanced community partnerships through targeted outreach events and ongoing coordination with Women, Infants, and Children (WIC) programs and other community resources to support families with young children. In addition, CalViva submitted all required deliverables to IHI and DHCS on schedule and remains in good standing with collaborative requirements.

The CHEC Sprint remains on track for completion in September 2026. CalViva will continue working with provider and community partners to sustain successful interventions, improve well-child visit utilization, and reduce disparities in preventive pediatric care.

4. Health Education

4.1 Member Incentives

During Q1 and Q2 2026, eligible CalViva members participating in four incentive programs received a total of 3,001 gift cards valued at $25 each, totaling $75,025, and 20 diaper backpack incentives valued at $41 each, totaling $820. Combined, these incentives represented a total award value of $75,845.

Of the 3,021 total incentives awarded, 91.6% were distributed to Fresno County members, 8.3% to Madera County members, and 0.1% to members residing across Fresno, Madera, and Kings counties. Compared to Q3 and Q4 2025, when 1,420 incentives were awarded, incentive distribution increased by 112.7% during Q1 and Q2 2026.

This increase reflects the timing of incentive distributions, which are intentionally concentrated during the first half of the year to support provider implementation of Quality EDGE improvement initiatives and action plans. Early distribution of point-of-care incentives allows providers sufficient time to engage members, implement

interventions, and drive improvement in targeted quality measures throughout the remainder of the measurement year. Similar distribution patterns were observed in 2025 and continue in 2026, resulting in a higher volume of incentives awarded during Q1 and Q2.

4.2 Member Materials Management

As of mid-year, a total of 13,462 pieces of member materials have been ordered for CalViva members. Providers may request materials through the online Health Education Material Order Form, while members can obtain printed health education materials by contacting Member Services.

4.3 FindHelp Health Education Data

As of mid-year 2026, a total of 184 referrals were made through the FindHelp resource. Fresno County accounted for 111 referrals, Madera County for 12 referrals, and Kings County for ten referrals.

Next Steps for Q3-Q4 2026

Quality Improvement:

CalViva will continue implementation of the 2026 QIHEd Work Plan, with a focus on completing the remaining 19 goals and planned year-end activities. Efforts will prioritize improving clinical quality performance through targeted interventions that support diabetes and blood pressure control, including enhanced member outreach, home-based testing strategies, and provider-focused root cause analyses to identify and address gaps in documentation and care delivery. CalViva will also continue expanding Community Health Worker engagement to improve member awareness, care coordination, and connection to resources that address health-related social needs. In addition, the Plan will complete required Performance Improvement Project (PIP) submissions and conclude participation in the Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative in September 2026.

Health Education:

Health Education activities will focus on sustaining provider and member engagement initiatives that support preventive care, chronic disease management, and healthy lifestyle behaviors. Key priorities include ongoing oversight of Quality EDGE corrective action plans, promotion of evidence-based health education resources, increased member awareness of available health education programs and services, and continued collaboration with provider partners to improve breast and cervical cancer screening rates. Additional efforts will support tobacco cessation, digital behavioral health resources, and Diabetes Prevention Program (DPP) participation through targeted outreach, education, and member engagement strategies.

Quality Improvement and Health Education 2026 Mid-Year Work Plan Evaluation

Purpose

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

Mission

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

Scope

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

Submitted by:

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

Glossary of Abbreviations/Acronyms

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

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

Glossary of Abbreviations/Acronyms (Measure Specific)

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

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

Glossary of Abbreviations/Acronyms (Measure Specific) - continued

Acronym:	Description
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
PCR	Plan All Cause Readmission
PDC-DM	Proportion of Days Covered - Diabetes
PDC-RAS	Proportion of Days Covered - Renin Angiotensin System
PDC-Statin	Proportion of Days Covered - Statin
PDS-E-DS	Postpartum Depression Screening and Follow-up - Depression Screening
PND-E-DS	Prenatal Depression Screening and Follow-up - Depression Screening
POD	Pharmacotherapy for Opioid Use Disorder
PPC-Pre	Prenatal and Postpartum Care: Prenatal Care
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care
RRF	Reducing Risk of Falls
SPC-RCV	Statin Therapy for Patients with Cardiovascular Disease - Received Therapy
SPD-RCV	Statin Therapy for Patients with Diabetes - Received Therapy
SSI-Colon	Surgical site infection following colorectal surgery
SUPD	Statin Use in Persons with Diabetes
TFL-CH	Topical Fluoride for Children
TRC	Transitions Of Care- Average
URI	Appropriate Treatment for Upper Respiratory Infection
W30	Well-Child Visits in the First 30 Months of Life
W30+6	Well-Child Visits 0-15 months – Six or more visits
W302+	Well-Child Visits 15-30 months – 2 or more visits
WCC	Children/Adolescents: BMI Percentile Documentation
WCV	Child & Adolescent Well-Care Visits

Acronym:	Description

Section I: Work Plan Initiatives

Goal: Implement activities to improve performance measures.

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

Section I: Work Plan Program

1. Access and Availability: Improving Provider Survey Results			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity - Monitoring of previously identified issue: Underperforming Access and Availability measures.
Program Type:	• Quality of Service	**Responsible Parties:**	Paul Fuentes, Provider Relations Specialist II, Access and Availability Steven Si, Sr. Manager, Compliance and Privacy

Goal(s):
1. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%.
2. To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%.

Activity Highlights	Access and Availability activities for CalViva are focused on ongoing monitoring and regulatory compliance through structured surveys, reporting, and provider engagement efforts. Key initiatives include quarterly provider training webinars and targeted outreach to improve compliance with timely access standards identified through telephonic and regulatory survey results. Performance is continuously tracked via KPI reporting and survey monitoring, with corrective action plans and educational interventions implemented for noncompliant providers to drive improvement. Additionally, teams support annual and regulatory reporting requirements (e.g., DMHC Timely Access Reporting and Provider Satisfaction Surveys) to ensure sustained oversight of appointment availability, after-hours access, and overall provider network accessibility.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
MY 2024: PAHAS: 100% (2/2) •Ability to Contact On-Call Physicians: 90.02% •Appropriate Emergency Instructions: 93.1% PAAS: 60% (3/5) •Ancillary Non-Urgent: 91% •PCP Non-Urgent: 86% •PCP Urgent: 77% •Specialists (All) Non-Urgent: 67%	MY 2025 PAHAS: 50% (1/2) •Ability to Contact On-Call Physicians: 86.9% •Appropriate Emergency Instructions: 93.7% PAAS: 60% (3/5) •Ancillary Non-Urgent: 81% •PCP Non-Urgent: 84% •PCP Urgent: 76%	Mid-Year (Jan-Jun): 100%, (1/1) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.) There were 7/7 ongoing or planned activity(s) on track to be completed by year-end. (0 year-end activity(s)	Not Applicable. Not PPP report measures.	

Section I: Work Plan Program

•Specialists (All) Urgent: 53%	•Specialists (All) Non-Urgent: 63% •Specialists (All) Urgent: 58%	on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Providers, particularly specialists and psychiatrists, may lack sufficient tools, guidance, and operational support to meet timely access standards and improve member satisfaction. Barriers may include limited office hours, part-time provider availability, staffing constraints, and high patient volume, which can impact providers' ability to offer appointments within required access timeframes. Opportunities: • Measures requiring improvement include Specialist Timely Access for both Urgent and Non-Urgent appointments. Performance gaps indicate challenges in meeting required access standards, impacting member experience and satisfaction. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: Based on MY 2025 PAAS results, CalViva will issue Corrective Action Plans (CAPs) to deficient PPGs and distribute targeted educational packets to network providers. Providers are required to submit an Improvement Plan (IP) within 30 days of CAP receipt. CAP packets will include resources such as Improve Health Outcomes – A Guide for Providers, the Provider Operations Manual, and a Timely Access Tip Sheet. CalViva will also conduct a series of provider education webinars focused on timely access standards, after-hours requirements, best practices, and survey readiness. In addition, performance-based incentive programs have been incorporated into provider contracts to support improvement in timely access metrics. The Plan has implemented an Advanced Access program and communicated its benefits to PCPs about providing enhanced access to their patients. **Year End:**

Section I: Work Plan Program

2. Behavioral Health: Improving Behavioral Health (Mental Health and Substance Use) Outcomes			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity – Monitoring of previously identified issue: Underperforming DHCS MPL measures.
Program Type:	• Quality of Care • Safety	**Responsible Parties:**	Adrianna Shoji, Program Manager III, Behavioral Health Quality Improvement Amy Schneider RN, Sr. Director Medical Management

Goal(s):
Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure(s):
• Follow-Up After ED Visit for Substance Abuse – 30 days (FUA-30): MPL is 39.10%
• Follow-Up After ED Visit for Mental Illness – 30 days (FUM-30): MPL is 57.13%.

Activity Highlights	The Behavioral Health POD for CalViva is advancing a comprehensive portfolio of oversight, outreach, and performance improvement initiatives focused on improving follow-up care after emergency department visits for mental health and substance use. Key activities include provider education on the use of Smart Phrases to complete and provide accurate medical documentation of services and referrals to meet the FUA/FUM HEDIS specifications, culturally appropriate education strategies for mental health and substance use disorder to increase follow-up care for the Hispanic population, and utilization of the Resiliency Center to increase provider notifications. Interventions include post-discharge outreach using ADT data/LANES report to support provider follow-up notifications, use of LCSWs, SUNs, and CHWs to promote coordination of care documentation, culturally responsive Quality Monitoring & Improvement Projects (QMIPs), and provider-focused educational resources. These efforts aim to strengthen care coordination, address data quality and access barriers, improve member engagement, and support sustained behavioral health quality improvement across CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
MY 2024: • FUA-30: (100% 3/3) Fresno: 29.48% Kings: 36.65%* Madera: 30.7% • FUM-30: (100% 3/3) Fresno: 42.94%	MY 2025: • FUA-30: (100% 3/3) Fresno: 38.06% Kings: 42.5%* Madera: 35.43% • FUM-30: (100% 3/3) Fresno: 47.12%	Mid-Year (Jan-Jun): 100%, (2/2) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.)	Off track (<75%): (16.67%, 1/6) Off Track Measures: Fresno: FUA-30, FUM-30 Kings: FUA-30 Madera: FUA-30, FUM-30	

Section I: Work Plan Program

Kings: 64.97%* Madera: 47.71% *Measures that met MPL: (33.33%, 2/6)	Kings: 63.97%* Madera: 55.42% *Measures that met MPL: (33.33%, 2/6)	There were 6/6 ongoing or planned activity(s) on track to be completed by year-end. (0 year-end activity(s) on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barrier: • Missing diagnosis codes and other ADT data issues make it difficult to accurately identify members who need timely follow-up care. Opportunities: • Collaborating with hospitals to identify and resolve missing diagnosis codes in the ADT feed. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: • Collaborate with hospitals across the Central Valley to evaluate and address data suppression issues that may limit the completeness and timeliness of information. **Year End:**

Section I: Work Plan Program

3. Care Coordination/Member Engagement: Improving Initial Health Appointments			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity – Monitoring of previously identified issue – DHCS regulatory activity, audit non-compliance.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Miriam Rosales, Program Manager III, QI Sia Xiong Lopez CVH Health Equity Officer

Goal(s):
Meet directional improvement from prior year. IHA does not have HEDIS benchmark but is a DHCS compliance measure.
* Required by DHCS for NEW Medi-Cal members within 120 days of enrollment.
* Goal: To ensure newly enrolled Medi-Cal members connect with a medical home/PCP, receive a comprehensive evaluation of health needs and receive needed care services across the care continuum.

Activity Highlights	The Care Coordination/Member Engagement POD for CalViva is advancing comprehensive strategies to ensure compliance with DHCS Initial Health Appointment (IHA) requirements through ongoing monitoring, quarterly reporting, and audit preparation activities. Core efforts include targeted provider engagement initiatives to address low-performing providers, with structured trainings, outreach campaigns, and operational support to improve appointment adherence and reduce missed visits. Member engagement strategies have been strengthened through enhanced Proactive Outreach Manager (POM) call campaigns, including the integration of AI-enabled call tracking and improved data capture, resulting in increased call completion rates and reduced invalid outreach attempts. Collectively, these activities demonstrate a coordinated, compliance-driven approach to improving IHA performance, strengthening provider and member engagement, and ensuring audit readiness for CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
MY 2024 • IHA: (100%, 2/2) The current IHA rate is 59.40%.	MY 2025 • IHA: (X%, X/2) - N/A at Mid-Year. The current IHA rate is X%.	Mid-Year (Jan-Jun): 0%, (0/0) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.)	Not Applicable. Not PPP report measures.	

Section I: Work Plan Program

		There were 5/5 ongoing or planned activity(s) on track to be completed by year-end. (0 year-end activity(s) on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Invalid member contact information and data discrepancies with the outreach vendor limited the effectiveness of member outreach efforts. • Providers initially had difficulty accessing accurate new member lists, resulting in delays in outreach activities. Opportunities: • The transition from Silverlink to the Genesys platform provides an opportunity to improve data quality and staff proficiency through ongoing training. • Recent Cozeva enhancements allow providers to access monthly member reports in real time, supporting more timely outreach efforts. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: • Collaborate with the SilverLink vendor to support the transition to the Genesys platform, resolve migration issues, and provide staff training. **Year End:**

Section I: Work Plan Program

4. Chronic Conditions: Improving Heart Health/Blood Pressure and Diabetes			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity - Maintain achievement of DHCS MPL measures.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Gigi Mathew, Program Manager III, QI

Goal(s):
Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure(s):
• Glycemic Status Assessment for Patients with Diabetes: GSD: MPL is 30.41% (inverted rate).
• Controlling Blood Pressure (CBP): MPL is 64.48%.

Activity Highlights	The Chronic Conditions POD for CalViva is advancing a comprehensive strategy to improve diabetes and blood pressure outcomes through coordinated provider outreach, member engagement, and data-driven gap closure initiatives. Key activities include deployment of direct-to-member interventions (e.g., A1c home testing kits, in-home assessments) and targeted provider campaigns leveraging root cause analysis and automated outreach to address uncontrolled measures. Performance data indicates moderate engagement across outreach channels, with opportunities identified to improve utilization rates and resolve data integration and reporting challenges, including Cozeva tracking and vendor connectivity. Collectively, these efforts demonstrate a multi-channel, compliance-aligned approach to improving chronic disease management, strengthening provider collaboration, and driving sustained HEDIS performance improvement for CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
MY 2024: •HBD >9%: (100%, 3/3) Fresno: 24.04%* Kings: 28.00%* Madera: 23.00%* •CBP: (100%, 3/3) Fresno: 68.92%* Kings: 79.00%* Madera: 72.00%*	MY 2025: •GSD>9%: (100%, 3/3) Fresno: 24.82%* Kings: 18.98%* Madera: 25.55%* •CBP: (100%, 3/3) Fresno: 72.26%* Kings: 73.24%* Madera: 73.24%*	Mid-Year (Jan-Jun): 100%, (6/6) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.) There were 8/8 ongoing or planned activity(s) on track to be completed by year-end. (0 year-end activity(s)	On track (>=75%): (100%, 6/6)	

Section I: Work Plan Program

*Measures that met MPL: (100%, 6/6)	*Measures that met MPL: (100%, 6/6)	on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • CalViva's GSD opportunity remains concentrated among members with missing or uncontrolled HbA1c/GMI results, requiring timely testing, documentation, and follow-up. • Provider response to RCA e-projects, member lead lists, BP DME workflows, in-home kit disposition files, and uncontrolled A1c or BP follow-up may vary by PPG/PCP capacity and competing operational priorities. • Recent review shows lower-than-expected utilization of the BP cuff benefit, indicating a need to further assess provider awareness, member access, and workflow barriers that may affect self • Continued use of Simple HealthKit in-home A1c testing through the remainder of the year depend on funding confirmation. Opportunities: • Close CBP gaps by reinforcing the Medi-Cal DME blood pressure monitor benefit, simplifying provider request workflows, expanding member education on accurate home blood pressure readings, and strengthening provider fax/faxback processes to support timely documentation. • Close GSD gaps by prioritizing members with missing or uncontrolled HbA1c/GMI results through coordinated RCA e-projects, repeat testing reminders, provider follow-up, and timely documentation of discrete numeric results. • Continue evaluating GMI data integration and related data-sharing pathways to improve glycemic data availability and support provider care planning. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: Review monthly care gap movement, vendor completion results, provider RCA responses, and BP/A1c documentation trends to determine whether additional reminders, provider support, or targeted outreach waves are needed before year-end. Use health equity data, language preference, geography, and social needs indicators to tailor live calls, digital outreach, diabetes education, CHW referrals, and community resource connections for Fresno, Kings, and Madera members. **Year End:**

Section I: Work Plan Program

5. Maternal Health/Hospital/Patient Safety: Improving hospital and maternal care.			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity – Monitoring of previously identified issue of hospital and patient safety measures; Maintain achievement of DHCS MPL.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Barbara Wentworth, Program Manager III, Quality Improvement

Goal(s):

1. Hospitals with sufficient reportable data: Directional improvement, based on appropriate scores (SIR=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (CAUTI, CLABSI, C.Diff, MRSA, and SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status.
• Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates.

2. Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure(s):
• Prenatal and Postpartum Care: Prenatal Care (PPC-pre): 50th percentile MPL is 86.37%
• Postpartum Care (PPC-pst): 50th percentile MPL is 82.48%.

3. Establish baseline for the following MCAS-MPL measure(s):
• Prenatal Depression Screening and Follow-up - Depression Screening (PND-E-DS)
• Postpartum Depression Screening and Follow-up - Depression Screening (PDS-E-DS)

Activity Highlights	The Maternal Health/Hospital/Patient Safety POD for CalViva is advancing a coordinated set of maternal health and hospital quality initiatives to improve prenatal and postpartum care, depression screening, and patient safety through targeted provider engagement and member outreach strategies. Key activities include revision and promotion of provider-facing tools and best practices such as maternal health tip sheets and depression screening guidance to improve care delivery and documentation; promotion of a Confirmation of Pregnancy incentive program for primary care providers; promotion of implicit bias training for perinatal providers; and engagement with DHCS and local providers as part of the 10-year Transforming Maternal Health (TMaH) model. Hospital-focused interventions include outreach to hospitals on C-section overuse and patient safety metrics, as well as collaboration with external quality organizations (Health Services Advisory Group, the Hospital Quality Institute,The Leapfrog Group, Cal Healthcare Compare, and CalHQI) to promote evidence-based improvement strategies and strengthen hospital accountability. Collectively, these activities reflect a structured, compliance-aligned approach to improving maternal health outcomes, enhancing health equity, and strengthening hospital quality and patient safety performance for CalViva.

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2025 (MY 2024) Objectives Met (%, ratio):	2026 (MY 2025) Objectives Met (%, ratio): *(populate at mid-year, if available)*	2026 Activities Completed (%, ratio): *(populate at mid-year and year-end)*	Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track): *(populate at mid-year)*	Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track): *(populate at year-end)*
MY 2024: (8/11, 73%) • CAUTI: SIR=<1.0: 100%; SIR>2.0: 0% • C.Diff: SIR=<1.0: 80%; SIR>2: 0% • CLABSI:SIR=<1.0: 100%; SIR>2: 0% • MRSA: SIR=<1.0: 75%; SIR>2: 0% • NTSV C-sections: Rate=<23.6%: 40% • SSI-Colon: SIR=<1.0: 75%; SIR>2: 0% MY 2024: (100%, 6/6) • PPC-pst: Fresno: 83.9%*, Kings: 87.00%*, Madera: 87.00%* • PPC-pre: Fresno: 90.4%*, Kings: 92.00%*, Madera: 93.00%* *Measures that met the MPL: (100%, 6/6)	MY 2025: (X/11, X%) - N/A at Mid-Year. • CAUTI: SIR=<1.0: X%; SIR>2.0: X% • C.Diff: SIR=<1.0: X%; SIR>2: X% • CLABSI:SIR=<1.0: X%; SIR>2: X% • MRSA: SIR=<1.0: X%; SIR>2: X% • NTSV C-sections: Rate=<23.6%: X% • SSI-Colon: SIR=<1.0: X%; SIR>2: X% MY 2025: (100%, 6/6) • PPC-pst: Fresno: 88.32%*, Kings: 88.08%*, Madera: 91.97%* • PPC-pre: Fresno: 90.02%*, Kings: 93.67%*, Madera: 92.46%* MY 2025: (100%, 6/6) - Establish baseline. • PND-E-DS Fresno: 21.55%*, Kings: 69.49%*, Madera: 11.26%* • PDS-E-DS Fresno: 19.19%*, Kings: 46.44%*, Madera: 16.30%* *Measures that met MPL: (100%, 12/12)	Mid-Year (Jan-Jun): 0%, (0/0) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.) There were 13/13 ongoing or planned activity(s) on track to be completed by year-end. (0 year-end activity(s) on hold, cancelled, or at risk.)	Off track (<75%). (66.67%, 8/12) Off Track Measures: Fresno: PPC-post, PPC-pre, PND-E -DS Kings: PPC-post Madera: PPC-post Hospital measures are not on the PPP report.	

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Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Early identification of pregnancy and documentation of timely prenatal visits can be challenging, and members may not recognize the importance of postpartum follow-up care. • Prenatal and postpartum depression screening are new DHCS priority measures that require increased provider awareness, consistent implementation, and accurate documentation. Opportunities: • Provider incentives for pregnancy confirmation create an opportunity to improve early pregnancy identification and prenatal care engagement. • The Transforming Maternal Health (TMaH) model provides an opportunity to strengthen partnerships with maternal health providers and improve prenatal care, postpartum care, depression screening, and other maternal health outcomes. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: • Promote the Confirmation of Pregnancy incentive program for PCPs to encourage early identification of pregnancies and support timely, documented prenatal care. • Collaboration with provider-facing teams presents an opportunity to implement best practices, enhance provider education, and address documentation barriers to improve prenatal and postpartum care rates, including depression screening and follow-up services. **Year End:**

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6. Member Experience: Improving CAHPS measures.			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity – Monitoring of previously identified issue: Underperforming CAHPS measures.
Program Type:	• Quality of Care • Quality of Service • Member Experience	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Guille Toland, Program Manager III, Quality Improvement

Goal(s):

1. Meet directional improvement from prior year on CAHPS Access measures including: Getting Needed Care, Getting Care Quickly, Care Coordination.

2. Meet the national 25th percentile benchmark or directional improvement on the following CAHPS measures: Rating of Health Plan, Customer Service, Ease of Filling Out Forms.

3. Meet directional improvement from prior year for the Flu Vaccine Adult Immunization Status (AISE-Flu).

MY 2025 Quality Compass (QC) benchmarks are not available until Q3 2026.

Activity Highlights	The Member Experience POD for CalViva is advancing initiatives to improve CAHPS performance through targeted provider education, enhanced member engagement strategies, and cross-functional stakeholder alignment. Key efforts include deployment of provider training programs and development of standardized resources (e.g., provider playbooks and communication articles) to strengthen provider communication, access, and overall member experience, with early engagement reflected in training participation rates. Member-focused campaigns, such as flu prevention outreach, leverage multi-channel approaches to increase preventive service utilization, while ongoing monitoring identifies implementation barriers, including vendor engagement challenges. Collectively, these activities reflect a coordinated, data-informed strategy to improve member satisfaction, enhance provider performance, and drive sustained improvement in CAHPS measures for CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
Adult Survey Results: MY 2024: (100%, 3/3) • Care Coordination: 87.2%*	Adult Survey Results: MY 2025: (33.3%, 1/3) • Care Coordination: 86.0%	Mid-Year (Jan-Jun): 100%, (2/2) of mid-year activities completed. (0	Not Applicable. Not PPP report measures.	

• Getting Care Quickly: 78.6%* • Getting Needed Care: 75.9%* MY 2024: (33.37%, 1/3) • Customer Service: 90.5%* • Ease of Filling Out Forms: 93.5% • Rating of Health Plan: 79.5%, •AISE Flu: 0% (0/3) Fresno: 20.24% Kings: 21.88% Madera: 19.68% *Measures that met directional improvement.	• Getting Care Quickly: 76.7% • Getting Needed Care: 78.8%* MY 2025: (0%, 0/3) - N/A ad Mid-Year • Customer Service: 91.2%* • Ease of Filling Out Forms: 92.3% • Rating of Health Plan: 78.3% NEW: Child Survey Results**: MY 2025: (100%, 3/3) - Establish baseline. • Care Coordination: 76.8% • Getting Care Quickly: 88.7% • Getting Needed Care: 83.7% NEW: MY 2025: (100%, 3/3) - Establish baseline. • Customer Service: 88.5% • Ease of Filling Out Forms: 95.4% • Rating of Health Plan: 90.7% • AISE Flu: (33.3%, 1/3) Fresno: 20.74%* Kings: 19.82%, Madera: 20.68%* * Measures that met directional improvement. **Child results are new this reporting year, so there is no year comparison data.	mid-year activity(s) on hold, cancelled, or at risk.) There were 8/9 ongoing or planned activity(s) on track to be completed by year-end. (1 year-end activity(s) on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Sustaining provider engagement and consistent implementation of improvement strategies across provider groups remains an ongoing challenge. • Variations in operational processes, competing priorities, and differing levels of adoption may affect the pace and overall impact of CAHPS improvement efforts.

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	Opportunities: • Ongoing root cause analysis findings continue to identify opportunities to improve CAHPS performance by addressing key drivers of member experience. • Strengthening provider education, outreach, and engagement can support broader adoption of best practices and more consistent implementation of improvement initiatives across provider groups. • Expand CAHPS webinar offerings to address additional topics that can enhance member experience and satisfaction. • The 2026 CAHPS survey results will provide valuable insights to further refine priorities, target interventions, and inform ongoing quality improvement efforts aimed at enhancing the member experience. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: Continue reviewing quarterly Appeals and Grievances (A&G) reports to identify member experience trends, emerging issues, and opportunities for improvement. Engage cross-functional teams to address findings, educate and train providers on best practices, and implement targeted actions to improve member satisfaction. **Year End:**

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7. Pediatric/Dental: Improving pediatric measures.			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity – Monitoring of previously identified issue: Underperforming DHCS MPL measures.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Juli Coulthurst, Program Manager III, Quality Improvement

Goal(s):
Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure:
• Topical Fluoride for Children (TFL-CH- Dental or Oral Total): MPL is 19.00%. Two fluoride applications each measurement year for all children 1 to 20 years of age.
• CIS-10-E 50th percentile MPL = 23.89%
• LSC 50th percentile MPL = 69.96%
• CDEV 50th percentile MPL = 35.70%
• W30-6+ 50th percentile MPL = 63.38%
• W30-2+ 50th percentile MPL = 72.32%
• IMA-2-E 50th percentile MPL = 34.14%
• WCV 50th percentile MPL = 55.41%

Activity Highlights	The Pediatric/Dental POD for CalViva is implementing a comprehensive portfolio of member outreach, provider engagement, and regulatory initiatives to improve pediatric preventive care, immunization rates, and dental utilization across key HEDIS measures. Core strategies include multi-channel member outreach campaigns (e.g., gap calls, text messaging, POM programs), large-scale educational efforts, and provider-focused interventions such as training, tip sheets, and targeted gap list distributions to drive care gap closure. Performance data indicates strong engagement rates in text and call campaigns, while ongoing initiatives continue to address data tracking challenges and optimize provider and member responsiveness. Additionally, equity-focused interventions, including health disparity PIPs, lead screening compliance activities, and community-based partnerships (e.g., BIH Fresno), demonstrate a coordinated, compliance-driven approach to improving health outcomes and reducing disparities for pediatric populations across CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*

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MY 2024 • TFL-CH: (100%, 2/3) Fresno: 23.77%*, Kings: 19.46%, Madera: 33.83%* • CDEV: (66.67%, 2/3) Fresno: 41.4%*, Kings: 7.48%, Madera: 66.65%* • CIS-10: (66.67%, 2/3) Fresno: 29.17%*, Kings: 14%, Madera: 39%* • LSC: (100%, 3/3) Fresno: 68.66%*, Kings: 64%*, Madera: 93%* • W30-2+: (100%, 3/3) Fresno: 67.7%, Kings: 59.91% , Madera: 78.64%* • W30-6+: (66.67%, 2/3) Fresno: 59.39%, Kings: 58.25%, Madera: 72.89%* • IMA-2: (100%, 3/3) Fresno: 39.60%*, Kings: 35.77%*, Madera: 52.29%* • WCV: (100%, 3/3) Fresno: 54.17%*, Kings: 49.28%,, Madera: 63.17%* *Measures that met the MPL: (66.67%, 16/24)	MY 2025: • TFL-CH: (100%, 3/3) Fresno: 26.28%*, Kings: 22.83%*, Madera: 36.12%* • CDEV: (100%, 3/3) Fresno: 53.04%*, Kings: 36.74%*, Madera: 73.48%* • CIS-10: (100%, 3/3) Fresno: 27.69%*, Kings: 17.08%, Madera: 44.77%* • LSC: (33.33%, 2/3) Fresno: 74.99%*, Kings: 57.67%, Madera: 89.39%* • W30-2+: (100%, 3/3) Fresno: 73.34%*, Kings: 64.27%, Madera: 82.77%* • W30-6+: (100%, 3/3) Fresno: 63.35%, Kings: 69.01%*, Madera: 73.05%* • IMA-E-2: (100%, 3/3) Fresno: 43.20%*, Kings: 43.87%*, Madera: 51.07%* • WCV: (100%, 3/3) Fresno: 56.80%*, Kings: 51.46%, Madera: 63.20%* *Measures that met MPL: (79.17%, 19/24)	Mid-Year (Jan-Jun): 100%, (6/6) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.) There were 18/19 ongoing or planned activity(s) on track to be completed by year-end. (1 year-end activity(s) on hold, cancelled, or at risk.)	On track (>=75%). (75%, 18/24) Off Track Measures: Fresno: TFL-CH-Dental or Oral Health Services-Total, WCV Kings: TFL-CH-Dental or Oral Health Services-Total, CIS-E-10, WCV Madera: TFL-CH-Dental or Oral Health Services-Total	

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Changes in childhood vaccine recommendations have led to confusion and increased vaccine hesitancy among providers and members. • Limited PCP email availability restricts efficient distribution of lead screening gap lists. • Provider outreach through Power Automate remain time-intensive and resource-demanding. Opportunities: • Develop provider tools and update provider and member communications on vaccines using Frameworks Institute language recommendations for immunizations. • Establish a process to collect and maintain provider email addresses from Provider Engagement to support future outreach efforts. • Explore text messaging as an alternative to mailed member education materials.

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	• Develop custom measures in Cozeva to provide providers with age-specific vaccine and lead screening gap lists. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: • Continue improving the Power Automate provider notification process by expanding PCP email collection and providing streamlined gap lists. • Promote digital health education resources and mobile health applications through community outreach and events. • Develop Cozeva measures for CIS-10 and LSC to support targeted provider outreach and performance monitoring. • Develop and submit text messaging materials for lead education to members under six years of age. • Implement targeted quality improvement initiatives to improve pediatric measure performance in Kings County. **Year End:**

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8. Pharmacy: Improving medication adherence.			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity - Maintain achievement of DHCS MPL measures.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Shekinah Wright, Director, Quality Improvement

Goal(s):
1. Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure(s):
• Asthma Medication Ratio (AMR): MPL is 63.66%

Activity Highlights	N/A. AMR has been removed from the MCAS for MY 2026/RY 2027.

2025 (MY 2024) Objectives Met (%, ratio):	**2026 (MY 2025) Objectives Met (%, ratio):** *(populate at mid-year, if available)*	**2026 Activities Completed (%, ratio):** *(populate at mid-year and year-end)*	**Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at mid-year)*	**Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track):** *(populate at year-end)*
MY 2024: • AMR: (100%, 3/3) Fresno: 67.62%* Kings: 76.86%* Madera: 74.41%* *Measures that met the MPL (100%, 3/3).	MY 2025: • AMR: (100%, 3/3) Fresno: 73.52%* Kings: 83.87%* Madera: 80.18%* *Measures that met the MPL (100%, 3/3).	N/A. AMR has been removed from the MCAS for MY 2026/RY 2027.	N/A. AMR has been removed from the MCAS for MY 2026/RY 2027.	

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: None. Opportunities: None **Year End:**
Program Continuation Status (*populate at mid-year and year end*)	**Mid-Year:** Discontinue: AMR is no longer a MCAS measure.

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	Year End:

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9. Preventative Health: Improving cancer and chlamydia screenings.			
Counties:	CVH: Medi-Cal (Fresno, Kings, Madera)	**Type of Activity:**	• Ongoing activity - Maintain achievement of DHCS MPL measures.
Program Type:	• Quality of Care • Quality of Service	**Responsible Parties:**	Amy Schneider RN, Sr. Director Medical Management Ravneet Gill, Program Manager III, Quality Improvement Reena.Patel@CENTENE.com

Goal(s):
1. Meet the 50th percentile benchmark or year-over-year directional improvement for the following MCAS-MPL measure(s):
• Breast Cancer Screening (BCS-E): MPL is 55.87%
• Cervical Cancer Screening (CCS-E): MPL is 52.32%
• Colorectal Cancer Screening (COL-E): MPL is 41.39%

Activity Highlights	The Preventive Health POD for CalViva is advancing a robust portfolio of initiatives to improve cancer screening and immunization performance through coordinated member outreach, provider engagement, and data-driven care gap closure strategies. Key efforts include targeted high-risk member identification and outreach for breast and colorectal cancer screenings, supported by multi-channel campaigns such as text messaging, direct mail partnerships, and provider notifications to increase screening completion rates. Provider-focused interventions—such as updated clinical tip sheets, automated outreach, and facility incentive programs—are strengthening care coordination and supporting adherence to best practices, while mobile mammography and community-based approaches are expanding access for underserved populations. Collectively, these activities reflect a comprehensive, equity-focused and compliance-aligned strategy to improve preventive care utilization, address access barriers, and drive sustained quality performance improvement for CalViva.

2025 (MY 2024) Objectives Met (%, ratio):	2026 (MY 2025) Objectives Met (%, ratio): *(populate at mid-year, if available)*	2026 Activities Completed (%, ratio): *(populate at mid-year and year-end)*	Mid-Year Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track): *(populate at mid-year)*	Year-End Projected Progress Towards MY 2026 Objectives (Glidepath) (>= 75% is on track): *(populate at year-end)*
MY 2024: • BCS: (100%, 3/3) Fresno: 59.99% Kings: 64.39%* Madera: 58.5% • CCS: (100%, 3/3) Fresno: 66.3%* Kings: 66%* Madera: 70%*	MY 2025: • BCS-E: (100%, 1/3) Fresno: 55.05%, Kings: 57.83%*, Madera: 50.25% • CCS-E: (100%, 3/3) Fresno: 62.60%* Kings: 62.38%* Madera: 67.13%*	Mid-Year (Jan-Jun): 100%, (5/5) of mid-year activities completed. (0 mid-year activity(s) on hold, cancelled, or at risk.) There were 9/9 ongoing or planned activity(s)	On track (>=75%). (77.79%, 7/9) Off Track Measures: Kings: BCS-E Madera: BCS-E	

• CHL: (100%, 3/3) Fresno: 64.83%* Kings: 65.81%* Madera: 66.96%* *Measures that met the MPL (100%, 9/9).	• COL-E: (100%, 3/3) Fresno: 42.76%* Kings: 46.37%* Madera: 45.39%* *Measures that met the MPL (77.78%, 7/9). COL-E was added. CHL was removed.	on track to be completed by year-end. (0 year-end activity(s) on hold, cancelled, or at risk.)		

Opportunities/ Barriers for Unmet Objectives *(populated at mid-year and year-end)*	**Mid-Year:** Barriers: • Madera and Kings counties remain off track despite the availability of mobile mammography services, indicating ongoing challenges in connecting eligible members to screening opportunities • Providers have not consistently leveraged geospatial analysis to identify geographic clusters of members overdue for breast cancer screening and strategically target mobile mammography events. • Additionally, there has been limited engagement with local radiology facilities in these counties to assess potential access barriers, such as appointment availability and capacity constraints, and to strengthen coordination for timely member scheduling and screening completion. Opportunities: • Leverage member address data to conduct geospatial analysis and identify geographic clusters of members who are overdue for breast cancer screening, allowing mobile mammography events to be strategically placed in areas with the highest unmet need. • Engage providers in discussions regarding local radiology facility access to assess potential barriers and opportunities to improve. **Year End:**
Program Continuation Status (*populate at mid-year and year end)*	**Mid-Year:** Continue Program with Modifications: • Promote geographic mapping tools to providers to identify members overdue for breast cancer screening. • Update and distribute the BCS-E tip sheet to PPGs. • Continue promoting high-risk member identification to prioritize outreach and screening efforts. • Encourage collaboration between PPGs and radiology facilities to address screening access barriers. **Year End:**

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log

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

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Behavioral Health Oversight					
Counties:	All Counties	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Amy Schneider, CalViva Sr. Director, Medical Management, Geoffrey Gomez, Director, Quality Improvement	**eQIPT ID:**	CA-0249
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**	2. Behavioral Health	

Intervention Description:
Conduct oversight of Behavioral Health (BH) through delegated reporting, including member satisfaction surveys and performance monitoring.

Measures Impacted:
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults
FUA - Follow-Up After Emergency Department Visit for Substance Use
FUM - Follow-Up After Emergency Department Visit for Mental Illness

Barriers:	Mid-year: Data integrity of admit, discharge, and transfer (ADT) report. Year-end:
Opportunities:	Mid-year: Connecting with hospitals to ensure all diagnosis codes are flowing to ADT report to ensure follow up of members. Year-end:
Mid-year Outcome(s):	Fresno County is on track for DSF screening; however, it is not on track for FUA or FUM. Despite not meeting target performance for FUA and FUM, both measures are performing higher than the previous year. Kings County is on track for DSF screening but is not on track for FUA or FUM. In addition, Kings County is performing below the previous year for both FUA and FUM. Madera County is not on track for DSF screening or FUM; however, FUM performance is higher than the previous year. Madera County is currently on track for FUA.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Complete Member Satisfaction Reports.					
Counties:	All Counties	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Amy Schneider, CalViva Sr. Director, Medical Management, Geoffrey Gomez, Director, Quality Improvement, Guille Toland, Program Manager III, CAHPS Quality Improvement, Louba Aaronson, Director, Quality Improvement, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0246
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**	6. Member Experience	

Intervention Description:
Develop integrated member satisfaction reports with the QIRA Team to meet NCQA ME.7 standards, incorporating appeals, grievances, CAHPS/ECHO results, barriers, opportunities, and improvement activities.

Measures Impacted:
CAHPS - All CAHPS Measures, ECHO Survey

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Behavioral Health (BH) POD developed a substance use disorder (SUD) resource repository for Fresno, Kings, and Madera counties. In addition, the POD created a provider tip sheet and a member-facing flyer outlining available SUD treatment services and access pathways. These materials are currently pending review by CalViva. The Member Experience (ME) POD successfully completed data collection for the Measurement Year (MY) 2025 CAHPS Member Satisfaction Survey in May. Quarterly root cause analyses (RCAs), leveraging resolved appeals and grievances data, have strengthened the organization's ability to identify key trends and inform targeted improvement initiatives. Following the release of final survey results to the health plan, the team will initiate development of the CalViva ME.7 report to support ongoing member experience analysis and reporting.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: NCQA Continuity of Care Reports					
Counties:	All Counties	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Miriam Rosales, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0251
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health Care Coordination/Member Engagement Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	2. Behavioral Health, 5. Maternal Health/Hospital/Patient Safety

Intervention Description:
Track and monitor NCQA QI 3 and QI 4 improvement activities and interventions to ensure compliance with accreditation timelines.

Measures Impacted:
APP - First-Line Psychosocial Care
FUA - Follow-Up After Emergency Department Visit for Substance Use
FUH - Follow-Up After Hospitalization for Mental Illness
FUI - Follow-Up After High-Intensity Care for Substance Use Disorder
FUM - Follow-Up After Emergency Department Visit for Mental Illness
IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The report is on track for completion by December 15, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Handling of Member Appeals and Grievances					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Andrea Munoz, Manager, Appeals and Grievances, Desiree Dalby, Project Manager II, Appeals and Grievances	**eQIPT ID:**	CA-0197
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality and Safety of Care and Service			**POD Goals Sections (if applicable):**	
Intervention Description: Monitor the handling of member grievances and appeals to ensure compliance with regulatory processes and turnaround time (TAT) requirements. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: Continue to monitor turnaround times (TAT) to ensure ongoing compliance. Monthly dashboards support regular performance review, monitoring, and timely identification of improvement opportunities. Year-end:				
Mid-year Outcome(s):	On track with ongoing activity.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Appeals and Grievance Trending Reports					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Andrea Munoz, Manager, Appeals and Grievances, Desiree Dalby, Project Manager II, Appeals and Grievances, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0199
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**		
Intervention Description: Review appeals and grievances to identify opportunities to improve member service, satisfaction, and overall member experience. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: Audit preparation and participation require significant time and resources, which may impact other operational activities. Availability of SMEs may be a barrier. Year-end:				
Opportunities:	Mid-year: The Appeals and Grievances (A&G) team established the A&G Governance Committee in 2025. There is an opportunity to enhance cross-functional visibility into trends, strengthen alignment across business areas, and advance data-driven improvement efforts. Year-end:				
Mid-year Outcome(s):	The Appeals and Grievances (A&G) team routinely shared reporting with key business areas to identify trends and improve the member experience. The team collaborated with call center leadership and participated in workgroups to review grievance data, validate processes, and evaluate improvement efforts. Key findings were escalated to leadership as appropriate, and ongoing training helped ensure compliance with contractual and regulatory requirements related to access and availability.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: MCAS Provider Training					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Erica Valdivia, Director, Provider Relations, Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0243
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**		
Intervention Description: Engage with CalViva provider offices to complete MY 2026 MCAS training on best practices for closing care gaps. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: Expand targeted provider education in collaboration with PPG and PCP partners to reinforce best practices for priority MCAS measures. Emphasis will be placed on integrating HEDIS-aligned guidance into routine provider engagement to promote sustained performance improvement and accelerate care gap closure across priority measures. Year-end:				
Mid-year Outcome(s):	he QI Program's Best Practice Guide for MY 2026 priority MCAS measures was distributed to the Provider Engagement team on February 5, 2026. Provider Engagement staff continue to reinforce targeted HEDIS education during routine provider interactions, supporting evidence-based practices and care gap closure across priority measures.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: CAHPS monitoring					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Guille Toland, Program Manager III, CAHPS Quality Improvement, Louba Aaronson, Director, Quality Improvement, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0234
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Maintain and manage the CAHPS Action Plan by partnering with measure owners to identify improvement opportunities and implement activities that enhance CAHPS performance. Collaborate with Provider Engagement and Medical Affairs to review provider improvement plans, share best practices, and recommend enhancements to strengthen the member experience and achieve measurable results.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: Provider engagement and consistent implementation vary across groups, which can slow the pace and impact of CAHPS improvement efforts. Year-end:
Opportunities:	Mid-year: Root cause analysis findings continue to identify key opportunities to improve CAHPS performance through targeted interventions. Strengthening provider education and engagement remains critical to driving consistent and sustained improvement. Upcoming MY 2026 CAHPS results will further inform priorities and refine data-driven strategies. Year-end:
Mid-year Outcome(s):	The CAHPS team has maintained consistent engagement with Provider Engagement (PE) and MA/PPG teams by delivering timely updates and reviewing ongoing initiatives during regularly scheduled meetings. Additionally, active participation in the CalViva Appeals and Grievances (A&G) Workgroup and Member Operations Meetings (MOM) has strengthened cross-functional alignment and supported coordinated efforts to advance member experience priorities.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: QIHEd and Wellness Program Work Plan and Evaluations					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Jamie Spears, Manager, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Lynn Pak, Senior Manager, Quality Improvement, Maya Marmo, Director, Data Analytics, Sharon Rushing, Shekinah Wright, Taline Jaghasspanian, Sr. Director, Quality Improvement, Tuyen Pham, Compliance Specialist, Program Accreditation	**eQIPT ID:**	CA-0399
Start Date: 01/01/26		**End Date:** 09/30/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Complete the annual evaluation of the prior year's QIHEd and Wellness Program in Q1 and conduct semi-annual evaluations of the QI Work Plan to assess progress and outcomes.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The 2025 year-end reports were completed in Q1, and mid-year evaluations are currently on track.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Lead Screening Compliance					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Juli Coulthurst, Program Manager III, Linda Armbruster, Quality Improvement Specialist, Pamela Carpenter, Director, Clinical Support Services, Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0400
Start Date: 01/01/26		**End Date:** 09/30/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Compliance Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**	7. Pediatric/Dental	

Intervention Description:
Maintain compliance with DHCS childhood blood lead screening requirements through quarterly monitoring of the HEDIS Lead Screening for Children (LSC) measure. Support compliance through member education materials, provider training and tools, and medical record reviews conducted during Facility Site Reviews, with results reported to DHCS twice annually.

Measures Impacted:
LSC - Lead Screening in Children

Barriers:	Mid-year: Several barriers have been identified impacting compliance with lead blood screening requirements: Provider Practices and Workflow • Use of incorrect coding by providers. • Low utilization of point-of-care (POC) lead screening tests in provider offices. • Providers must implement standardized workflows and obtain regulatory approval to conduct in-office capillary lead screening. • Audit findings indicate consistent screening at 12 months of age; however, screening at 24 months remains inconsistent. • Some providers lack EMR prompts or checklists to support anticipatory guidance and screening compliance. Member Access and Engagement • Members are reluctant to visit external laboratory locations for lead screening. • Laboratories typically do not offer capillary lead screening, contributing to member and caregiver discomfort. • Missed appointments continue to impact screening rates. Data and Reporting Limitations • FSR/MRR record reviews demonstrate variability in documented lead screening and anticipatory guidance compliance. • Barriers include reliance on the DHCS provider list for CalViva, limited provider participation in reviews, and a high proportion of records that are not applicable to lead screening or anticipatory guidance. Year-end:
Opportunities:	Mid-year: Expand the Lead Analyzer Initiative by onboarding a vendor to streamline EDGE-funded lead blood analyzer payments, device distribution, and onsite training. These efforts can increase access to point-of-care testing, reduce member hesitancy, and improve lead screening compliance. Additional opportunities include partnering with Provider Engagement to onboard priority LSC providers to Cozeva, leverage EDGE funding to enhance workflows and screening capacity, and conduct a follow up focused medical record review to evaluate status improvement in meeting anticipatory guidance standards.Opportunities to identify providers without lead anticipatory guidance flags in their EMR and fund the addition of lead anticipatory guidance flags in EMR systems. Year-end:
Mid-year Outcome(s):	The Q3 2025 LSC Compliance Report to DHCS was submitted and accepted on January 30, 2026. The Q4 2025 CalViva LSC Compliance Report is due June 19, 2026, and remains on track. Q4 QIUM 26 Lead Screening Quarterly Report was submitted and accepted June 19, 2026. FSR/MRR data are received approximately one month prior to the quarter. Q4 2025 data were received January 28, 2026, and Q1 2026 data were received April 3, 2026.

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

	Q3 FSR/MRR results reflected lower compliance rates compared to Q1 and Q2, as well as the lowest volume of records reviewed. This resulted in a decrease in overall member-level compliance for lead screening and anticipatory guidance to 76%, and a PCP site compliance rate of 50%. Q4 FSR/MRR results showed improvement over Q3; however, overall member-level compliance was 73%, and PCP site compliance was 56%. From January through March 2026, no new lead blood analyzers were approved because none were requested. In April, one analyzer was approved for a Fresno County provider. In May, an analyzer was approved for a provider that had previously received one in 2023 (new device, existing provider). No additional analyzers were approved in June because none were requested. The Provider Engagement team continues to promote analyzer adoption and provide LSC training and compliance best practices to participating providers. The project is currently in contract negotiations with Medline to expand the Lead Analyzer Initiative and streamline payment and distribution processes. A prior onboarding effort with McKesson Medical-Surgical was discontinued due to non-compliance with vendor security requirements.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: PPG Delegation Oversight Scorecards					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Manisha Makwana, Director, Provider Relations, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0240
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Monitor Delegation Oversight activities through quarterly PPG scorecards that track audit results and performance. The scorecards help identify trends, monitor performance, and highlight high- and low-performing PPGs.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Q4 2025 PPG scorecard production was completed on March 20, 2026, covering six PPGs serving the CalViva service area. The PPG Performance Governance Committee drives cross-functional accountability to improve PPG performance and approves remediation plans for underperforming PPGs. Production of the Q1 2026 PPG scorecard is anticipated in July 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Provider Satisfaction Survey					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Manjula Miyashiro, Director, PNM Operations, Rudolph Davila, Program Manager II, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0221
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability
Intervention Description: Coordinate data collection, analysis, and reporting for the annual Provider Satisfaction Survey. **Measures Impacted:** Survey – Provider Satisfaction (CA)					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	Activity is on track.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Provider Satisfaction Survey					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Manjula Miyashiro, Director, PNM Operations, Rudolph Davila, Program Manager II, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0218
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**	1. Access and Availability	
Intervention Description: Monitor appropriate after-hours messaging and timely access to urgent/emergent care. Refer to Access and Availability Work Plan for additional details. **Measures Impacted:** Survey – Provider Satisfaction (CA)					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	Activity is on track.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: A&G Quality of Care Concerns					
Counties:	All Counties	**Initiative Point of Contact:**	Amy Schneider, CalViva Sr. Director, Medical Management, Pamela Carpenter, Director, Clinical Support Services	**eQIPT ID:**	CA-0362
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality and Safety of Care and Service			**POD Goals Sections (if applicable):**	

Intervention Description:
Review and update the Clinical Appeals and Grievances (A&G) Quality of Care Concerns Policy and Procedure and the Peer Review Committee Policy and Procedure to ensure they remain current and compliant.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Quarterly timelines were met. Activity is on track.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Health Education Materials Management					
Counties:	All Counties	**Initiative Point of Contact:**	Anabel Jayme, Program Manager II, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0423
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Manage and maintain health education materials to ensure content is current, accurate, and available to support member and provider education.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	On Track: As of mid-year, a total of 4,312 printed health education materials have been requested and fulfilled across the CalViva service area.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Health Education Program					
Counties:	All Counties	**Initiative Point of Contact:**	Anabel Jayme, Program Manager II, Quality Improvement, Louba Aaronson, Director, Quality Improvement, Shekinah Wright, Director, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0426
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health		**POD Goals Sections (if applicable):**		
Intervention Description: Maintain Health Education System policies and procedures, monitor health education initiatives, manage printed and digital educational materials, and promote health education resources to providers. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	On Track: As of mid-year, all policies and procedures (P&Ps) have been reviewed and updated as appropriate. Initiatives, digital programs, and printed materials continue to be monitored in alignment with their established review cycles.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: PPG Delegates Compliance Oversight					
Counties:	Fresno	**Initiative Point of Contact:**	Anastassia Tonkogolosuk, Sr. Manager, Ethics and Compliance, Karen Bowling, Sr. Manager, Delegation Oversight	**eQIPT ID:**	CA-0324
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality and Safety of Care and Service			**POD Goals Sections (if applicable):**	
Intervention Description: Monitor delegated PPG activities and issues, including corrective action plans (CAPs), and report findings at least annually to the CalViva Credentialing Subcommittee and QIUM Committee. Oversight includes Utilization Management, Complex Case Management (CCM), credentialing, and claims payment. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	As of mid-year 2026, Third Party Risk Management (TPRMO) remains on track to effectively monitor delegated activities across PPGs. Identified findings will be formally reported to the appropriate committees by year-end.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Vendor Onboarding					
Counties:	All Counties	**Initiative Point of Contact:**	Arzoo Mojadedi, Sr. Health Education Specialist, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0410
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Manage the onboarding and ongoing oversight of the Diabetes Prevention Program (DPP) vendor to ensure eligible Medi-Cal members have access to program services.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Explore the use of social media strategies to promote program awareness, enhance member engagement, and increase participation across target populations. Year-end:
Mid-year Outcome(s):	The member mailer is currently in progress.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Safety and Quality Plan					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement, Sharon Rushing, Sr. Manager, Quality Improvement	**eQIPT ID:**	CA-0389
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Evaluate and maintain the written plan for safety and quality data collection to support patient safety and ensure provider and practitioner safety and quality information is collected, analyzed, and reported at least annually.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Partnership with the Hospital Quality Institute provides access to track and trend data for priority hospital quality metrics, supporting ongoing performance monitoring and improvement efforts. Year-end:
Mid-year Outcome(s):	The initial QIHEd and Wellness work plan was completed in Q1 2026. The year-end QIHED and Wellness program evaluation was completed in Q2. In Q1, a hospital quality report was completed for five hospitals with reportable data, including facility-specific trend analyses and engagement activities related to priority metrics. Key areas of vulnerability identified include SSI-Colon Standardized Infection Ratios and C-section rate performance.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Integrated Care Management					
Counties:	Fresno	**Initiative Point of Contact:**	Carrie-Lee Patnaude, Director, Care Management	**eQIPT ID:**	CA-0331
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality and Safety of Care and Service		**POD Goals Sections (if applicable):**		
Intervention Description: Implement the Population Health Management (PHM) pyramid as a predictive modeling tool to identify high-risk members for referral to Integrated Care Management (ICM). Evaluate the ICM Program based on readmission rates, emergency department utilization, healthcare costs, and member satisfaction. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: Low referral volumes were observed across select programs, accompanied by higher “unable to reach” rates. Additionally, no member participation was recorded for the Care Management (CM) satisfaction survey during the reporting period. Year-end:				
Opportunities:	Mid-year: The Care Management (CM) team is developing and implementing a shortened satisfaction survey to be administered internally via a texting platform. The survey will be distributed weekly to members upon completion of the CM program to support timely feedback collection and continuous quality improvement. Year-end:				
Mid-year Outcome(s):	Performance is meeting established targets for readmission reduction, emergency department (ED) utilization reduction, and overall healthcare cost reduction goals.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Pregnancy Program					
Counties:	All Counties	**Initiative Point of Contact:**	Carrie-Lee Patnaude, Director, Care Management, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0435
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health			**POD Goals Sections (if applicable):**	
Intervention Description: Monitor the CalViva Health Pregnancy Program and identify high-risk members through Care Management to support timely interventions and improve maternal health outcomes. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: Lower pregnancy volumes were observed compared to previous years. Additionally, no member participation was recorded for the Care Management (CM) satisfaction survey during the reporting period. Year-end:				
Opportunities:	Mid-year: The Care Management (CM) team will implement a shortened CM Satisfaction Survey using an internal texting platform. The survey will be distributed weekly to members upon completion of the CM program to support timely feedback collection and continuous quality improvement. Year-end:				
Mid-year Outcome(s):	Performance is on track to meet program goals for prenatal, postpartum, and preterm care measures.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: GeoAccess Report					
Counties:	All Counties	**Initiative Point of Contact:**	Dao Fang, Manager, Health Equity, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0227
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** Canceled	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	
Intervention Description: Assess and report on provider network availability, identify improvement opportunities, and inform Provider Network Management of areas where additional provider contracting is needed. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	The GeoAccess report is conducted biennially, with the next report scheduled for completion by August 31, 2027.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Health Equity Report					
Counties:	All Counties	**Initiative Point of Contact:**	Dao Fang, Manager, Health Equity, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0224
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	
Intervention Description: Evaluate and report on cultural and linguistic services and needs. **Measures Impacted:** No Associated Measure					

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Mid-Year Health Equity Work Plan and Language Access Program (LAP) evaluation are on track for completion by August 31, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Disease/Chronic Conditions Management					
Counties:	Fresno	**Initiative Point of Contact:**	Denise Miller, Program Manager III, Vendor Performance Management	**eQIPT ID:**	CA-0320
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**		

Intervention Description:
Monitor the Chronic Conditions Management Program to ensure appropriate quarterly member outreach and engagement activities are conducted.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year : Member engagement in disease management and health coaching through the opt-in model remains limited. Current program participation is primarily concentrated in Asthma, Lifestyle Management, and Diabetes programs. Year-end:
Opportunities:	Mid-year: Expand targeted outreach based on the most common diagnoses across all CalViva counties. Increase program enrollment by automatically enrolling high-risk members identified during onboarding while allowing members to opt out. Year-end:
Mid-year Outcome(s):	A total of 144 members received disease management and health coaching services. The top five programs by participation include: • Asthma (70) • Lifestyle management (e.g., exercise, weight management, nutrition) (40) • Diabetes (34) • Obesity (34) • Depression/Anxiety screening (24) Note: Members may be actively enrolled in more than one program simultaneously; therefore, total program participation exceeds the number of unique members served.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Quality EDGE					
Counties:	All Counties	**Initiative Point of Contact:**	Erica Valdivia, Director, Provider Relations, Michelle Najarro, Manager, Program Accreditation	**eQIPT ID:**	CA-0231
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**		
Intervention Description: In collaboration with Provider Engagement, work with Quality EDGE priority provider offices to improve access to care and implement interventions that address systemic barriers affecting HEDIS performance. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: Non-compliance with the documentation of anticipatory guidance for Lead Screening for Children (LSC) has been identified as a key gap. Year-end:				
Opportunities:	Mid-year: Implement a pilot initiative to support individual providers by activating anticipatory guidance flags within EMR/EHR systems for Lead Screening for Children (LSC). This effort aims to improve timely screening, reinforce documentation practices, and increase overall compliance rates. Year-end:				
Mid-year Outcome(s):	Year-to-date, there have been 83 EDGE funding requests submitted, totaling $211,900.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Preventive Screening Guidelines					
Counties:	All Counties	**Initiative Point of Contact:**	Justina Felix, Sr. Health Education Specialist, Quality Improvement	**eQIPT ID:**	CA-0414
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health		**POD Goals Sections (if applicable):**		

Intervention Description:
Distribute and make Preventive Screening Guidelines (PSGs) available to members and providers to support preventive care and screening compliance.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Final remediated CalViva PSGs were received from the Marketing team on April 3, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: PPG Delegates Credentialing/Recredentialing Oversight					
Counties:	Fresno	**Initiative Point of Contact:**	Karen Bowling, Sr. Manager, Delegation Oversight	**eQIPT ID:**	CA-0316
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Monitor delegated PPG credentialing and recredentialing activities to achieve and maintain annual audit scores of 90% to 100% compliance.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Third Party Risk Management (TPRMO) remains on track and will continue to effectively monitor delegated PPG credentialing and recredentialing processes to ensure compliance with applicable requirements.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Clinical Practice Guidelines					
Counties:	All Counties	**Initiative Point of Contact:**	Kimberly Greaney-Macsicza, Director, Clinical Programs	**eQIPT ID:**	CA-0339
Start Date: 01/01/26		**End Date:** 06/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Health Education/Wellness Preventative Care Ongoing Monitoring Activities Quality	**POD Goals Sections (if applicable):**			
Intervention Description: Adopt and distribute Medical Clinical Practice Guidelines (CPGs) to providers. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	An update to the Clinical Practice Guidelines (CPG) Grid was completed in February 2026. Provider notification was distributed on April 17, 2026.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Member Newsletter					
Counties:	All Counties	**Initiative Point of Contact:**	Kristen Kaila, Senior Health Education Specialist, Quality Improvement, Sia Lopez, CalViva Health Equity Officer, Stacey Noonan, Health Educator, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0407
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Create and distribute the member newsletter to meet NCQA requirements for member communications and provide important health plan information directly to members.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: • Print production and distribution delays. • Dependency on cross-functional inputs and approvals. . Year-end:
Opportunities:	Mid-year: • Align print and digital content for consistent access. • Elevate CAHPS visibility in condensed print materials. • Drive engagement via QR-enabled digital content. • Broaden accessibility across formats (e.g., Braille, multilingual). Year-end:
Mid-year Outcome(s):	Translations and alternative format quotes have been provided and approved. The vendor has completed translations, which are currently undergoing internal review.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: HEDIS Care Gap Reports					
Counties:	All Counties	**Initiative Point of Contact:**	Lakhwinder Kaur, Data Analyst IV, Quality Improvement Analytics	**eQIPT ID:**	CA-0383
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality Improvement and Infrastructure		**POD Goals Sections (if applicable):**		
Intervention Description: Produce weekly HEDIS care gap reports at the contract and Participating Provider Group (PPG) levels to identify members who are not compliant with required care measures and support targeted outreach efforts. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	On track. Care gap reports are produced on a periodic basis to support ongoing monitoring and targeted outreach efforts.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva DHCS IHA 2026 Audit					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement; Miriam Rosales, Program Manager III, Quality Improvement; Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0811
Start Date: 04/01/26		**End Date:** 08/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Care Coordination/Member Engagement Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	3. Care Coordination/Member Engagement

Intervention Description:
In preparation for the DHCS IHA audit covering the April 1, 2025 through December 31, 2025 review period, Health Net submitted the full CalViva member population for audit selection. DHCS selected a sample for review, and supporting documentation is being submitted on an ongoing basis, including quarterly reports, outreach records, and member and provider education materials to demonstrate compliance with IHA requirements.

Measures Impacted:
IHA - Initial Health Assessment

Barriers:	Mid-year: The mid-year audit was challenged by short turnaround times, high record volumes, and blood lead screening documentation requirements. Delayed, incomplete, or incorrect provider submissions, missing no-record responses, and outdated provider systems slowed record collection and submission. Additional challenges included inaccurate member and provider data, limited responsiveness from non-contracted providers, third-party record access issues, and lengthy retrieval timelines from PPGs and other provider sites. These factors required extensive manual follow-up and made health plan expectations for rapid submission of large record volumes operationally difficult to achieve. Year-end:
Opportunities:	Mid-year: Establish a dedicated team and standardized audit process for requesting medical records from PCPs, PPGs, and other provider sites to improve accountability, response times, and audit readiness. Additionally, enhance data accuracy by ensuring member demographics and PCP information are updated at enrollment, provider changes, re-enrollment, and during the 120-day Initial Health Assessment or well-child visit. This approach can strengthen outreach efforts, reduce data-related issues, and support timely completion of health plan audit requirements. Year-end:
Mid-year Outcome(s):	The DHCS IHA audit covers the period from April 1, 2025, through December 31, 2025. The full CalViva member universe was submitted, and DHCS selected a focused review sample. Medical records continue to be submitted on a rolling basis as they become available. To accelerate completion of outstanding sample records, Quality Improvement partnered with the G&A Provider Relations Management Team after repeated outreach did not yield the requested documentation. Audit progress was constrained by high record volume, limited turnaround times, Provider Engagement capacity, delayed and incomplete provider responses, inaccurate internal provider and member data, and technical limitations within some provider offices, including outdated EMR systems and restricted electronic transmission capabilities. Additional barriers included large record files, non-responsive non-contracted providers, ticketing requirements for participating physician groups and third-party providers, and occasional records withheld pending payment. In cases where fax or mail was not feasible, field staff retrieved records onsite and management supported scanning and submission. Quality Improvement and leadership also completed added research across internal systems to validate provider contact information and member data needed to support record retrieval. Record submission to CalViva remains ongoing, with frequent status updates provided, and audit process improvements are underway. To date, 30 of 40 sample member records have been submitted.
Year-end Outcome(s):	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Initial Health Appointment Compliance					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement; Miriam Rosales, Program Manager III, Quality Improvement; Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0726
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Care Coordination/Member Engagement Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	3. Care Coordination/Member Engagement

Intervention Description:
Maintain compliance with DHCS Initial Health Appointment (IHA) three-pronged outreach requirements by monitoring outreach activities and completing the annual IHA Compliance Monitoring Report to evaluate performance and ensure regulatory compliance.

Measures Impacted:
IHA - Initial Health Assessment

Barriers:	Mid-year: • Duplicate call-time fields identified in reporting outputs • Incomplete voicemail timestamp data impacting accuracy • File formatting issues increasing the need for manual data scrubbing • Higher no-answer and disconnected call rates during first- and second-attempt English outreach • Increased call volume in May, which adversely affected overall completion performance Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Monthly Health Net POM call analyses were completed and submitted on schedule from January through May 2026. Early analyses identified reporting and outreach challenges, leading to implementation of the Genesys AI tool and six new call completion codes to improve call tracking, classification, and reporting visibility. QI continued to collaborate with the Genesys AI team to address reporting limitations, including voicemail tracking and file compatibility issues. Reporting enhancements implemented in March improved trend analysis and performance monitoring. Outreach performance showed overall positive results, with call completion rates improving from 86% in March to 89% in April, before declining to 68% in May. Invalid call rates remained stable at approximately 11%, reflecting ongoing efforts to improve data quality and outreach effectiveness. Overall, reporting enhancements and continued process improvements have strengthened monitoring capabilities and supported more effective member outreach efforts.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Health Education Program and Services Flyer					
Counties:	All Counties	**Initiative Point of Contact:**	Maria Lin, Program Manager II, Sia Lopez, CalViva Health Equity Officer, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0420
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Wellness/Preventive Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Distribute the Health Education Programs and Services Flyer to members through the Medi-Cal welcome packet to increase awareness of available health education resources and services.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The 2026 Health Ed Services Flyers are distributed monthly. The 2027 Health Ed Services Flyers are on track with DHCS approval.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Facility Site Reviews and Medical Record Reviews					
Counties:	All Counties	**Initiative Point of Contact:**	Pamela Carpenter, Director, Clinical Support Services	**eQIPT ID:**	CA-0368
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Compliance Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	

Intervention Description:
Maintain compliance with Facility Site Review (FSR) and Medical Record Review (MRR) requirements to ensure provider offices and medical records meet DHCS standards under APL 22-107. Conduct Physical Accessibility Reviews (PARs) in accordance with MMCD Policy Letters 12-006 and 15-023, monitor provider compliance, and submit FSR/MRR results to DHCS twice annually (January 31 and July 31), including all sites with failed scores.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Dual submission of DHCS reporting files is in progress, utilizing both Excel and pilot JSON formats via the SFTP pathway for ingestion into DHCS's Managed Site Review Program (MSRP) database.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Potential Quality Issues (PQI)					
Counties:	All Counties	**Initiative Point of Contact:**	Pamela Carpenter, Director, Clinical Support Services	**eQIPT ID:**	CA-0365
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Compliance Ongoing Monitoring Activities Quality and Safety of Care and Service		**POD Goals Sections (if applicable):**		
Intervention Description: Monitor potential quality incidents (PQIs) and quality of care (QOC) findings, report results to CalViva quarterly, and ensure all cases are completed within the 90-day turnaround time (TAT) to maintain compliance. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	All quarterly timelines have been met, and activities remain on schedule.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Peer Review					
Counties:	All Counties	**Initiative Point of Contact:**	Pamela Carpenter, Director, Clinical Support Services	**eQIPT ID:**	CA-0357
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Compliance Ongoing Monitoring Activities Quality and Safety of Care and Service		**POD Goals Sections (if applicable):**		
Intervention Description: Monitor peer review determinations and provide quarterly reports to the CalViva Credentialing Subcommittee. **Measures Impacted:** No Associated Measure					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	All quarterly timelines have been met, and activities remain on schedule.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Credentialing					
Counties:	All Counties	**Initiative Point of Contact:**	Pamela Carpenter, Director, Clinical Support Services	**eQIPT ID:**	CA-0356
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Credentialing/Recredentialing Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**		
Intervention Description: Monitor peer review determinations and report findings to the CalViva Credentialing Subcommittee on a quarterly basis to support ongoing oversight and quality improvement activities. **Measures Impacted:** No Associated Measure					

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	All quarterly timelines have been met, and activities remain on schedule.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Access Survey Results					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0217
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability

Intervention Description:
Monitor timely appointment availability and after-hours access to identify non-compliant PPGs and providers during Q1 and Q2. In Q3 and Q4, issue corrective action plans (CAPs) and educational materials to providers that do not meet access standards.

Measures Impacted:
Survey – Provider After Hours (CA)
Survey – Provider Appointment Availability (CA)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	On track. MY 2025 PAAS and After-Hours survey results are scheduled for release in Q3–Q4 2026. Non-compliant PPGs and providers will be identified, and corrective action plans (CAPs) will be issued accordingly.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Telephone Access Survey					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0215
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability
Intervention Description: Conduct quarterly surveys to assess provider compliance and issue corrective action plans (CAPs) to providers that do not meet required standards. **Measures Impacted:** Survey – Telephone Access (CA)					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	On track. MY 2025 PAAS and After-Hours survey results are anticipated for release in Q3–Q4 2026. Non-compliant PPGs and providers will be identified, and corrective action plans (CAPs) will be issued as appropriate.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: DHCS Medi-Cal Managed Care Timely Access Survey Report					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0212
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability

Intervention Description:
Conduct quarterly educational outreach to providers identified through the survey as non-compliant to improve compliance and support corrective actions.

Measures Impacted:
Survey – Provider Appointment Availability (CA)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	DHCS quarterly Timely Access Study results will be reviewed and analyzed, and responses to DHCS inquiries will be developed and submitted as required.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: DMHC Timely Access Report (TAR)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0208
Start Date: 01/01/26		**End Date:** 05/01/26		**Activity Status:** Complete	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability

Intervention Description:
Complete and submit the DMHC Timely Access Report (TAR) by the required filing deadline of May 1, 2026, ensuring compliance with DMHC reporting requirements.

Measures Impacted:
Survey – Provider Appointment Availability (CA)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Report was completed and submitted to DMHC.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Access Survey Monitoring					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0205
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities			**POD Goals Sections (if applicable):**	1. Access and Availability
Intervention Description: Monitor and report compliance with access-to-care standards using telephonic surveys conducted by contracted vendor(s). Analyze survey results to identify access issues, monitor performance, and support improvement efforts. **Measures Impacted:** Survey – Provider Appointment Availability (CA)					
Barriers:	Mid-year: None. Year-end:				
Opportunities:	Mid-year: None. Year-end:				
Mid-year Outcome(s):	On track. The survey is scheduled to be conducted in Q3–Q4 2026.				
Year-end Outcome(s):					
Activity Change for Following Year:					

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Access Provider Training					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Paul Fuentes, Provider Relations Specialist, Access & Availability, Steven Si, CalViva Compliance Manager	**eQIPT ID:**	CA-0203
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability, Satisfaction and Service Ongoing Monitoring Activities		**POD Goals Sections (if applicable):**	1. Access and Availability	

Intervention Description:
Conduct quarterly provider webinars to support provider education and engagement.

Measures Impacted:
Survey – Provider Appointment Availability (CA)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	On track. Preparation for the 2026 Timely Access Provider Training Webinars is underway. Webinar dates (Pacific Time) are currently being finalized and will be communicated upon confirmation. August 5 – 12:00 p.m. August 19 – 12:00 p.m. October 7 – 12:00 p.m. October 21 – 4:00 p.m. November 4 – 12:00 p.m. November 18 – 12:00 p.m. December 2 – 12:00 p.m. December 16 – 12:00 p.m.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: HEDIS Best Practices Tools					
Counties:	All Counties	**Initiative Point of Contact:**	Shekinah Wright, Director, Quality Improvement	**eQIPT ID:**	CA-0380
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality Improvement and Infrastructure		**POD Goals Sections (if applicable):**		
Intervention Description: Develop and support HEDIS best practice tools to improve provider performance and care gap closure. **Measures Impacted:** No Associated Measure					

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	On track. The QI Program's Best Practice Guide for MY 2026 priority measures was developed and distributed to the Provider Engagement team on February 5, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Cozeva Adoption					
Counties:	All Counties	**Initiative Point of Contact:**	Steven Myers, Sr Manager, Provider Engagement Strategy	**eQIPT ID:**	CA-0377
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Ongoing Monitoring Activities Quality Improvement and Infrastructure		**POD Goals Sections (if applicable):**		

Intervention Description:
Promote continued adoption and use of the Cozeva platform among PCPs and provider groups during the program's fifth year. Expand Cozeva-EHR integrations and bidirectional data sharing with priority providers and clinics, and enhance platform functionality to support regulatory requirements, quality initiatives, and improvement opportunities.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Targeted interventions will start in Q3 to address KPI gaps (e.g., email campaigns to practices with no 2026 logons or data submission, in-app reminders to super users to validate access for the practice, etc.) Year-end:
Mid-year Outcome(s):	Cozeva platform engagement among CalViva Medi-Cal providers is currently 43%, below the 50% year-end goal.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva W30-6+ Health Disparity PIP					
Counties:	Fresno	**Initiative Point of Contact:**	Arpitha Banaji, Quality Improvement Specialist Senior, Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0653
Start Date: 01/01/26		**End Date:** 08/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
The CalViva Health W30-6+ Disparity PIP is a DHCS-mandated Performance Improvement Project assigned to CalViva Health from 2023 through 2026. The project focuses on increasing Well-Child Visits in the First 30 Months of Life (W30-6+) among the Black/African American (B/AA) population to reduce disparities and improve infant well-child care rates.

Measures Impacted:
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Prioritize early completion of the PIP to avoid last-minute rush. Year-end:
Mid-year Outcome(s):	The W30-6+ Clinical Performance Improvement Project (PIP) concluded on December 31, 2025. CalViva will continue its partnership with the Black Infant Health (BIH) Program by referring Black/African American (B/AA) pregnant and postpartum members to receive culturally responsive support and education. During the PIP intervention period (June 1, 2024–December 31, 2025), CalViva referred a total of 660 B/AA prenatal and postpartum members to BIH. Of these, 65 members were already enrolled in the program, and 291 (48.9%) were successfully contacted. CalViva is currently finalizing PIP submission materials for timely submission to HSAG by August 6, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Initial Health Appointments (IHA) Quarterly Reporting					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement Specialist	**eQIPT ID:**	CA-0539
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Care Coordination/Member Engagement		**POD Goals Sections (if applicable):**	3. Care Coordination/Member Engagement	

Intervention Description:
Provide quarterly updates on Initial Health Appointment (IHA) rates, compliance status, and program performance to stakeholder committee members to support oversight and improvement efforts.

Measures Impacted:
IHA - Initial Health Assessment

Barriers:	Mid-year: Reporting remains challenging due to multiple data sources, a four-month lag in capturing the 120-day enrollment window, and QIRA data delays related to audit and CAP workloads. Inaccurate member contact information, delayed claims and encounter data from billing errors, and gaps in continuous enrollment have limited outreach effectiveness. Missed appointments and increased ICE activity in the Central Valley have also contributed to lower member engagement and reduced in-office visits. Year-end:
Opportunities:	Mid-year: Opportunities exist for Quality Improvement (QI) to leverage the Marathon dashboard to generate care gap lists, improving analyst efficiency and streamlining workflow processes. Enhancing data collection processes to ensure complete and accurate member demographics at the time of enrollment will further strengthen outreach efforts. Additional opportunities include revising provider training to reinforce timeliness of billing and adherence to documentation requirements, as well as reviewing exception logic related to non-continuous enrollment to ensure appropriate outreach triggers. Collaboration with Community Health Workers (CHWs) also presents an opportunity to address member-level barriers, including fear-based concerns and transportation challenges, to improve engagement and access to care. Year-end:
Mid-year Outcome(s):	The QIUM #36 Initial Health Assessment (IHA) CalViva Health Quarterly Compliance Report was submitted on February 20, 2026, and subsequently approved. The Q4 report was submitted on June 19, 2026. The IHA workgroup meets monthly to review data reporting and identify opportunities for improvement and innovation. Provider training has been enhanced to emphasize billing timeliness, and an on-demand IHA training module was launched in the provider portal in March 2026. In May 2026, the plan collaborated with Member Services and G&A Integrated Systems teams to identify root causes of failed outreach attempts associated with non-continuous enrollment processes. Investigations are currently in progress, and findings will be reported upon completion.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva: Initial Health Appointments (IHA) Low Performing Providers					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement Specialist	**eQIPT ID:**	CA-0583
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Care Coordination/Member Engagement			**POD Goals Sections (if applicable):**	3. Care Coordination/Member Engagement

Intervention Description:
Identify low-performing Initial Health Appointment (IHA) providers each quarter in collaboration with QIRA and work with Provider Engagement to provide targeted training, education, and support to improve performance and compliance.

Measures Impacted:
IHA - Initial Health Assessment

Barriers:	Mid-year: Barriers identified from January through June included low member engagement; high rates of missed, canceled, and no-show appointments; clinical workflow challenges; and limited staffing capacity to support care gap reporting, appointment scheduling, and extended office hours. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The CalViva High-Volume, Low-Performing Provider (HVLP) Q3 2025 analysis was submitted to the IHA Senior Manager on February 19, 2026. The report identified at least 10 HVLP providers and summarized cumulative Initial Health Appointment (IHA) trainings conducted by the Provider Engagement (PE) team each quarter, including associated action plans, barriers, and interventions. Key barriers identified in Q3 included low member engagement—reflected in missed, canceled, and no-show appointments—as well as clinical workflow challenges, such as limited staff capacity to generate care gap reports and schedule appointments. In response, the PE team supported providers through targeted interventions, including assistance with care gap list generation, implementation of call campaigns, utilization of EDGE funding for staff incentives, and expansion of office hours to increase IHA appointment access. A total of 761 IHA trainings were conducted in Q3 2025, with best practices reviewed and reinforced with participating providers. The Q4 HVLP provider analysis is currently in progress and is expected to be completed in July 2026, following submission of the QI_UM #36 IHA Health Net Quarterly Compliance Report due June 19, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: (CalViva) Confirmation of Pregnancy Forms					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement, Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0752
Start Date: 01/05/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety			**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety

Intervention Description:
Manage the Confirmation of Pregnancy (COP) Form Program, which encourages primary care providers (PCPs) to complete and submit COP forms as documentation for the PPC Timely Prenatal Care measure. Providers receive incentives for submitting complete and accurate forms, supporting timely prenatal care identification and reporting.

Measures Impacted:
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care

Barriers:	Mid-year: No CalViva forms had been received as of May 14, 2026. Year-end:
Opportunities:	Mid-year: Provider updates regarding the Confirmation of Pregnancy (COP) PCP Incentive will be distributed on a quarterly basis. Year-end:
Mid-year Outcome(s):	A provider update was distributed in Q2 to promote submission of Confirmation of Pregnancy (COP) forms and awareness of the associated PCP incentive. The Provider Engagement team was also trained on the program to support outreach and promote adoption among network providers.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Digital Health Education Resources to Support Patients					
Counties:	All Counties	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement, Lora Maloof-Miller, Program Manager II, Quality Improvement, Maria Lin, Program Manager II	**eQIPT ID:**	CA-0352
Start Date: 03/02/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Health Education/Wellness			**POD Goals Sections (if applicable):**	4. Chronic Conditions, 5. Maternal Health/Hospital/Patient Safety, 6. Member Experience, 7. Pediatric/Dental, 8. Pharmacy, 9. Preventative Health

Intervention Description:
Promote Krames and other nationally recognized health education resources that providers can share with patients to support health education and preventive care. Develop and maintain a PowerPoint resource covering a broad range of health topics, including content that supports quality measures and care gap closure efforts.

Measures Impacted:
AMR - Asthma Medication Ratio
CAHPS / AFV - Annual Flu Vaccine
CBP - Controlling High Blood Pressure
CCS-E - Cervical Cancer Screening
CIS - Childhood Immunization Status
CIS-E (10) - Childhood Immunization Status Combination 10
CIS-E (3) - Childhood Immunization Status Combination 3
COA - Care for Older Adults
COU - Risk of Continued Opioid Use
DEV-CH - Developmental Screening in the First Three Years of Life
DIAB / PDC - Adherence to Diabetes Medications
EED - Eye Exam for Patients with Diabetes
FRM - Fall Risk Management
HBD - Hemoglobin A1c Control for Patients with Diabetes - HbA1c Control (>9%)
IBC - Improving Bladder Control
IMA-E - Immunizations for Adolescents
IMPH - Improving or Maintaining Physical Health
LSC - Lead Screening in Children
MPA - Monitoring Physical Activity
OSW - Osteoporosis Screening in Older Women
PAO - Physical Activity in Older Adults
PBH - Persistence of Beta-Blocker Treatment After a Heart Attack
PPC - Prenatal and Postpartum Care
RRF - Reducing the Risk of Falling
SPD - Statin Therapy for Patients With Diabetes
STAT / PDC - Adherence to Cholesterol Medication (Statins)
TFC - Topical Fluoride for Children
W30 - Well Child Visits in the First 30 Months of Life
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Leverage surveys to collect user feedback and evaluate usability, adoption, satisfaction, and provider perspectives to inform ongoing resource improvement and optimization.

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

	Year-end:
Mid-year Outcome(s):	The Digital Health Education Resources PowerPoint includes educational QR codes linking to Krames and other nationally recognized resources for providers to share with patients. Key activities included updating provider-facing materials, distributing the PowerPoint to internal teams for feedback, and establishing key performance indicators (KPIs) to evaluate program effectiveness. The resources have been finalized and are now available, with the Provider PowerPoint posted on the Provider Engagement site within the provider portal. Established KPIs include targets for satisfaction (≥70% positive), adoption (≥70% utilization and sharing), usability (≤30% reporting barriers), and provider feedback (≥65% positive). No mid-year barriers were identified. Opportunities for improvement include leveraging user surveys to assess usability, adoption, satisfaction, and provider reception of the resources to inform ongoing enhancements.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Lead Blood Screening Provider Member Gap List					
Counties:	All Counties	**Initiative Point of Contact:**	Davita Herrington, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0350
Start Date: 06/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Pediatric/Dental		**POD Goals Sections (if applicable):**	7. Pediatric/Dental	

Intervention Description:
Conduct quarterly outreach to providers on blood lead screening requirements and provide member gap lists identifying children who have not completed required lead blood screenings by age 1, age 2, or age 6. Support providers in closing screening gaps and improving compliance with lead screening requirements.

Measures Impacted:
LSC - Lead Screening in Children

Barriers:	Mid-year: Limited availability of PCP email contact information and challenging provider data quality contributed to delays in Q2 provider notifications. Additionally, significant time was required to implement Power Automate outreach. Year-end:
Opportunities:	Mid-year: Quality Improvement (QI) continues to refine the provider notification process with each data generation cycle and through ongoing enhancements to the implemented Power Automate workflows. Efforts are also underway to expand provider contact lists by collecting additional PCP email addresses, thereby increasing notification reach and improving communication effectiveness. Year-end:
Mid-year Outcome(s):	For Q1, provider gap lists were distributed to four PPGs, all of which attested to following up with PCPs and/or members to address lead screening gaps. Additionally, ten PCP-level gap lists were distributed, with eight PCPs confirming intent to follow up with members. Q1 gap lists were generated at the PCP level; however, due to limited availability of PCP email contact information, Quality Improvement (QI) transitioned to generating subsequent gap lists at the PPG level to increase member coverage and outreach reach. Q2 gap list production has been delayed due to complexities associated with provider data at the PPG level.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Lead Blood Screening Anticipatory Guidance Member Flyer and Cover letter					
Counties:	All Counties	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement Specialist	**eQIPT ID:**	CA-0347
Start Date: 02/01/26		**End Date:** 05/28/26		**Activity Status:** Complete	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Mail the "Protect Your Child from Lead" anticipatory guidance flyer annually to members with children under age 6 to promote lead poisoning prevention and awareness of recommended lead screening requirement

Measures Impacted:
LSC - Lead Screening in Children

Barriers:	Mid-year: Lengthy approval processes for member-facing materials have been identified as a key barrier, contributing to delays in dissemination and program implementation. Year-end:
Opportunities:	Mid-year: Explore the use of text messaging as a channel to educate members on lead poisoning prevention, including the integration of links to California Department of Public Health (CDPH) educational materials to enhance accessibility to credible resources.. Year-end:
Mid-year Outcome(s):	A member mailing was completed on May 27, 2026, distributing a cover letter and the CDPH “Protect Your Child from Lead” flyer to 35,385 households with members under six years of age. Quality Improvement (QI) is exploring the use of text messaging as an alternative outreach strategy to improve efficiency and enhance member engagement.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Lead Anticipatory CAP					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Davita Herrington, Program Manager II, Quality Improvement, Juli Coulthurst, Program Manager III	**eQIPT ID:**	CA-0719
Start Date: 01/05/26		**End Date:** 06/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Review and update policies and procedures, provide quarterly provider notifications on identified care gaps, and conduct member mailings with anticipatory guidance materials to promote preventive care and timely service utilization.

Measures Impacted:
LSC - Lead Screening in Children

Barriers:	Mid-year: Limited availability of verified PCP email addresses significantly constrained outreach efforts, resulting in communication with only 10 providers. Challenges with overall provider data quality further contributed to reduced outreach capacity and delays in engagement. Year-end:
Opportunities:	Mid-year: Enhance the provider notification process with each data pull and distribution cycle to improve timeliness and accuracy of communications. Expand outreach capacity by systematically collecting verified PCP email addresses in collaboration with the Provider Engagement (PE) team. Additionally, leverage QI EDGE funding to support providers in implementing EMR-based prompts and checklists for anticipatory guidance, promoting improved documentation practices and increased compliance with Lead Screening for Children (LSC) requirements. Year-end:
Mid-year Outcome(s):	The Lead Screening Policies and Procedures (P&P) were revised in February 2026. Q1 provider notifications, including member gap lists, were distributed to 10 PCPs and four PPGs beginning March 27, 2026, utilizing Power Automate. Follow-up outreach to both PCPs and PPGs was conducted for three weeks after the initial notification. Delays in Q2 provider notifications occurred due to data quality challenges; however, distribution is anticipated to begin by the end of June 2026. A member mailing was completed on May 27, 2026, reaching 35,385 households with members under six years of age. A special lead compliance audit conducted in March–April 2026 identified strong performance in screening children by age 1 (95%), but lower compliance for screening by age 2 (55%). Additionally, anticipatory guidance compliance was significantly higher among providers utilizing EMR prompts or checklists (92%) compared to those without such tools (22%).
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: DSF Provider Tip Sheet					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0855
Start Date: 02/01/26		**End Date:** 09/01/26		**Activity Status:** Complete	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Create a step-by-step provider tip sheet on how to identify, document, and close DSF care gaps.

Measures Impacted:
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	A tip sheet has been created and is pending MarComm review.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Member Substance Abuse Resource Sheet					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0809
Start Date: 02/01/26		**End Date:** 09/01/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	2. Behavioral Health

Intervention Description:
Create a member flyer that provides information on substance use resources and explains how members can access available services and support.

Measures Impacted:
FUA - Follow-Up After Emergency Department Visit for Substance Use - 7-day follow up
FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up
FUI - Follow-Up After High-Intensity Care for Substance Use Disorder
IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD treatment
IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD treatment (HPR)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	A member flyer on substance abuse and available resources has been developed and is pending CalViva review.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: SUD Resource Directory for CalViva Providers					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0808
Start Date: 02/01/26		**End Date:** 06/30/26	**Activity Status:** Complete		
Program and Drivers (POD):	Behavioral Health		**POD Goals Sections (if applicable):**	2. Behavioral Health	

Intervention Description:
Create and maintain a substance use resource directory for Madera, Kings, and Fresno Counties to help members access local treatment, recovery, and support services.

Measures Impacted:
FUA - Follow-Up After Emergency Department Visit for Substance Use - 7-day follow up
FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up
FUI - Follow-Up After High-Intensity Care for Substance Use Disorder
IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD treatment
IET / DMC14 - Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD treatment (HPR)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The resource directory for Fresno, Kings, and Madera counties has been completed and submitted to CalViva.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva outreach following discharge from emergency department (FUA/FUM)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Adrianna Shoji, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0545
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	2. Behavioral Health

Intervention Description:
Conduct telephone outreach to members recently discharged from a hospital for a mental health condition using the Admit, Transfer, and Discharge (ADT) report to support follow-up care and reduce readmissions.

Measures Impacted:
FUA - Follow-Up After Emergency Department Visit for Substance Use
FUM - Follow-Up After Emergency Department Visit for Mental Illness

Barriers:	Mid-year: Data integrity issues have been identified within the ADT report, impacting the accuracy and reliability of reporting outputs. Year-end:
Opportunities:	Mid-year: Collaborate with the Provider Engagement (PE) team to engage facilities, identify potential causes of data suppression, and implement corrective actions to improve reporting accuracy and data completeness. Year-end:
Mid-year Outcome(s):	Outreach rates have ranged from 16% to 24%. Kings County is on track for Follow-Up After Mental Illness (FUM), while Madera County is on track for Follow-Up After Emergency Department Visit for Mental Illness (FUA).
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Me+U Priming Text - MCL CalViva					
Counties:	Fresno	**Initiative Point of Contact:**	Alicia Bednar, Program Manager III, Quality Improvement, Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0846
Start Date: 05/11/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Multi-Gap/Operations Pediatric/Dental Preventative Care	**POD Goals Sections (if applicable):**	4. Chronic Conditions, 7. Pediatric/Dental, 9. Preventative Health		

Intervention Description:
Use the Me+U platform to send text message reminders to members that promote preventive care, encourage service utilization, and support care gap closure.

Measures Impacted:
BCS-E - Breast Cancer Screening
CIS-E (10) - Childhood Immunization Status Combination 10
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)
IMA - Immunizations for Adolescents Combo 2
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: Data integrity issues and complex household identification rules, including the one-text-per-household requirement, affected text delivery accuracy. Minor-to-parent mapping and household exclusion logic also created workflow inefficiencies. Year-end:
Opportunities:	Mid-year: Refine the targeting algorithm and strengthen collaboration with the analytics team to improve household identification accuracy, reduce missed eligible households, and enhance the effectiveness of text outreach efforts. Year-end:
Mid-year Outcome(s):	The Me+U platform was used to send text messages supporting care gap closure efforts, achieving a 27% reach rate.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Care Gap Cozeva Contact Tracking					
Counties:	All Counties	**Initiative Point of Contact:**	Ana Sem, Program Manager II	**eQIPT ID:**	CA-0555
Start Date: 02/02/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Multi-Gap/Operations		**POD Goals Sections (if applicable):**	4. Chronic Conditions, 7. Pediatric/Dental, 9. Preventative Health, 9. Preventative Health	

Intervention Description:
Load monthly care gap outreach campaigns into Cozeva to support member outreach, track interventions, and improve care gap closure efforts.

Measures Impacted:
BCS-E - Breast Cancer Screening
CBP - Controlling High Blood Pressure
CCS-E - Cervical Cancer Screening
CIS-E (10) - Childhood Immunization Status Combination 10
COL-E - Colorectal Cancer Screening
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)
IMA-E - Immunizations for Adolescents
W30 - Well Child Visits in the First 30 Months of Life
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: QOT data exports require formatting and accurate measure-code mapping for Cozeva compatibility. Outreach data is also split between the HEDIS call database and QOT, resulting in dual files and additional processing. Year-end:
Opportunities:	Mid-year: Consolidate outreach data into a single Cozeva-compatible file to streamline uploads, improve efficiency, and reduce the risk of data discrepancies. Year-end:
Mid-year Outcome(s):	Gap call data through April 22, 2026, have been loaded into Cozeva.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Provider Initiative Survey - Email					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Ana Sem, Program Manager II, Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0701
Start Date: 01/12/26		**End Date:** 02/27/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Collaborate with Provider Engagement (PE) and Provider Engagement Account Executives (PEAEs) to distribute provider surveys that promote Chronic Conditions initiatives and identify providers interested in follow-up discussions and program participation.

Measures Impacted:
CBP - Controlling High Blood Pressure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	A survey was completed on March 20, 2026, with 86 respondents. In addition, a Chronic Conditions PowerPoint presentation was developed, and collaboration with Provider Engagement Account Executives (PEAEs) and PEA Managers supported the promotion of chronic conditions initiatives.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Monthly Birthday Proactive Outreach Message (POM) for Members 3-17 Years					
Counties:	All Counties	**Initiative Point of Contact:**	Arpitha Banaji, Quality Improvement Specialist Senior, Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0507
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Monitor and report the outcomes of monthly birthday POM messages sent to parents of members ages 3 to 17, encouraging them to schedule and complete annual well-child visits (WCVs).

Measures Impacted:
CIS-E (10) - Childhood Immunization Status Combination 10
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: Lengthy translation review and approval processes for CalViva materials have been identified as a barrier. Year-end:
Opportunities:	Mid-year: A monthly POM campaign is under consideration for launch in July 2026. Year-end:
Mid-year Outcome(s):	The project progressed from initial planning and translation submission in January to near completion of CalViva translation review and approval by June. Despite delays associated with the extended review and approval process, the initiative remains on track, with launch readiness pending final approval. The next anticipated step is the potential rollout of a monthly POM campaign beginning in July 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Quarterly Proactive Outreach Message (POM) for Members 2-28 Months					
Counties:	All Counties	**Initiative Point of Contact:**	Arpitha Banaji, Quality Improvement Specialist Senior, Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0441
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Configure quarterly Corporate POM campaign data for members ages 2 to 28 months to support Quality Improvement (QI) monitoring and reporting.

Measures Impacted:
CIS-E (10) - Childhood Immunization Status Combination 10
W30 - Well Child Visits in the First 30 Months of Life
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months

Barriers:	Mid-year: Lengthy translation review and approval processes for CalViva materials. Year-end:
Opportunities:	Mid-year: A quarterly POM campaign is under consideration for launch in July 2026. Year-end:
Mid-year Outcome(s):	The project progressed from initial planning and translation submission in January to near completion of CalViva translation review and approval by June. Despite delays associated with the extended review and approval process, the initiative remains on track, with launch readiness pending final approval. The next anticipated step is the potential rollout of a quarterly POM campaign beginning in July 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Provider update on Maternal health depression screening measures					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0834
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety			**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety

Intervention Description:
Conduct provider outreach on the Prenatal Depression Screening (PND) and Postpartum Depression Screening (PDS) measures to educate providers on screening best practices, documentation requirements, and strategies to improve measure performance.

Measures Impacted:
PDS-E - Postpartum Depression Screening and Follow-up
PND-E - Prenatal Depression Screening and Follow-up

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Provider Engagement team received training in Q2 on prenatal and postpartum depression screening metrics to support promotion of best practices among network providers and improve data capture. Training also emphasized the availability of Teladoc virtual mental health resources for member access and support.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Maternal Health - MY 2026 Tip Sheets					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0831
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety			**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety

Intervention Description:
Update and rebrand maternal health HEDIS provider tip sheets as needed to align with MY 2026 technical specifications and support provider compliance with measure requirements.

Measures Impacted:
PDS-E - Postpartum Depression Screening and Follow-up
PND-E - Prenatal Depression Screening and Follow-up
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The PND Provider Tip Sheet draft has been completed and is in the final approval stage. The PDS Tip Sheet draft has also been completed and is currently undergoing internal review and approval.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Hospital outreach about patient safety					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0487
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety	

Intervention Description:
Conduct outreach to hospitals on patient safety measures, performance expectations, and improvement opportunities. Focus on key metrics and reports, including hospital-acquired infections, sepsis management, the Patient Safety Honor Roll, and the Opioid Care Honor Roll.

Measures Impacted:
HPQI - Health Plan Quality Improvement

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: At least two hospitals have been confirmed as enrolled in the CMS-funded Quality Improvement Organization (QIO) program with the Health Services Advisory Group (HSAG). In addition, HSAG quality improvement tools have been expanded and are now accessible to a broader network of hospitals to support ongoing improvement efforts. Year-end:
Mid-year Outcome(s):	Outreach was conducted to quality leadership at three of five hospitals with reportable data on priority metric performance. During these engagements, quality improvement tools and partner organizations were promoted to support performance improvement across key measures. All hospitals are scheduled to receive a Provider Update in early Q3 outlining quality metrics, performance targets, and patient safety tools. In addition, an annual meeting with St. Agnes Medical Center is planned for August as part of a multi-plan collaborative effort.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Serve on Leapfrog Partners Advisory Committee and Data Users Group					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0473
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety	

Intervention Description:
Participate in Leapfrog's Partners Advisory Committee as co-chair and support related activities. Collaborate with Leapfrog through the Data Users Group to utilize survey results and performance data to help network hospitals improve patient safety and quality metrics.

Measures Impacted:
HPQI - Health Plan Quality Improvement

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: A Southern California's documentation of how they used the Leapfrog Hospital Survey as a structured roadmap for quality improvement is a useful example that can be disseminated to other lower performing facilities. By adopting a long-term, strategic approach to advancing patient safety and performance, the hospital achieved significant improvement, advancing its Leapfrog grade from a “D” to an “A.” Year-end:
Mid-year Outcome(s):	Co-chaired two quarterly Partners Advisory Committee meetings focused on Leapfrog Survey measures, hospital quality trends, and improvement opportunities. Additionally, maintained ongoing consultation with Leapfrog staff on issues relevant to California facilities to support alignment with best practices and performance improvement efforts.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Collaboration with Hospital Quality Institute (HQI), Health Services Advisory Group (HSAG), and the California Maternal Quality Care Collaborative (CMQCC)					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0472
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety	

Intervention Description:
Collaborate with the Hospital Quality Institute (HQI), Health Services Advisory Group (HSAG), and California Maternal Quality Care Collaborative (CMQCC) to support hospital quality improvement efforts. Leverage performance tools, quality improvement resources, and maternal health initiatives to improve hospital outcomes and patient care.

Measures Impacted:
HPQI - Health Plan Quality Improvement

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	HSAG tools are now available online, and the Hospital Quality Institute (HQI) platform has been expanded to all network hospitals to support tracking and trending of priority quality metrics. Regular meetings are held with the Senior Executive Director of the Health Services Advisory Group (HSAG), including an in-person session in April, to strengthen collaboration and alignment. Efforts are ongoing to promote hospital participation in HSAG's CMS-sponsored Quality Improvement Organization (QIO) and utilization of associated quality improvement tools. Approval was obtained from HSAG to extend promotion of their online platform to all network hospitals, beyond those participating in the QIO. In parallel, ongoing collaboration with the Hospital Quality Institute supports increased hospital engagement with performance tracking platforms. Additionally, partnerships with the California Maternal Quality Care Collaborative (CMQCC) continue to advance awareness of maternal health trends and identify opportunities for quality improvement.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Hospital outreach about C-section overuse and maternal health issues					
Counties:	All Counties	**Initiative Point of Contact:**	Barbara Wentworth, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0466
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety	

Intervention Description:
Conduct outreach to hospitals on C-section rates, clinical standards, and improvement opportunities to reduce unnecessary cesarean deliveries. Promote best practices and support maternal health equity initiatives to improve outcomes for all birthing populations.

Measures Impacted:
HPQI - Health Plan Quality Improvement

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: The Transforming Maternal Health Model (TMaH) initiative introduces a renewed focus on maternal healthcare in the region. Initial discussions with providers have commenced as CMS and DHCS continue to define the structure and implementation framework of this 10-year program. Year-end:
Mid-year Outcome(s):	Outreach to quality leadership was conducted at three of the four hospitals not meeting the C-section rate target. All maternity hospitals are scheduled to receive a Provider Update in early Q3 outlining C-section rate targets, associated quality improvement opportunities, and available support programs.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Q2-Q4 Medi-Cal Gap Calls - CalViva					
Counties:	Fresno	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0843
Start Date: 05/04/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Multi-Gap/Operations Pediatric/Dental	**POD Goals Sections (if applicable):**	4. Chronic Conditions, 7. Pediatric/Dental, 9. Preventative Health		

Intervention Description:
Conduct outreach to members with identified care gaps from May through December to encourage timely provider visits and completion of recommended services. Outreach efforts will target various quality measures, which may change based on program priorities and performance needs.

Measures Impacted:
BCS-E - Breast Cancer Screening
CIS-E (10) - Childhood Immunization Status Combination 10
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)
IMA - Immunizations for Adolescents Combo 2
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: • Data Integrity Issues: Inaccurate member phone numbers (e.g., provider contact numbers listed in place of member numbers) are limiting successful outreach and reducing call completion rates. • Data Completeness Gaps: Missing or invalid member phone numbers hinder effective outreach and member engagement. • Enrollment Data Quality Issues: Errors in enrollment files, including lack of valid or usable phone numbers, result in members being unreachable. • Ongoing Data Quality Challenges: Persistent data accuracy and integrity issues continue to negatively impact outreach effectiveness and operational efficiency year over year. Year-end:
Opportunities:	Mid-year: Implement an ongoing data monitoring process to proactively identify, track, and resolve data integrity issues affecting outreach performance, reporting accuracy, and member engagement efforts. Year-end:
Mid-year Outcome(s):	The Q2–Q4 Medi-Cal Family Unit Multi-Gap Call Program launched on May 6, 2026, targeting Well Child Visits (WCV) and Childhood Immunization Status – Combination 10 (CIS-10) using Measurement Year 2026 data, with priming text messages deployed prior to outreach calls. CalViva identified 25,204 eligible members in Fresno, with 5,284 (21%) attempted and 1,148 (22%) successfully reached.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: SimpleTexting: Program Launch					
Counties:	All Counties	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0740
Start Date: 01/01/26		**End Date:** 03/31/26		**Activity Status:** Canceled	
Program and Drivers (POD):	Multi-Gap/Operations			**POD Goals Sections (if applicable):**	

Intervention Description:
Launch and implement the SimpleTexting program to send one-way text message outreach to Medi-Cal members, promoting preventive services, health education, and care gap closure.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: Vendor was not contracted for all LOBs. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The activity was cancelled because the vendor is not contracted with the Medicaid line of business.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Vaccine Communication to Providers and Members					
Counties:	All Counties	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0712
Start Date: 02/18/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	6. Member Experience, 7. Pediatric/Dental

Intervention Description:
Develop a multi-channel communication strategy to educate providers and members on the latest vaccine recommendations. Ensure messaging supports immunization education, aligns with CDPH guidelines, and incorporates the "Reframing of Immunization" approach to improve vaccine awareness and uptake.

Measures Impacted:
AIS-E - Adult Immunization Status
CIS - Childhood Immunization Status
IMA-E - Immunizations for Adolescents

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Vaccine Communication to Providers and Members initiative implemented a multi-channel approach to disseminate updated vaccine recommendations, supporting “Reframing of Immunization” messaging aligned with CDPH guidelines. Key activities included the development and distribution of the 2026 Immunization Update Provider Communication on April 2, 2026, with support from Dr. May and Dr. Zuniga. This outreach reached a comprehensive network of stakeholders across all counties, including physicians, practitioners, PPGs/IPAs, hospitals, ancillary providers, enhanced care management, community supports providers, and behavioral health providers. Additionally, an Immunization Toolkit is under development to support consistent “Reframing of Immunization” messaging across providers, member-facing teams, and community partners. Results: The provider communication was successfully distributed in April 2026. Toolkit development is ongoing, with a focus on addressing common parental concerns—such as vaccine safety, volume, and media influence—while equipping frontline staff with empathetic, trust-based communication strategies that reinforce the health plan’s role in supporting children’s health and encourage scheduling of PCP visits. No mid-year barriers or additional opportunities were identified.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Q1 MCL Gap Calls - CalViva					
Counties:	Fresno Kings	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement	**eQIPT ID:**	CA-0355
Start Date: 01/12/26		**End Date:** 04/30/26	**Activity Status:** Complete		
Program and Drivers (POD):	Multi-Gap/Operations Pediatric/Dental		**POD Goals Sections (if applicable):**	7. Pediatric/Dental, 9. Preventative Health	

Intervention Description:
Conduct outreach in Q1 to members who did not complete a Well-Child Visit (WCV) in the previous year, encouraging them to schedule a visit with their provider and close the care gap.

Measures Impacted:
BCS-E - Breast Cancer Screening
CIS - Childhood Immunization Status
CIS-E (10) - Childhood Immunization Status Combination 10
IMA-E - Immunizations for Adolescents
IMA - Immunizations for Adolescents Combo 2
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: • Data Integrity Issues: Inaccurate member phone numbers (e.g., provider contact numbers listed in place of member numbers) are limiting successful outreach and reducing call completion rates. • Data Completeness Gaps: Missing or invalid member phone numbers hinder effective outreach and member engagement. • Enrollment Data Quality Issues: Errors in enrollment files, including lack of valid or usable phone numbers, result in members being unreachable. • Ongoing Data Quality Challenges: Persistent data accuracy and integrity issues continue to negatively impact outreach effectiveness and operational efficiency year over year. Year-end:
Opportunities:	Mid-year: Ongoing Data Monitoring: Implement continuous monitoring process to identify, track, and address data integrity issues impacting outreach performance and effectiveness. Year-end:
Mid-year Outcome(s):	The Q1 Medi-Cal Family Unit Multi-Gap Call Program (January–April 2026) conducted outreach targeting WCV, CIS-10, and flu measures across CalViva Kings County using MY 2025 data, with Hmong language support. Final results demonstrated strong outreach efforts, with a 94% attempt rate and 23% reach rate.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Power Automate Outreach Email					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Brittany Head, Program Manager II, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0606
Start Date: 01/06/26		**End Date:** 12/31/26		**Activity Status:** Canceled	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Conduct provider email outreach through PAD to identify children ages 6 months to 2 years who are missing one or both recommended flu vaccinations and encourage completion of immunization requirements.

Measures Impacted:
CIS-E (10) - Childhood Immunization Status Combination 10

Barriers:	Mid-year: Provider email addresses could not be verified for PHI transmission, and maintaining a reliable directory of PHI-eligible emails proved challenging, resulting in the project being placed on hold. Year-end:
Opportunities:	Mid-year: Project planning will resume in Q3 with refreshed data aligned to the start of flu season, enabling a more targeted and timely outreach approach. Year-end:
Mid-year Outcome(s):	The Power Automate email outreach initiative targeted providers across all Medi-Cal counties for children aged 6 months to 2 years who were missing at least one flu vaccination. Key activities included developing provider survey questions to identify barriers, creating Power Automate (PAD) email outreach content, and submitting QIRA data requests. Results: The project is currently on hold due to a key limitation—provider email addresses cannot be reliably verified for PHI transmission, and maintaining an accurate directory of PHI-eligible emails has proven challenging. Project planning will resume in Q3 with refreshed data aligned to the start of flu season, with the timeline extended through year-end to support a more targeted and timely outreach approach.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: HEDIS Provider Tip Sheet - EED					
Counties:	All Counties	**Initiative Point of Contact:**	Chris Palma, Sr. Quality Improvement Specialist, Quality Improvement	**eQIPT ID:**	CA-0875
Start Date: 01/05/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	

Intervention Description:
Update the EED Provider Tip Sheet to reflect MY 2026 HEDIS specifications.

Measures Impacted:
EED - Eye Exam for Patients with Diabetes

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Posted to Provider Portal.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: HEDIS Provider Tip Sheets - BPC-E					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Christiana Cooper, Sr. Manager, HEDIS, Gigi Mathew, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0795
Start Date: 01/15/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	

Intervention Description:
Update the BPC-E provider tip sheet to align with MY 2026 HEDIS specifications, ensuring providers have current guidance on documentation, reporting requirements, and best practices for improving measure performance.

Measures Impacted:
BPC-E - Blood Pressure Control for Patients With Hypertension

Barriers:	Mid-year: The original due date of April 30 was not feasible due to the reassignment of work to the QIPM team. Year-end:
Opportunities:	Mid-year: Developed an educational resource for providers outlining HEDIS BPC-E specifications and evidence-based best practices to support accurate documentation and improved measure performance. Year-end:
Mid-year Outcome(s):	The BPC-E tip sheet underwent final edits on June 1, 2026, for all lines of business, including CalViva. Following remediation, the finalized version was successfully posted to the provider portal on June 18, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Abbott Diabetes Care Pilot					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Gerred Smith, Gigi Mathew, Program Manager III, Quality Improvement, Lynn Kafer, Program Manager III, HEDIS, Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0618
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Implement a pilot program, initially focused on Medi-Cal members with uncontrolled A1c levels, to improve diabetes management. The pilot includes provider education and outreach, onboarding providers to the LibreView platform, and integrating continuous glucose monitoring (CGM) data into the electronic health record (EHR).

Measures Impacted:
GSD - Glycemic Status Assessment for Patients with Diabetes
GSD - Glycemic Status Assessment for Patients with Diabetes (Glycemic Status < 8%)
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)

Barriers:	Mid-year: Delays in contractual execution have impacted project timelines and progress. Year-end:
Opportunities:	Mid-year: Opportunity exists to scale efforts more broadly through the Epic Payer Platform, leveraging a streamlined integration approach to enhance efficiency and expand reach. Year-end:
Mid-year Outcome(s):	Advance contract finalization to enable AGP report access. Validate the AGP report with corporate and audit teams, and confirm SFTP requirements and data layout to prevent onboarding delays. The QIPM team will continue Epic Payer Platform discussions with Abbott and Corporate and provide updates to POD as available.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: HEDIS Provider Tip Sheet - KED					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0735
Start Date: 01/05/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	

Intervention Description:
Update the KED provider tip sheet to align with MY 2026 HEDIS specifications, ensuring providers have current guidance on kidney health evaluation for patients with diabetes.

Measures Impacted:
KED - Kidney Health Evaluation for Patients with Diabetes

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Developed a provider educational resource outlining KED specifications and best practices to support accurate documentation and improved measure performance. Year-end:
Mid-year Outcome(s):	The GSD tip sheet was remediated, versioned for CalViva, and successfully posted to the provider portal on April 3, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: HEDIS Provider Tip Sheet - GSD					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0734
Start Date: 01/05/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Update the GSD provider tip sheet to align with MY 2026 HEDIS specifications, ensuring providers have current guidance on screening, documentation, follow-up requirements, and best practices for improving measure performance.

Measures Impacted:
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Develop a provider educational resource outlining GSD specifications and best practices to support accurate documentation and improved measure performance. Year-end:
Mid-year Outcome(s):	The GSD tip sheet was remediated, versioned for CalViva, and successfully posted to the provider portal on April 24, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CAHPS Screensaver					
Counties:	All Counties	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement, Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0890
Start Date: 04/01/26		**End Date:** 08/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Create and distribute a provider office screensaver promoting the "Make Every Visit Count" message, encouraging staff to welcome, ask, listen, review, and follow up with patients. The initiative supports improved patient experiences and helps drive performance on CAHPS measures.

Measures Impacted:
CAHPS - All CAHPS Measures

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	CAHPS screensaver was completed in July. Currently the team is planning on sharing with the Provider Engagement team to send to providers.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CAHPS Posters					
Counties:	All Counties	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement, Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0883
Start Date: 04/01/26		**End Date:** 08/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Leverage corporate-developed, non-branded posters in provider offices to promote patient-centered care, enhance the member experience, and support improvement in CAHPS performance measures.

Measures Impacted:
CAHPS - All CAHPS Measures

Barriers:	Mid-year: None Year-end:
Opportunities:	Mid-year: None Year-end:
Mid-year Outcome(s):	A total of 1,696 CAHPS posters were distributed to 9 PPGs and 3 Provider Engagement managers on July 31, 2026.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Sprinter Health Engagement					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement, Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0682
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Implement a member outreach campaign through Sprinter Health to provide in-home assessments and screenings for key quality measures, including Eye Exam for Patients with Diabetes (EED), Controlling High Blood Pressure (CBP), Hemoglobin A1c (A1c), and Kidney Health Evaluation for Patients with Diabetes (KED).

Measures Impacted:
CBP - Controlling High Blood Pressure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: N/A Year-end:
Mid-year Outcome(s):	The Risk Assessment team launched the Sprinter IHA campaign in February, expanding outreach to a broader population of CalViva members. Communications were distributed to Customer Service to equip representatives to address QI- and Risk Assessment-related inquiries, helping to minimize member abrasion. Per the May 29 report, 53 visits were completed by CalViva members who were referred by QI, with the majority completing CBP and A1c screenings. Positive member engagement was observed with Sprinter services, with 372 CalViva members successfully contacted and 89 visits scheduled.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: eProject: Sprinter Health Kit (SHK) Provider Outreach					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Gigi Mathew, Program Manager III, Quality Improvement; Ana Sem, Program Manager II, Quality Improvement; Chris Palma, Sr. Quality Improvement Specialist, Quality Improvement	**eQIPT ID:**	CA-0787
Start Date: 02/26/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions, 9. Preventative Health

Intervention Description:
Send provider outreach via Power Automate on Sprinter Health kit dispositions and remediation of A1c, KED, EED, CBP, and COL-E care gaps.

Measures Impacted:
CBP - Controlling High Blood Pressure
COL-E - Colorectal Cancer Screening
EED - Eye Exam for Patients with Diabetes
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)

Barriers:	Mid-year: Medi-Cal plan-level disposition data is not currently available, limiting the ability to analyze outcomes and measure program impact by health plan. In addition, provider engagement criteria have not been clearly defined, making it difficult to consistently evaluate participation and effectiveness. Year-end:
Opportunities:	Mid-year: Work with the analyst to obtain plan-specific disposition reporting and establish standardized provider engagement criteria to improve performance monitoring, reporting accuracy, and evaluation of provider participation. Year-end:
Mid-year Outcome(s):	CalViva launched Sprinter outreach in late January, targeting 808 members with valid contact information. As of March 5, Sprinter contacted 641 members, reached 143, scheduled 118 visits, and completed 5 visits. While CalViva-specific disposition data was unavailable, 389 Medi-Cal members declined services. Outreach efforts included communications to 51 PPGs through SHK and 45 PPGs through Sprinter. Since April 24, nine PPGs have confirmed receipt of member lists, and feedback indicates that many are using the lists to support follow-up outreach and care gap closure activities.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Provider Communication CAHPS Article					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Guille Toland, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0819
Start Date: 01/01/26		**End Date:** 04/30/26	**Activity Status:** Complete		
Program and Drivers (POD):	Member Experience		**POD Goals Sections (if applicable):**	6. Member Experience	

Intervention Description:
Distribute CAHPS articles and measure performance rates to providers and stakeholders to increase awareness, promote best practices, and support improvement in member experience outcomes.

Measures Impacted:
CAHPS - All CAHPS Measures

Barriers:	Mid-year: Because the resource is passively distributed, providers may not consistently review or utilize the information. Year-end:
Opportunities:	Mid-year: Ongoing promotion, reminders, and reinforcement are needed to encourage engagement and support improvements in provider communication and member experience. Year-end:
Mid-year Outcome(s):	Provider communication was successfully published on March 2, 2026, distributed to providers, and made accessible in the provider library for ongoing reference.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Flu Tip Sheet					
Counties:	All Counties	**Initiative Point of Contact:**	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0530
Start Date: 06/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Update the flu provider tip sheet as needed to reflect current recommendations and best practices, helping providers improve vaccination rates and implement effective immunization strategies within their practices.

Measures Impacted:
AIS-E - Adult Immunization Status - Influenza

Barriers:	Mid-year: Delayed availability of flu guidelines may hinder the timely update and distribution of the flu season tip sheet to providers. Year-end:
Opportunities:	Mid-year: Increase awareness by incorporating the flu tip sheet into existing communications and trainings, and improve usability by integrating it into daily workflows. Ongoing reinforcement, along with simple supports such as staff training and reminders, can further enhance adoption. Year-end:
Mid-year Outcome(s):	The flu tip sheet will be reviewed in Q3 to ensure alignment with the latest flu vaccine recommendations, with updates incorporated as needed to maintain accuracy and relevance.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CAHPS Provider Playbook					
Counties:	All Counties	**Initiative Point of Contact:**	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0524
Start Date: 07/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Revise and maintain the CAHPS Provider Playbook by consolidating best practices into a single resource that providers can use to improve patient experience, communication, access to care, and CAHPS performance.

Measures Impacted:
CAHPS - All CAHPS Measures

Barriers:	Mid-year: None Year-end:
Opportunities:	Mid-year: Enhance playbook usability by embedding it into existing workflows and communications, clearly aligning recommended actions with performance outcomes, and emphasizing simple, high-impact interventions. Combined with targeted support, ongoing education, and the sharing of best practices, these strategies can strengthen provider adoption and drive sustained performance improvement. Year-end:
Mid-year Outcome(s):	The CAHPS Playbook, which outlines best practices and provider recommendations to improve CAHPS measures, was reviewed and confirmed to remain current, with no updates required at this time. The CAHPS team will continue to collaborate with Provider Engagement and Medical Affairs teams to promote and disseminate these resources, supporting ongoing provider alignment and adoption of best practices.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Fluvention Campaign					
Counties:	All Counties	**Initiative Point of Contact:**	Guille Toland, Program Manager III, Quality Improvement, Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0278
Start Date: 04/30/26		**End Date:** 12/31/26		**Activity Status:** Canceled	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Review and monitor the multi-channel flu prevention campaign developed by Corporate, including email communications, IVR on-hold messages, website content, member messaging, and Provider Outreach and Messaging (POM) calls.

Measures Impacted:
CAHPS / AFV - Annual Flu Vaccine

Barriers:	Mid-year: The Fluvention campaign was paused following a corporate decision to reassess prevention, wellness, and vaccination strategies, limiting opportunities to implement planned outreach activities and measure their impact on member vaccination rates and experience. Year-end:
Opportunities:	Mid-year: The pause in the Fluvention campaign provides an opportunity to reassess and redesign outreach strategies to improve scalability, cost-effectiveness, and alignment with member and business needs. Year-end:
Mid-year Outcome(s):	The 2025–2026 Fluvention campaign cycle was successfully completed by the end of March, For 2026-2027, the Fluvention campaign was paused.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Pediatric/Dental MY 2026 HEDIS Tip Sheets					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Juli Coulthurst, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0573
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Update and rebrand pediatric and dental HEDIS provider tip sheets as needed to align with MY 2026 technical specifications.

Measures Impacted:
CIS-E (10) - Childhood Immunization Status Combination 10
DEV-CH - Developmental Screening in the First Three Years of Life
IMA - Immunizations for Adolescents Combo 2
LSC - Lead Screening in Children
TFC - Topical Fluoride for Children
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Revise HEDIS tip sheets to be more concise and user-friendly for providers, focusing on clear, actionable guidance and streamlined formatting to improve readability and usability. Year-end:
Mid-year Outcome(s):	The Lead HEDIS and Compliance tip sheet was updated, completed, and distributed to Provider Engagement (PE) for dissemination to providers. It was also shared with providers receiving lead screening notifications for members identified with care gaps. The W30, WCV, and TFL HEDIS tip sheets are currently under review to streamline language and improve conciseness and provider usability.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: PE training and QFT (Quality Focus Touchbase) for all pediatric and dental HEDIS Measures for MY 2026					
Counties:	All Counties	**Initiative Point of Contact:**	Juli Coulthurst, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0567
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** Complete		
Program and Drivers (POD):	Pediatric/Dental		**POD Goals Sections (if applicable):**	7. Pediatric/Dental	

Intervention Description:
Provide MY 2026 HEDIS training to Provider Engagement on pediatric, perinatal, and dental measures, and review actions needed to improve rates.

Measures Impacted:
CIS-E (10) - Childhood Immunization Status Combination 10
DEV-CH - Developmental Screening in the First Three Years of Life
IMA - Immunizations for Adolescents Combo 2
LSC - Lead Screening in Children
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Provider Engagement training was completed on January 26, 2026, covering pediatric measures for children under age 3, including W30, CIS-10, LSC, and DEV. A subsequent training on May 12, 2026, addressed WCV, IMA-2, and TFL, with a focus on best practices and measure performance improvement.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Well-Child Visits Provider Education					
Counties:	All Counties	**Initiative Point of Contact:**	Juli Coulthurst, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0266
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Care Coordination/Member Engagement Pediatric/Dental		**POD Goals Sections (if applicable):**	7. Pediatric/Dental	

Intervention Description:
Educate providers on the importance of well-child visits and developmental screenings.

Measures Impacted:
W30 - Well Child Visits in the First 30 Months of Life
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months

Barriers:	Mid-year: Provider Limitations: Some providers lack access to the DEV tool within their EMR, limiting functionality and workflow efficiency. Access Barriers: Limited appointment availability for well-care visits, particularly Well Child Visits (WCV), continues to impact timely access to care and measure performance. Year-end:
Opportunities:	Mid-year: Enhance provider scheduling practices to prioritize well-care visits and implement standardized checklists that ensure completion of all required screenings and immunizations during each visit. Year-end:
Mid-year Outcome(s):	The Provider Engagement Team was trained on pediatric measures on January 26 and May 12, 2026. Training included sharing best practices and tip sheets for distribution to provider offices to support measure performance.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Kick It California (KIC) - Smoking Cessation Services					
Counties:	All Counties	**Initiative Point of Contact:**	Justina Felix, Sr. Health Education Specialist, Quality Improvement	**eQIPT ID:**	CA-0396
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** On Hold	
Program and Drivers (POD):	Health Education/Wellness			**POD Goals Sections (if applicable):**	

Intervention Description:
Explore expanding the partnership with KIC to increase member participation in smoking cessation programs and provide Nicotine Replacement Therapy (NRT) kits. The health plan will conduct initial member outreach through notification letters before KIC contacts members. Update all required contractual and compliance documents (SOW, BAA, MSA, IRQ Form etc.)

Measures Impacted:
CAHPS / MSC - Medical Assistance With Smoking and Tobacco Use Cessation

Barriers:	Mid-year: Ongoing challenges have been encountered in engaging the vendor to complete contract revision updates due to reported limited bandwidth, resulting in continued delays in advancing required contracting activities. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The KIC Smoking Cessation initiative has experienced delays due to vendor engagement challenges, including limited vendor capacity, responsiveness issues, and incomplete contracting and risk assessment activities. As a result, implementation remains in the planning phase and no measurable outcomes are available at this time.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Modality Equity Analysis					
Counties:	All Counties	**Initiative Point of Contact:**	Justina Felix, Sr. Health Education Specialist, Quality Improvement, Michelle Cai, Quality Improvement Specialist, Sr., Ravneet Gill, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0645
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** Complete	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Analyze colorectal cancer screening methods across different populations to identify disparities. Implement strategies that promote equitable access, informed choice, and timely follow-up for all screening options.

Measures Impacted:
COL-E - Colorectal Cancer Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Analysis was completed and used to inform the High-Risk and Historical Colonoscopy e-Project, targeting members at high risk and those with a history of completing a colonoscopy.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Exact Sciences Cologuard Letter					
Counties:	All Counties	**Initiative Point of Contact:**	Justina Felix, Sr. Health Education Specialist, Quality Improvement, Ravneet Gill, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0612
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Partner with Exact Sciences to conduct outreach to Medi-Cal members on the importance of colorectal cancer screening through culturally tailored member letters. Outreach materials include versions for Asian American, Black/African American, Hispanic, Native American, and general populations to support equitable engagement. Exact Sciences will also mail Cologuard® kits to eligible members when screening orders are placed.

Measures Impacted:
COL-E - Colorectal Cancer Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Exact Sciences CalViva Health Cologuard letters have progressed through key internal review phases, including Clinical, Privacy, and C&L. Materials were submitted to CalViva Health Compliance, where feedback was received requiring minor revisions. As of June 2026, updates are in progress with the vendor to address feedback prior to resubmission and regulatory submission to DHCS.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Initial Health Assessment Compliance					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Linda Armbruster, Quality Improvement Specialist Shekinah Wright, Director Quality Improvement Miriam Rosales, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0837
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Access, Availability & Service			**POD Goals Sections (if applicable):**	3. Care Coordination/Member Engagement

Intervention Description:
Maintain compliance with DHCS Initial Health Appointment (IHA) three-pronged outreach requirements and complete the Annual IHA Compliance Monitoring Report.

Measures Impacted:
IHA - Initial Health Assessment

Barriers:	Mid Year: • Reporting Limitations: Duplicate call-time fields and incomplete voicemail timestamps reduce data reliability and require additional validation. • Data Formatting Issues: File formatting inconsistencies increase the need for manual data scrubbing and impact reporting efficiency. • Outreach Challenges: Higher no-answer and disconnected call rates during English first- and second-attempt outreach limit successful member contact. • Operational Impact: Increased call volume in May contributed to lower completion rates and affected overall outreach performance. Year-end:
Opportunities:	Mid-year: Integrate POM data sources into a single system to enable standardized, streamlined, and concise reporting of outreach results. Year-end:
Mid-year Outcome(s):	The January 2026 CalViva Proactive Outreach Manager (POM) call analysis, submitted on February 17, 2026, demonstrated early improvements in outreach quality, including reductions in invalid calls and enhanced classification of call outcomes. In response to issues identified in the November 2025 file pull, Genesys AI was implemented, and six new call completion codes were introduced to improve visibility into incomplete and invalid call dispositions and strengthen reporting accuracy. Monthly analyses through June 8, 2026, indicate continued progress in reporting maturity, including a March redesign to better display rates and trends. Performance improved from 86% completion in March to 89% in April, before declining to 68% in May, driven by increased call volume and higher rates of no-answer and disconnected calls during English outreach attempts. Invalid call rates remained stable at 11% in April and May, reflecting sustained data quality improvements despite operational variability. Ongoing limitations include duplicate call-time fields, incomplete voicemail timestamps, and file formatting issues requiring manual data scrubbing. The team continues to collaborate with the POM Call and Genesys AI teams to enhance report usability, accuracy, and timeliness.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Teladoc PSV (Primary Source Verification) - DSF					
Counties:	All Counties	**Initiative Point of Contact:**	Maria Lin, Program Manager II	**eQIPT ID:**	CA-0305
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Complete validation of CalViva Health PHQ-9 data from Teladoc and obtain PSV auditor approval so the data can be used as a supplemental data source to improve HEDIS DSF-E performance and reporting.

Measures Impacted:
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults

Barriers:	Mid-year: No barriers identified. Year-end:
Opportunities:	Mid-year: Looking into entering negative screened member data into Trucare for data synchronization. Year-end:
Mid-year Outcome(s):	Successfully passed the PSV (Primary Source Verification) audit, demonstrating full compliance with credentialing verification requirements and established regulatory standards.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Teladoc Mental Health Digital Program Implementation					
Counties:	All Counties	**Initiative Point of Contact:**	Maria Lin, Program Manager II	**eQIPT ID:**	CA-0297
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	

Intervention Description:
Implement the 2026 email campaign to promote the Teladoc Mental Health Digital Program.

Measures Impacted:
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The Teladoc Mental Health Program email campaign remains on track, with launches scheduled for June and July as planned.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: eProject: Root Cause Analysis (RCA) CBP					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0770
Start Date: 06/01/26		**End Date:** 12/31/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Send provider outreach emails through Power Automate to address Controlling High Blood Pressure (CBP) performance issues identified through root cause analysis (RCA).

Measures Impacted:
CBP - Controlling High Blood Pressure

Barriers:	Mid-year: Outdated provider contact information and Provider Engagement Account Executive assignments caused delays in email distribution and provider communications. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The RCA E-Project launched as scheduled and remains on track.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: eProject: Root Cause Analysis (RCA) A1c					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0765
Start Date: 05/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Send provider outreach emails through Power Automate to address uncontrolled Hemoglobin A1c (A1c) performance based on root cause analysis (RCA) findings.

Measures Impacted:
GSD - Glycemic Status Assessment for Patients with Diabetes
GSD - Glycemic Status Assessment for Patients with Diabetes (Glycemic Status < 8%)
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)

Barriers:	Mid-year: Outdated provider contact information and Provider Engagement Account Executive assignments caused delays in email distribution and provider communications. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The RCA E-Project launched as scheduled and remains on track.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Direct Mail Kits for Blood Glucose (HbA1c/A1c) - CalViva-All					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Martha Zuniga, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0457
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Conduct a member outreach campaign to identify and support members due for an A1c test. In partnership with Simple HealthKit, mail at-home A1c testing kits directly to eligible members to improve diabetes monitoring, increase screening completion, and close care gaps.

Measures Impacted:
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)

Barriers:	Mid-year: Collateral review delayed Kit shipment from 2025 to 2026. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	A total of 1,035 kits were distributed, with 62 tests completed, resulting in a 5.99% utilization rate.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: CAHPS Stakeholder Meetings					
Counties:	All Counties	**Initiative Point of Contact:**	Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0335
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Member Experience			**POD Goals Sections (if applicable):**	6. Member Experience

Intervention Description:
Improve communication and collaboration with stakeholder departments through monthly Quality Focus Touchbase and Quality Governance Committee meetings to identify, implement, and monitor interventions that enhance CAHPS performance and the member experience.

Measures Impacted:
CAHPS - All CAHPS Measures

Barriers:	Mid-year: None Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The CAHPS team presented results and updates during the January Office Hours session, as well as at one QFT-PE meeting in March and one PEAE meeting in May, supporting ongoing provider engagement and awareness.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CAHPS Provider Training Series via Sullivan Group					
Counties:	All Counties	**Initiative Point of Contact:**	Matthew Anderson, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0269
Start Date: 01/01/26		**End Date:** 04/30/26	**Activity Status:** Complete		
Program and Drivers (POD):	Member Experience		**POD Goals Sections (if applicable):**	6. Member Experience	

Intervention Description:
Offer physician-led webinar trainings focused on improving provider communication and enhancing access to care.

Measures Impacted:
CAHPS / GCQ / ZGCQ - Getting Care Quickly (Adult)
CAHPS / GCQ / ZGCQ - Getting Care Quickly (Child)
CAHPS / RHP / ZHPL - Rating of Health Plan (Adult)
CAHPS / RHP / ZHPL - Rating of Health Plan (Child)

Barriers:	Mid-year: Although the training series generated strong interest, only 56% of registered participants attended. Provider availability, competing priorities, and engagement challenges across provider groups limited participation. Ongoing reinforcement, follow-up education, and monitoring are needed to support sustained improvements in communication, access, and member experience outcomes. Year-end:
Opportunities:	Mid-year: The CAHPS Provider Training Series demonstrated strong provider interest and created opportunities to improve member experience by increasing awareness of key CAHPS drivers. Through seven physician-led webinars, providers received practical strategies to enhance communication, improve access to care, and strengthen patient-provider interactions. With 209 registrations and 117 attendees, the series established a foundation for continued provider education, engagement, and targeted quality improvement initiatives. Year-end:
Mid-year Outcome(s):	Seven CAHPS Provider Training Series webinars were conducted, focusing on provider communication and access to care as key opportunities to improve the member experience. The trainings generated 209 registrations, with 117 providers attending, resulting in a 56% attendance rate. These physician-led sessions increased provider awareness of member experience drivers and provided actionable strategies to enhance communication, improve access, and support CAHPS performance improvement efforts.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Distribution of the Newborn Checklist (CalViva)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0668
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Pediatric/Dental		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety, 7. Pediatric/Dental	

Intervention Description:
Distribute the updated Newborn Checklist to providers and stakeholders across CalViva Health counties.

Measures Impacted:
PPC - Prenatal and Postpartum Care
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care
W30 - Well Child Visits in the First 30 Months of Life
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Expand the initiative to all CalViva counties. Year-end:
Mid-year Outcome(s):	As of June 12, 2026, CalViva approved revisions to the Newborn Checklist. The document will proceed to NOA submission, Spanish and Hmong translations, and final remediation.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Covered CA PPC Compliance Maternal Health Equity Resources and Trainings: Implicit Bias Training (CalViva)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0664
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety			**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety

Intervention Description:
Provide implicit bias training to OB providers and share maternal health equity resources, training materials, and educational links to support equitable maternity care. Maintain partnership with Dr. Sayida Peprah-Wilson to deliver provider education and updates, with the contract extended through December 31, 2026 due to higher-than-expected enrollment.

Measures Impacted:
PDS-E - Postpartum Depression Screening and Follow-up
PND-E - Prenatal Depression Screening and Follow-up
PPC - Prenatal and Postpartum Care
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: The implicit bias training contract has been extended and will remain available to providers throughout 2026. Year-end:
Mid-year Outcome(s):	As of May 2026, 308 participants registered for the implicit bias training. Providers were notified via Q1 Provider Updates, which included guidance on training requirements, non-compliance penalties, and instructions for accessing sponsored training opportunities.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Promote CDC'S Milestone Tracker App (CalViva)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0661
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Promote the CDC Milestone Tracker App through member newsletters, website content, QR code resources, and outreach within CalViva's Pregnancy and First Year of Life programs. Continue targeted promotion to high-volume W30-6+ providers and Fresno Black Infant Health (BIH) members to increase awareness of developmental milestone tracking and early identification of developmental concerns.

Measures Impacted:
CIS - Childhood Immunization Status
CIS-E (10) - Childhood Immunization Status Combination 10
CIS-E (3) - Childhood Immunization Status Combination 3
W30 - Well Child Visits in the First 30 Months of Life
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: Expand the initiative to all CalViva counties. Year-end:
Mid-year Outcome(s):	There were a cumulative total to 194 scans/clicks for the year to date.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva W30-6+ PIP: Referrals to Black Infant Health (BIH) Fresno					
Counties:	Fresno	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0658
Start Date: 01/01/26		**End Date:** 08/30/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Pediatric/Dental		**POD Goals Sections (if applicable):**	7. Pediatric/Dental	

Intervention Description:
Refer Black/African American (B/AA) pregnant and postpartum members to BIH Fresno for additional education, resources, and support services to promote healthy pregnancies, improve birth outcomes, and address maternal health disparities.

Measures Impacted:
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months

Barriers:	Mid-Year: CalViva submitted BIH Referral List #14 in December 2025; however, receipt of outcome data was delayed due to BIH staffing changes, organizational restructuring, and the loss of outreach staff, limiting timely reporting and evaluation of referral outcomes. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The W30-6+ Clinical PIP concluded on December 31, 2025. CalViva will continue its partnership with the Black Infant Health (BIH) Program by referring Black/African American prenatal and postpartum members for culturally responsive support and education. During the intervention period (June 1, 2024 – December 31, 2025), CalViva referred 660 members to BIH. Of these, 65 were already enrolled, and 291 (48.91%) were successfully contacted. Referral List #14 remains in progress, with delays in outcome reporting due to BIH staffing shortages.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva W30-6+ PIP: Member Incentives					
Counties:	Fresno	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0657
Start Date: 01/01/26		**End Date:** 08/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Provide member incentives through BIH Fresno to encourage participation in prenatal and postpartum group sessions as part of the Performance Improvement Project (PIP), supporting member engagement and maternal health outcomes.

Measures Impacted:
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Last year, BIH Fresno indicated that an agreement with CVH was needed to continue providing member participation incentives (gift cards). To support this need, BIH was included in the agreement with Fresno Department of Public Health (DPH), enabling BIH to access a portion of the grant funding provided by CVH to Fresno DPH. In collaboration with Krystal Harris, this approach was developed to help sustain referrals to BIH and support health education, infant safety initiatives, member participation incentives, and BIH data exchange and reporting.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva W30-6+ PIP: Provider Webinar					
Counties:	Fresno	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0655
Start Date: 02/12/26		**End Date:** 02/12/26		**Activity Status:** Complete	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Host a provider webinar with Fresno BIH to promote the partnership and share program information and resources.

Measures Impacted:
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	CalViva hosted a provider webinar on February 12, 2026, in partnership with Fresno BIH to promote the collaboration and share program information and available resources. The webinar had a total of 13 attendees.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: PPC Workgroup (CalViva)					
Counties:	All Counties	**Initiative Point of Contact:**	Meena Dhonchak, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0629
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Maternal Health/Hospital/Patient Safety		**POD Goals Sections (if applicable):**	5. Maternal Health/Hospital/Patient Safety	

Intervention Description:
Assess and address data capture challenges for PPC and prepare for the MY 2028 measure transition.

Measures Impacted:
PPC - Prenatal and Postpartum Care
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care

Barriers:	Mid-year: NCQA has revised its approach to the PPC measures, indicating they will be fully replaced rather than transitioning away from medical record review in MY 2028. At this time, limited details are available regarding the structure or specifications of the new measures. Year-end:
Opportunities:	Mid-year: Efforts to improve data capture for the current PPC measure will remain relevant and necessary through Measurement Year 2027. Year-end:
Mid-year Outcome(s):	A workgroup was established to improve data capture for Prenatal and Postpartum Care (PPC) HEDIS measures, with a focus on validating and expanding data capture through Health Information Exchanges (HIEs). In addition, Provider Engagement team has received multiple trainings on PPC best practices and documentation requirements to drive improvements in data capture.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Ongoing Monitoring Activities: Credentialing/Recredentialing Practitioners/Providers					
Counties:	Fresno	**Initiative Point of Contact:**	Michael Catello, Sr. Manager, Quality Improvement	**eQIPT ID:**	CA-0313
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Credentialing/Recredentialing		**POD Goals Sections (if applicable):**		

Intervention Description:
Achieve and maintain 100% compliance with timeliness and accuracy requirements.

Measures Impacted:
No Associated Measure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	Achieved and maintained 100% timely compliance and 100% accuracy throughout the reporting period.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: High Risk COL-E					
Counties:	All Counties	**Initiative Point of Contact:**	Michelle Cai, Quality Improvement Specialist, Sr.	**eQIPT ID:**	CA-0649
Start Date: 01/26/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Identify members at high risk for Colorectal Cancer Screening (COL-E) care gaps and provide actionable lists to providers for targeted outreach, follow-up, and care coordination.

Measures Impacted:
COL-E - Colorectal Cancer Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The e-project distributed member lists to PPGs on March 31, 2026, resulting in 21.3% engagement, with 23 of 108 PPGs actively participating.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Member Incentive - Medi-Cal					
Counties:	All Counties	**Initiative Point of Contact:**	Rahma Abdillah, Project Manager III, Quality Improvement	**eQIPT ID:**	CA-0841
Start Date: 01/01/26		**End Date:** 12/31/26	**Activity Status:** In Progress		
Program and Drivers (POD):	Health Education/Wellness		**POD Goals Sections (if applicable):**	2. Behavioral Health, 4. Chronic Conditions, 5. Maternal Health/Hospital/Patient Safety, 7. Pediatric/Dental, 9. Preventative Health	

Intervention Description:
Implement member incentives to encourage completion of required screenings and services, support care gap closure, and ensure compliance with current California Department of Health Care Services (DHCS) requirements.

Measures Impacted:
BCS-E - Breast Cancer Screening
CBP - Controlling High Blood Pressure
CCS-E - Cervical Cancer Screening
CHL - Chlamydia Screening in Women
CIS-E (10) - Childhood Immunization Status Combination 10
COL-E - Colorectal Cancer Screening
DEV-CH - Developmental Screening in the First Three Years of Life
DSF-E - Depression Screening and Follow-Up for Adolescents and Adults
FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up
FUM - Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow up
GSD - Glycemic Status Assessment for Patients with Diabetes - Poor Control (>9)
IMA-E - Immunizations for Adolescents
LSC - Lead Screening in Children
PDS-E - Postpartum Depression Screening and Follow-up
PND-E - Prenatal Depression Screening and Follow-up
PPC-P - Prenatal and Postpartum Care—Postpartum Care
PPC-T - Prenatal and Postpartum Care—Timeliness of Prenatal Care
TFC - Topical Fluoride for Children
W30 - Well Child Visits in the First 30 Months of Life - Well Child in first 15 months
W30 - Well Child Visits in the First 30 Months of Life - Well Child age 15 months to 30 months
WCV - Child and Adolescent Well-Care Visits

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	As of mid-year, all member incentive program activities remain current with DHCS requirements. CalViva-DPP-2025 has been updated for the current reporting period, with the annual update due by April 4, 2027. CalViva-PPC-PST-CHEC-2026 and CalViva-W15-W30-CHEC-2026 remain active and are scheduled to conclude on November 15, 2026. CalViva-PREV-2025 was previously approved by DHCS and consolidated several member incentive initiatives into a single program. The following programs were completed and concluded in 2025: CalViva-BCS-2018, CalViva-CCS-2018, CalViva-PPC-W-15-24, CalViva-WCV-2022, and CalViva-CIS-10-2019. Overall, all member incentive program submissions, reporting requirements, and program activities are on track and in good standing.

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Mobile Mammography Program					
Counties:	Fresno Madera	**Initiative Point of Contact:**	Rahma Abdillah, Project Manager III, Quality Improvement, Ravneet Gill, Program Manager III, Quality Improvement	**eQIPT ID:**	CA-0643
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Increase access to breast cancer screening services, particularly for individuals in rural, underserved, and other hard-to-reach communities. Partner with local clinics to host on-site screening events that improve access, promote early detection, and help close preventive care gaps.

Measures Impacted:
BCS-E - Breast Cancer Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	As of mid-year, three Breast Cancer Screening (BCS) outreach events were conducted in Fresno County within the CalViva Health service area. A total of 148 individuals registered for BCS, with 63 screenings completed, resulting in a 42.57% completion rate. These BCS outreach events were requested by providers and strategically held at specific locations throughout Fresno County to address identified care gaps. The targeted outreach approach supported efforts to increase access to BCS services, engage members due for screening, and contribute to the closure of identified care gaps.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Mammogram Facility Incentive Program (MFIP) Projects					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Ravneet Gill, Program Manager III, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0633
Start Date: 02/02/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Implement multiple electronic outreach projects to promote and launch MFIP, including:
• Send a provider group announcement via Power Automate.
• Develop an opt-in survey for interested radiology facilities.
• Host a required launch webinar for provider groups interested in participating.

Measures Impacted:
BCS-E - Breast Cancer Screening

Barriers:	Mid-year: Limited provider engagement and inconsistent follow-through have impacted progress and overall effectiveness. Year-end:
Opportunities:	Mid-year: Opportunities focus on strengthening both provider and member engagement to improve participation, follow-through, and overall program effectiveness. Year-end:
Mid-year Outcome(s):	The MFIP initiative was successfully launched, with outreach conducted to PPGs and care gap distribution beginning April 27, 2026. This resulted in active participation from one CalViva PPG, establishment of care gap reporting and data exchange workflows, and implementation of scheduled monthly data refreshes to support ongoing program operations.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: High Risk BSC-E					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Ravneet Gill, Program Manager III, Quality Improvement, Wendy Hernandez, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0599
Start Date: 01/26/26		**End Date:** 04/30/26		**Activity Status:** Complete	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Identify members at high risk for Breast Cancer Screening (BCS-E) care gaps and provide actionable lists to providers to support targeted outreach, follow-up, and care coordination.

Measures Impacted:
BCS-E - Breast Cancer Screening

Barriers:	Mid-year: Engagement remains low at 18.7%, with performance impacted by access barriers and limited member engagement. Year-end:
Opportunities:	Mid-year: The completed project identified opportunities to improve future performance by refining outreach and targeting strategies and addressing access barriers to increase participation and conversion rates. Year-end:
Mid-year Outcome(s):	The e-project was distributed on March 31, 2026. As of April 14, 2026, the BCS High-Risk engagement rate was 18.7% (23 of 123). Project outcomes indicate an opportunity to improve future performance by refining member targeting and addressing access barriers to increase conversion beyond initial engagement.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: DHCS Non-Clinical PIP: Behavioral Health					
Counties:	Fresno Madera	**Initiative Point of Contact:**	Rhonda Dick, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0561
Start Date: 01/01/26		**End Date:** 08/07/26	**Activity Status:** Complete		
Program and Drivers (POD):	Behavioral Health		**POD Goals Sections (if applicable):**	2. Behavioral Health	

Intervention Description:
Implement the CalViva Performance Improvement Project (PIP) to increase provider notification rates for members with Substance Use Disorder (SUD) or Mental Health (MH) diagnoses within 7 days of an emergency department (ED) visit in Fresno and Madera Counties. Key interventions include enhancing coding education with Smart Phrases, providing cultural competency training, and promoting referrals to the Resiliency Center, with the goal of supporting its designation as a CalAIM Enhanced Care Management (ECM) provider.

Measures Impacted:
FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up
FUM - Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow up

Barriers:	Mid-year: Appropriate procedure and diagnosis codes are utilized to ensure accurate reporting. Emergency Department staff, including LCSWs, CHWs, and Substance Use Counselors, have been educated on follow-up and documentation requirements to support continuity of care. Disparities persist, with Hispanic populations disproportionately affected by depression and demonstrating lower adherence to treatment, which may contribute to increased ED utilization for SUD and mental health-related diagnoses. Expanding access to referral pathways and support services remains critical to addressing these gaps and improving outcomes. Year-end:
Opportunities:	Mid-year: Follow-up processes were implemented with CHWs and social workers in the emergency department to close care gaps, utilizing daily ADT reports to identify and prioritize member outreach and coordination of care. Year-end:
Mid-year Outcome(s):	FUA/FUM rates are trending upward, with final HEDIS results pending and expected the week of June 15, 2026. The PIP Submission form was reviewed with CalViva; the “Threats to Validity” section remains to be completed. • Intervention 1: Smart Phrase training completed; target met, with data updates in progress. • Intervention 2: Cultural training completed and will be embedded into onboarding for new hires. • Intervention 3: Resiliency Center intervention discontinued due to low referral volume; however, the Resiliency Center will transition to serve as an ECM provider. The final PIP submission write-up is in progress. The internal PIP team is scheduled to meet on June 24, 2026, to review the final draft in preparation for the meeting with CalViva on June 30, 2026. 7.13.26: Final Drafts are completed, scheduled to meet with CVH 7/23/26 to review documents for August submission.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Quality Monitoring & Improvement Project (QMIP) Madera County (2026)					
Counties:	Madera	**Initiative Point of Contact:**	Rhonda Dick, Sr. Quality Improvement Specialist	**eQIPT ID:**	CA-0559
Start Date: 01/01/26		**End Date:** 09/30/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Behavioral Health			**POD Goals Sections (if applicable):**	2. Behavioral Health

Intervention Description:
Implement culturally appropriate education and outreach strategies for members with mental health (MH) and substance use disorder (SUD) needs to improve follow-up care after an emergency department (ED) visit. Interventions include Community Health Worker (CHW) training, implementation of the Lanes real-time database, and use of the Resiliency Center referral process to increase follow-up visits within 30 days of an ED visit.

Measures Impacted:
FUA - Follow-Up After Emergency Department Visit for Substance Use - 30-day follow up
FUM - Follow-Up After Emergency Department Visit for Mental Illness - 30-day follow up

Barriers:	Mid-year: Members with an ED visit for SUD who do not receive follow-up care within 7 days are highly unlikely to receive follow-up within 60 days, indicating the critical importance of timely post-ED engagement. Year-end:
Opportunities:	Mid-year: Follow-up with CHWs, Social Workers in the ED to close care gaps. Year-end:
Mid-year Outcome(s):	In Madera County, follow-up care rates after an emergency department visit for substance use (FUA) or mental illness (FUM) exceeded the minimum performance level (MPL) of 26%. Final HEDIS rates were 37.44% for FUA and 47.99% for FUM. To support continued improvement, provider and member tip sheets were developed, including telehealth resources to enhance access and engagement. The Resiliency Center transitioned to an Enhanced Care Management (ECM) provider, further expanding support services. The project will continue through 2026 to sustain and improve performance.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Blood Pressure Cuff Benefit Flyer 2026					
Counties:	All Counties	**Initiative Point of Contact:**	Stacey Noonan, Health Educator	**eQIPT ID:**	CA-0862
Start Date: 01/21/26		**End Date:** 05/04/26		**Activity Status:** Complete	
Program and Drivers (POD):	Chronic Conditions			**POD Goals Sections (if applicable):**	4. Chronic Conditions

Intervention Description:
Review and update the provider flyer that explains coverage options for home blood pressure monitors and cuffs.

Measures Impacted:
CBP - Controlling High Blood Pressure

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The BP Cuff Flyer was updated with 2026 content and posted in the Medi-Cal Provider Library under Education, Training, and Other Resources.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: CalViva Quarterly Dental Proactive Outreach Manager (POM)					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Wendy Hernandez, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0376
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Implement Dental POM calls to encourage CalViva Health members to complete dental checkups and topical fluoride applications.

Measures Impacted:
TFC - Topical Fluoride for Children

Barriers:	Mid-year: Due to recent process changes, alignment with analyst was required to understand and adapt to the updated workflow. QIRA data remains pending, delaying the ability to finalize reporting. Year-end:
Opportunities:	Mid-year: Alignment with the updated workflow has been established, positioning the team for more efficient execution moving forward. Follow-up efforts have been initiated to obtain the pending QIRA data, which will enable completion of reporting and enhance data visibility once received.. Year-end:
Mid-year Outcome(s):	The team has adapted to the updated process and aligned workflows, positioning for smoother execution. Reporting remains pending due to QIRA data clarifications; follow-up is underway to obtain the necessary data and finalize reporting with improved visibility.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Cozeva Provider Outreach					
Counties:	Fresno Kings Madera	**Initiative Point of Contact:**	Wendy Hernandez, Senior Quality Improvement Specialist	**eQIPT ID:**	CA-0353
Start Date: 01/12/26		**End Date:** 12/31/26		**Activity Status:** In Progress	
Program and Drivers (POD):	Pediatric/Dental			**POD Goals Sections (if applicable):**	7. Pediatric/Dental

Intervention Description:
Send Cozeva push notifications to provider offices with targeted care gap lists, enabling providers to identify members needing services and take timely action to close care gaps.

Measures Impacted:
CIS - Childhood Immunization Status

Barriers:	Mid-year: Delays in finalizing Cozeva workflows, establishing provider access, and addressing system and data limitations impacted the timely scaling of push notification outreach. Year-end:
Opportunities:	Mid-year: Opportunity to enhance provider engagement by expanding targeted Cozeva outreach and supporting providers with clear guidance and training to drive timely action on care gaps. Year-end:
Mid-year Outcome(s):	Targeted Cozeva outreach is contributing to a significant reduction in non-compliant members, while also identifying opportunities to further scale efforts and streamline provider engagement to maximize impact.
Year-end Outcome(s):	
Activity Change for Following Year:	

Section II: Enterprise Quality Improvement & Performance Tracker Activities Log (Initiatives)

Intervention Name: Preventative Care - Provider Tip Sheets					
Counties:	All Counties	**Initiative Point of Contact:**	Wendy Hernandez, Senior Quality Improvement Specialist, Michelle Cai, Quality Improvement Specialist, Sr., Ravneet Gill, Program Manager III, Quality Improvement, Elisa Stomski, Quality Improvement Specialist Senior	**eQIPT ID:**	CA-0637
Start Date: 01/01/26		**End Date:** 12/31/26		**Activity Status:** Complete	
Program and Drivers (POD):	Preventative Care			**POD Goals Sections (if applicable):**	9. Preventative Health

Intervention Description:
Develop or update provider tip sheets to reflect current measure requirements, coding guidelines, documentation standards, and best practices that support compliance and improved performance.

Measures Impacted:
BCS-E - Breast Cancer Screening
CCS-E - Cervical Cancer Screening
COL-E - Colorectal Cancer Screening

Barriers:	Mid-year: None. Year-end:
Opportunities:	Mid-year: None. Year-end:
Mid-year Outcome(s):	The BCS, CCS, and COL tip sheets have been completed and posted to the Provider Library.
Year-end Outcome(s):	
Activity Change for Following Year:	

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

Item #10
Attachment 10.A-B

2026 Utilization Management Care Management
Work Plan Mid-Year Evaluation

A. Executive Summary
B. Work Plan Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Patrick Marabella, MD, Chief Medical Officer, Amy Schneider, RN, Senior Director Medical Management
COMMITTEE DATE:	September 17th 2026
SUBJECT:	2026 CalViva Utilization Management/Care Management Work Plan Mid-Year Evaluation Executive Summary

Summary:

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

The metrics below were identified as too soon to tell for the mid-year evaluation reporting period:

- 2.2 – Timeliness of Processing the Authorization Request
- 3.1 – Improve Medi-Cal shared risk and FFS UM acute in-patient performance
- 3.3 - PPG Profile and Vendor List

Purpose of Activity:

CalViva Health (CalViva) has delegated responsibilities for utilization management and care management (UM/CM) activities to Health Net Community Solutions, Inc. (Health Net), but CalViva oversees the UM/CM Programs. CalViva's UM/CM activities are handled by qualified staff in Health Net.

The Utilization and Care Management Program is designed for all CalViva 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 including behavioral health, provided through review/discussion of routine reports and regular oversight audits.

The mid-year evaluation of the UM/CM Work Plan encompasses a review of medical management activities through the documentation of current and future strategic initiatives and goals. The work plan tracks key performance metrics, regulatory compliance, provides for an assessment of our progress and identifies critical barriers to achieving annual goals.

This plan requires involvement from many areas such as Appeals & Grievances, Delegation Oversight, Compliance, Information Technology, Medical Informatics, Member Services, Pharmacy, Provider Oversight, Provider Network Management, Provider Operations, Quality Improvement, Medical Management, and Behavioral Health.

Analysis/Findings/Outcomes:

I. UMCM Committee Oversight and Structure

In the first half of 2025, CalViva's UMCM Program was successfully supported by the CalViva QI/UM Committee which met three times. The committee supervised the UMCM Program, provided feedback, decision support, and recommendations for the UMCM program throughout the year. The QI/UM Committee reported to the CalViva Regional Health Authority (RHA) Commission three times in the first half of 2026. CalViva's QI/UM Committee structure is supported by the HNCS Committee structure as noted in the Annual Program Description.

The QI/UM Workgroup supports the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI/UM Workgroup aids in the identification and pursuit of opportunities to improve health outcomes, safety, access, member satisfaction and provider satisfaction. Significant findings and follow-up were reported to the QI/UM Committee and RHA Commission.

The QI/UM Workgroup met eighteen (18) times in the first half of 2026 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including the Senior Director of Medical Management (who is a Registered Nurse) and a Manager of Medical Management Services (also a registered nurse); and Health Net staff from Utilization and Care Management, Quality Improvement, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider Network Management, and Provider Relations. The Workgroup conducted review of UMCM routine and special reports and discussions of monitoring UMCM activities, findings, barriers, and interventions to develop and implement actions.

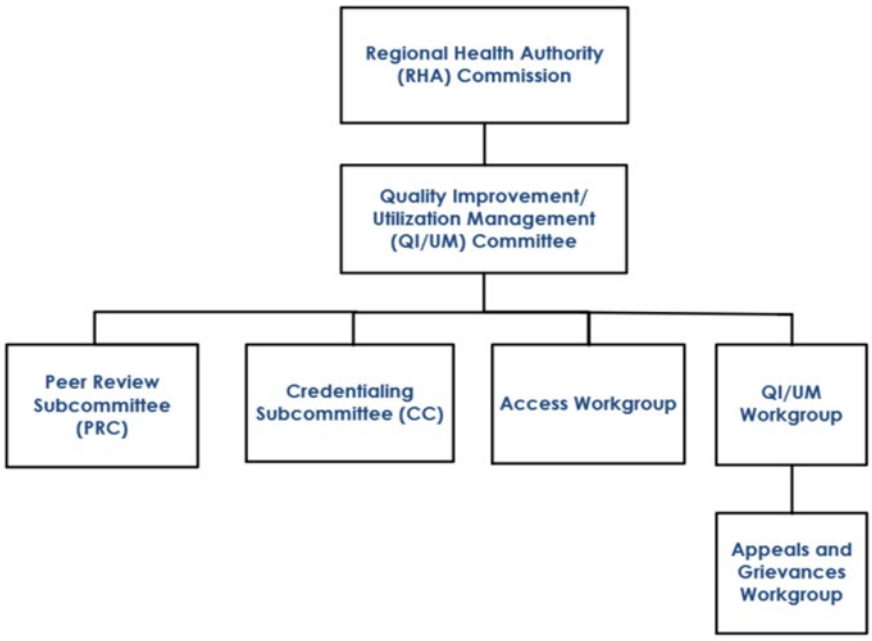
The Appeal and Grievance Workgroup reports to the QI/UM Workgroup and supports the UMCM program through the review and analysis of appeal and grievance data. The Workgroup processed, tracked, and trended member grievances and appeals for the first half of 2026 at the provider and plan level evaluating for type, severity, volumes, rates, and the identification of opportunities for improvement. The Workgroup submitted reports to the QI/UM Workgroup and Peer Review Subcommittee to review, act, and follow-up on identified significant events or trends. The Appeals and Grievances Workgroup met four times in the first half of 2026.

The CalViva Health Access Workgroup reports directly to the QI/UM Committee through quarterly reports and committee minutes. This access focused Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions. CalViva's Access Workgroup met four times in the first half of 2026.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's UMCM Program, as demonstrated in the organizational chart below. The subcommittees met 2 times each in the first half of 2026.

Please refer to the 2026 Utilization Management and Care Management Program Descriptions for more information on the committees and sub-committees.

CalViva's Quality Improvement Utilization Management Committee Organizational Chart



II. Compliance with Regulatory & Accreditation Requirements

All activities related to compliance with regulatory & accreditation requirements are on target for this mid-year evaluation, with the following barriers identified:

a. Periodic audits for compliance with regulatory standards (work plan element 1.4)

Ongoing monthly regulatory standard auditing continues of 30 sample size per metric.

Barrier identified:

- No systemic barriers were identified in completing the scheduled audit activities. Opportunities for process reinforcement were identified through routine audit monitoring and are being addressed through education, trend review, and corrective action follow-up.

Action taken:

- Continue scheduled monthly regulatory file audits.
- Continuing trend monitoring and expanded sampling when indicated.
- Provide targeted staff education when audit findings identify process gaps.
- Track corrective actions through completion and escalate recurring or significant findings through the established compliance and auditing process.

III. Monitoring the Utilization Management Process

UM Process Monitoring activities were on target for this mid-year evaluation with the exception of workplan element 2.2 Timeliness of Processing the Authorization Request which is listed as too soon to tell.

a. Timeliness of Processing the Authorization Request (work plan element 2.2)

The Plan monitored Turn Around Time (TAT) as planned in the first half of 2026.

Authorization TAT	Q1	Q2
Pre-Service Routine	100%	100%
Pre-Service Routine with Extension/Deferral	100%	100%
Pre-Service Expedited	98.46%	94.12%
Pre-Service Expedited with Extension/Deferral	100%	100%
Post Service	100%	100%
Concurrent	100%	100%

Barriers identified:

- During quarter 1 (Q1), two urgent pre-service cases exceeded the required turnaround time because of a temporary system and assignment disruption, increased urgent inventory, and manual routing delays involving the transplant review team. During Q2, urgent pre-service performance remained below the 100% goal. Identified barriers included incorrect priority validation, routing to the wrong queue, inconsistent adherence to established processes, missed escalation when clarification was needed, and a June capacity gap caused by high authorization volume and limited staffing.

Actions Taken:

- The following actions were taken to address the turnaround time barriers: continue daily turnaround-time huddles, hourly urgent queue reviews, proactive staffing and workload adjustments, monthly audit trending, workflow monitoring, and escalation of identified compliance risks.

IV. Monitoring Utilization Metrics

All activities related to compliance with Monitoring Utilization Metrics requirements activities were on target for this mid-year evaluation with the exception of workplan elements 3.1 Improve Medi-Cal shared risk and Fee For Service (FFS) Utilization Management (UM) acute in-patient performance, and 3.3 Preferred Provide Group (PPG) Profile and Vendor List which are listed as too soon to tell.

High inpatient utilization was driven by members with complex medical and behavioral health conditions, compounded by limited engagement in post-discharge care plans and follow-up appointments, as well as challenges in coordinating services across multiple providers and care settings for high-risk members.

a. Improve Medi-Cal shared risk and FFS UM acute in-patient performance (work plan element 3.1)

Based on data through June 2026, 30-day inpatient readmissions show increase in 2026. It is too soon to tell whether this metric will meet the 2-3% reduction goal.

Key Indicator Report thru June 2026:

Metric	2025	2026 Q1-Q2	% Change
Admits PTMPY	38.1	41.3	+8.40%
Bed Days Acute PTMPY	188.4	204.3	+8.44%
ALOS Acute	4.9	4.9	0.00%
Readmit 30 Day	12.1	13.5	+11.57%

Action taken:

- The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout the first 6 months of 2026.

- The Plan partnered with Valley Children's in Q2 in ongoing effort to support transition to lower level of care through onsite Transition Care Services (TCS).
- Opportunities remain to further strengthen transitions of care, provider engagement, and member adherence to post-discharge plans, which may contribute to increased inpatient utilization and readmission activity.
- Compared with the 2025 averages, Q1 2026 readmissions were elevated for MCE and SPD populations and increased further in Q2, while TANF rates improved in Q2 after a higher Q1 rate.
- Continue efforts to reduce avoidable readmissions by strengthening care transitions, requiring review of complex inpatient cases during Discharge Planning Rounds, implementing mandatory Case Management referrals for 30-day readmissions, and maintaining collaboration among Utilization Management, Case Management, and facility partners to support effective discharge planning and post-discharge care.

b. Over/under utilization (work plan element 3.2)

Annual Over-Under Utilization Management Report was presented to CalViva Health Q2-2026. PPG UM data is shared at CalViva Management Oversight Meetings, every quarter. Shifts in utilization were reviewed in quarterly Joint Operating Meetings (JOMs) with PPGs.

Barriers identified:

- Shifts in utilization patterns and variations in specialty referral performance among PPGs are ongoing challenges.
- Variation in utilization among PPGs is partly reflective of demographic differences and access to inpatient care.
- Of the four PPGs listed in the adjacent column, only one has instituted an 'eConsult first' policy.
- To mitigate specialty access challenges, faster adoption of eConsults, greater leveraging of telehealth capabilities, wider provision of high quality primary care and better triaging of specialty referrals (especially referrals that do not require surgical procedures) is needed.
- When operationalized, closed loop referrals will provide better line of sight into referral utilization and reasons for delay.

Action taken:

- HN promotes the use of Health Net Empowered Living Program (H.E.L.P.) for assisting providers with timely access to specialists.
- HN continues to promote eConsult adoption with Federally Qualified Health Centers (FQHC) and PPGs, for timely access to specialty care.
- Regional Medical Director advocates for better care coordination, member experience and value-based care by participating in interdisciplinary care team (ICT) meetings. RMD also convenes discussions with clinical leaders in acute care facilities across the region.
- Annual Over/Under Utilization report was submitted in May 2026.
- Utilization data is shared with PPGs on a quarterly basis. In addition to HN generated high-utilizer reports (which have a time lag) PPGs are asked to supplement these with their own ED high utilizer and IP high utilizer reports. PPG reporting is closer to real time.

c. PPG Profile and Vendor List (work plan element 3.3)

PPG monitoring activities are conducted monthly including tracking and trending of performance. Delegation Oversight monitors corrective action plans (CAPs) to ensure actions are implemented,

documented and followed to completion. Both PPGs with CAPs have implemented an action plan to ensure compliance with denial letters/template.

Barriers identified:

- PPG B – Routine Decision & Member Notification TAT was non-compliant Staffing and workflow issues. Workflow is being evaluated to determine root cause and appropriate remediation activities.
- PPG C - Routine Decision & Member Notification TAT was non-compliant. Delegate has changed MSO relationship. Monitoring and working with new MSO to oversee performance trends.

Actions taken:

- The Plan continued monitoring of open PPG CAPs.

V. Monitoring Coordination with Other Programs

Monitoring Coordination with Other Programs activities are on target for this mid-year evaluation with the following barriers identified.

a. Care Management (CM) Program (work plan element 4.1), Referrals to Perinatal Care Management (work plan element 4.2) and Behavioral Health (BH) Case Management Program (work plan element 4.3).

Barriers identified:

- Low Member participation in Satisfaction Survey.

Action Taken:

- Launched shortened survey via texting platform in June.

b. Disease/ Chronic Condition Management (work plan element 4.4)

Through Q2 2026, 104 members participated in the Chronic Condition Disease Management Program. Ongoing monitoring activities were completed as planned. Annual disease management outcomes will be presented in Q3 2026.

Barrier identified:

- The transition away from MicroStrategy (June 2025) to Power BI caused some data alignment issues in reporting on program engagement, outcomes, and market specific data.

Action taken:

- A job aid is being developed to align data sources. The Plan will be meeting with teams to resolve in Q3/Q4, however, teams are actively collaborating with Shared Services to resolve these issues. In support of these efforts, job aid is being developed to standardize data sources and reporting processes.

c. Enhanced Care Management (work plan element 4.8)

ECM program enrollment rates by county are reported quarterly CalViva Health (CVH) UM/QI Committee and CVH Medical Operations Management Meeting (MOM).

Barrier identified:

- ECM growth has been slower than anticipated due to provider outreach capacity constraints and referral pathway challenges. These barriers increase the time required to identify, contact, engage, and enroll eligible members, particularly among Children and Youth populations, resulting in a longer timeline to achieve measurable increases in ECM penetration and sustain 12-month growth.

Action taken:

- Since February 2026, Health Net/CVH has advanced a targeted "Getting to 1%" strategy to increase ECM penetration through provider incentives, enhanced referral and outreach processes, community partnerships, and focused enrollment efforts for high-opportunity populations, particularly Children and Youth. These interventions are being implemented throughout 2026 to improve enrollment conversion, increase the percentage of members receiving ECM, and demonstrate sustained 12-month growth consistent with DHCS requirements.

VI. Monitoring Activities for Special Populations

All monitoring activities for special populations activities are on target for this mid-year evaluation with the following barriers identified.

a. Monitor California Children's Services (CCS) identification rate (work plan element 5.1)

Teams continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy.

The CCS identification rates for the CVH under 21 population continue to trend above 7% in all counties.

2026 Monthly CCS Identification Rates

Month	Fresno	Kings	Madera	Average
Jan	8.60%	7.65%	8.35%	8.20%
Feb	8.60%	7.75%	8.42%	8.26%
Mar	8.57%	7.73%	8.43%	8.24%
Apr	8.58%	7.70%	8.47%	8.25%
May	8.50%	7.77%	8.46%	8.24%
Jun	8.66%	7.90%	8.62%	8.39%

Barrier identified:

- We are seeing some denials from Madera and Kings County related to Service Authorization Request (SAR) submissions that do not appear to follow the All Plan Letter (APL) 16-008 related to Neonatal Intensive Care Unit (NICU) and other inpatient admissions. We are taking advantage of the Reconsideration Process for resolution however we still receive denials. We have engaged DHCS for further support and will continue to monitor for resolution.

Actions taken:

- Reconsiderations will continue to be submitted. We have recently engaged DHCS for further support and resolution of these denials.

VII. Adequacy of UMCM Program Resources

Based upon the results of the mid-year 2026 monitoring activities noted above and within the attached full Work Plan, CalViva has determined that it is too soon to tell if the program resources meet the needs of CalViva membership and providers.

VIII. Program Scope, Processes, Information Sources

It is too soon to tell whether the scope of services offered to CalViva members meets the state of California requirements for Medi-Cal Managed Care Plans. Ongoing out-reach efforts to CalViva membership demonstrate a commitment to informing and engaging members in the programs and services available to them. From prenatal services to Behavioral Health Case Management, to Enhanced Care Management, and Community Supports services and many more, appropriate benefits and services are available for all members. Identification of opportunities to improve processes, care, and service is something that CalViva and HNCS continually work on together. Ongoing monitoring of interventions is essential for all areas to ensure appropriate actions are being taken to meet goals.

IX. Practitioner Participation and Leadership Involvement in the UM Program

The CalViva committee structure ensured that external and internal physicians with various specialties participated in the oversight, monitoring, evaluation, and improvement of the UMCM Program. Six external providers were participants in the QI/UM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Family Medicine, Behavioral Health, Internal Medicine, Obstetrics and Gynecology, and General Surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate. The behavioral health provider (psychologist) has consistently attended QI/UM meetings since her appointment to the QI/UM Committee in June 2023. She actively participates in the review, discussion, and decision making for reports, data, and performance improvement activities related to behavioral health.

Practitioner involvement in 2026 included: reviewing and approving the 2025 UMCM Work Plan Annual Evaluation, and the 2026 UMCM Work Plan and 2026 Program Descriptions for both Utilization Management and Care Management and the 2026 UMCM Work Plan Mid-Year Evaluation. Practitioners discussed monitoring results of performance. Practitioners were also involved in discussions regarding opportunities for improvement based upon findings and experience.

CalViva's Chief Medical Officer and Senior Director of Medical Management RN participate in weekly Multi-disciplinary Care Rounds with the Health Net Concurrent Review team to assess adequacy of care and address barriers to discharge for high-risk members.

Health Net ensures senior physician involvement in the planning, design, implementation, and review of the UMCM program. This includes the behavioral health aspects of the UM Program. See attached full Work Plan Annual Evaluation for more information.

Next Steps:

Teams are continuing monitoring of 2026 activities. Ongoing monitoring of interventions is essential for all areas to ensure appropriate actions are being taken to meet goals.

CalViva Health
2026
Utilization Management (UM)/ Care Management (CM) Work Plan Mid-Year Evaluation

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1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide clinical continuing education opportunities for staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Courses offering clinical continuing education units (CEUs) are available to team members through the Plan's online learning management system. Clinical courses that include CEUs are also offered to the external provider community and internal staff are able to attend. New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered, and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform). IRR training and testing are on target for completion in Q3-Q4.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements	☒ Medi-Cal	Each year there is new healthcare-related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance with UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in compliance committees to review and monitor compliance with standards.	See work plan elements 2.2 and 3.3	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and are reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire. Annual reminders will be distributed in Q3 or Q4 2026. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Q3-2026 (reminder) This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.4 Periodic audits for compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2026, April 2026, July 2026, October 2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly regulatory file audits continued during the first half of 2026 using established audit methodology, including standard sample review and expanded sampling when variances were identified. Audit findings were documented, trended, and reviewed through the compliance and auditing process. Corrective action follow-up and staff education were initiated as appropriate based on audit outcomes.	No systemic barriers were identified in completing the scheduled audit activities. Opportunities for process reinforcement were identified through routine audit monitoring and are being addressed through education, trend review, and corrective action follow-up.	• Provide targeted staff education when audit findings identify process gaps. • Track corrective actions through completion and escalate recurring or significant findings through the established compliance and auditing process.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors CMO/CHEO Meetings ▪ MMCD workgroups ▪ DHCS-MCP Quality and Health Equity Think Tank There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer/ Health Equity Officer participate in DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation in key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2026. The Health Equity Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2026. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Scheduled reports to CVH and HN Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CVH Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for the first two quarters of the year and the CMO/CHEO Meeting on March 19, 2026, and June 4, 2026. Health Net Medical Directors participated in DHCS-MCP Health Equity & Quality Think Tank on February 5, 2026, and May 7, 2026.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures as needed and at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements. Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Core group comprised of State Health Programs Chief Medical Officer (CMO), Regional Medical Directors, VP and Directors of PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2026 UM and CM Program Descriptions. Write and receive CalViva approval of 2025 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2026 UMCM Work Plan. Write and receive CalViva approval of 2026 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q1 2026 Q1 2026 Q1 2026 Q3 2026 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2025 Year End UM/CM Work Plan Evaluation, 2026 UM/CM Work Plan, 2026 UM Program Description and the 2026 CM Program Description were submitted to CalViva QIUM Committee and CalViva RHA Commission and approved in Q1 2026. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.7 Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making	☒ Medi-Cal	All new and current UM clinical criteria and practice guidelines related to UM decision making are reviewed and approved annually by the Medical Advisory Council (MAC), which includes input from local Medical Directors. The Plan makes UM criteria and clinical practice guidelines available to practitioners via the provider portal.	Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) reviews and approves policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. Medical policies and clinical practice guidelines are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria, are available to providers upon request. CalViva QIUM Committee reviews and adopts policies for physical and behavioral health clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Confirm annually: • Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviews, updates as necessary, and approves policies for clinical criteria and behavioral health criteria for UM decision making. • Ensure UM/BH clinical criteria and UM/BH clinical practice guidelines are made available to practitioners via provider portal (or website) and practitioners are notified of new policies and changes via the monthly Provider Update.	Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Annual review of clinical criteria on target for completion by end of year. Behavioral health clinical criteria and guidelines set forth by the APA and CASP were reviewed and approved by MAC in February 2026. Clinical Practice Guidelines were presented to the CVH QI/UM Work Group in July 2026. All websites are up to date with current UM clinical criteria and UM clinical practice guidelines and monthly provider updates regarding new policies and changes were communicated.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
1.8 Evaluate inclusion of new technologies and new applications of existing technologies in applicable benefit packages including: medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies	☒ Medi-Cal	Standardized process is used for review of new technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages	New technologies are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Decisions are based on nationally recognized primary sources including: Hayes® Medical Technology Directory and Hayes® Alert technology-based evaluations, InterQual® and information from evidence-based medical journals, colleges and academies. CalViva QIUM Committee reviews and adopts policies for clinical criteria for UM/BH decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Evaluate new technologies and ensure inclusion in member benefits as applicable throughout 2026	Ongoing monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Continuous monitoring new technology via MAC and Centene's CPC occurred in the first half of 2026. There were three new policies developed during Q1 and Q2 of 2026. The policies are: • Applied Behavioral Analysis (CA-Specific policy for Medi-Cal) • Immobilized Lipase Cartridges (Relizorb) • Concert Genetic Testing: Identity and Forensics	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend physical and behavioral health authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Number of denials appealed and overturned	Utilize the Key Indicator Report and BH Performance Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Continue support for long-term care benefit carve in and ensure continuity of care.	Ongoing

<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Monthly Key Indicator (KIR) and Staffing reports are reviewed to track trends, results, and opportunities and are discussed in Leadership Meetings. Action plans are developed/implemented as needed based on results/trends to mitigate risks with meeting requirements.

Long Term Care and Community Supports prior authorization objectives are on track.

Prior Authorization requirements were continuously assessed to ensure appropriateness of requirements and updated based on Plan evaluation. Changes were communicated internally and externally.

Authorization volume and denial rates increased in April due to changes in requirements which normalized in subsequent months.

<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Denied</th><th>Modified</th></tr>
<tr><td>January</td><td>7006</td><td>1127</td><td>288</td></tr>
<tr><td>February</td><td>6552</td><td>1182</td><td>284</td></tr>
<tr><td>March</td><td>7117</td><td>1410</td><td>357</td></tr>
<tr><td>April</td><td>7183</td><td>1646</td><td>265</td></tr>
<tr><td>May</td><td>6182</td><td>1421</td><td>256</td></tr>
<tr><td>June</td><td>6629</td><td>1576</td><td>242</td></tr>
<tr><td>Totals</td><td>40669</td><td>8362</td><td>1692</td></tr>
</table>
</td>
<td>None identified</td>
<td>Evaluated opportunities to review and determine authorizations more efficiently.

Prior Authorization Requirements and Metrics were posted to the Plan website per CMS Final Rule 0057F and were further developed to meet DHCS APL 26-008 Interoperability Final Rule which will include reporting to DHCS and CalViva QI/UM Committee.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2027</td>
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</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend physical and behavioral health authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report and behavioral health performance indicator report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining. Initiate end to end assessment of UM TAT monitoring processes.	Ongoing UM TAT summaries due monthly 12/31/2026

<table>
<tr><th></th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr><td>Mid-Year Report

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td><td>Health Net quarterly monitoring shows all TAT goals were met at 95% or better in the first half of the year, except for Pre-Service Expedited.

The leadership team conducted structured daily and weekly activities to monitor and enhance operational performance, focusing on turnaround times (TAT), resource management, and process improvements.

CVH initiated a TAT CAP, along with its duration. Pending July data, the CAP may be reinstated

The following practices ensure alignment with program goals:
1. Daily Leadership Meetings:
• Identify barriers impacting performance and develop actionable solutions.
• Implement real-time staffing adjustments to address workload imbalances and ensure adherence to TAT benchmarks.
2. Weekly Remediation Plans:
• Compile a summary of key metrics, challenges, and outcomes from the daily reviews.
• Develop detailed remediation plans to address recurring issues or significant deviations from targets.

<table><tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr><tr><td>Pre-Service Routine</td><td>100%</td><td>100%</td></tr><tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>100%</td></tr><tr><td>Pre-Service Expedited</td><td>98.46%</td><td>94.12%</td></tr><tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td></tr><tr><td>Post Service</td><td>100%</td><td>100%</td></tr><tr><td>Concurrent</td><td>100%</td><td>100%</td></tr></table></td><td>During Q1, two urgent pre-service cases exceeded the required turnaround time because of a temporary system and assignment disruption, increased urgent inventory, and manual routing delays involving the transplant review team.

During Q2, urgent pre-service performance remained below the 100% goal. Identified barriers included incorrect priority validation, routing to the wrong queue, inconsistent adherence to established processes, missed escalation when clarification was needed, and a June capacity gap caused by high authorization volume and limited staffing.

During Q1, the CAP was successfully met. Ongoing monitoring will continue to ensure sustained performance and compliance with established turnaround time standards.</td><td>Continue daily turnaround-time huddles, hourly expedited queue reviews, proactive staffing and workload adjustments, monthly audit trending, workflow monitoring, and escalation of identified compliance risks.</td><td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td></tr>
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</table>

☐ CONTINUE ACTIVITY IN 2027				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology / Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development administers new hire and annual IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews All new hire and annual staff must achieve a minimum passing score of 90% on each IRR test.	Administer the Change HealthCare/Optum InterQual and relevant non profit criteria IRR tests in Q3-Q42026 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews for medical, behavioral, and pharmacy benefits. Documented coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented coaching may include but is not limited to the following: precepting of staff, retraining of the staff or auditing five (5) cases in production, providing two additional testing opportunities to demonstrate remediation success, for any IRR Product(s) not passed. In the event the new hire and annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and documented coaching is initiated by the People Leader.	Q3-4 2026 Q4-2026

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	IRR testing and training will be held Q3-4 2026 for medical and behavioral health (BH) teams. The Change HealthCare/Optum InterQual IRR testing and training is held for medical teams. BH teams administer IRR testing for ABA and Psychological.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of physical and behavioral health clinical appeals for physical and behavioral health received for authorization decisions and the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. Utilize the CalViva Health A&G Dashboard on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Appeals & Grievances timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements in addition to reviewing overturn rates and patterns of high overturn rates. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing

<table>
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☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Appeals data is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Data Review Period: January – June 2026

There were 404 cases resolved including standard and expedited appeals.

The top trends were not medically necessary, and community supports Related services. Top trends were Community Supports (CS) Services.CS does not have “Medical Necessity and DME being not medically necessary.

The Compliance rate was 99.75% for all cases.
<table>
<tr><th colspan="3">2026 Bi-Annual Count of Appeal Type</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>156</td><td>38.61%</td></tr>
<tr><td>Uphold</td><td>167</td><td>41.34%</td></tr>
<tr><td>Partial Uphold</td><td>62</td><td>15.35%</td></tr>
<tr><td>Withdrawal</td><td>19</td><td>4.70%</td></tr>
<tr><td>Case Total</td><td>404</td><td>100%</td></tr>
</table>

Aggregated grievance outcomes were shared with the CVH QI/UM Committee and CalViva A&G Workgroup. Actions taken related to identified opportunities are discussed in the CVH Peer Review Committee, Access Work Group, and QI/UM Committee.</td>
<td>None identified</td>
<td>None</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
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</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
2.5 Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction	☒ Medi-Cal	Continually assess customers' satisfaction with the UM process to identify areas that can be improved. Interventions are implemented to improve satisfaction levels where dissatisfaction is identified.	The Plan strives to improve Satisfaction with UM Process. Annually, satisfaction surveys are conducted and followed by: • Review of satisfaction survey data and trends. • Comparison of survey results with other source data. • Prioritization and implementation of interventions to improve member and practitioner satisfaction with UM processes. • Re-measurement of satisfaction periodically to ensure interventions is effective. Improved member and practitioner satisfaction results based on surveys and other satisfaction data, including but not limited to: <u>Member</u> Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Member Grievances <u>Practitioner Survey</u> Provider Satisfaction Survey	Complete annual Member and Practitioner Satisfaction surveys to assess satisfaction with UM Process. Assess annual satisfaction survey outcomes. Utilize the CalViva Health Dashboard on a monthly basis as a tool for systematic oversight of Grievance trends.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The MY2025 Regulatory CAHPS member satisfaction surveys were successfully conducted during Q1 and Q2 of 2026. Member grievances continued to be tracked and monitored on a monthly and quarterly basis to identify trends and opportunities for improvement. Findings related to member and practitioner satisfaction with UM processes were reviewed with the A&G Workgroup, resulting in ongoing evaluation of potential drivers and process improvement opportunities. In support of regulatory and quality improvement reporting requirements, the CAHPS Program Manager III will prepare the NCQA Standard ME7 report. CalViva Health will present the findings and related analysis to the QI/UM Committee in Q4 2026 to support oversight of member experience and UM program performance. The 2026 annual Provider Satisfaction Survey administration period was April to June 2026. Overall Provider Satisfaction is at 63%, which is 5 points above the national average for Centene. The Plan continues to monitor feedback from annual satisfaction survey and monthly pulse surveys to providers. The plan reviewed authorization decision materials for clarity of decision and identify opportunities for improvement.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance.	☒ Medi-Cal	Health Net Central Medical Directors and PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting. ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days. 2026 Goals: • TBD	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data and predictive modeling to identify high cost/high utilizing members to target for care management. The UM team will continue transitional care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care post-acute care settings, including recuperative care, short-term post hospitalization housing, Residential Care Facilities for the Elderly (RCFE), Adult Residential Facilities (ARF) and other settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Support on-site and telephonic enrollment of members into programs such as CalAim, Complex Care Management and Community Supports. Explore areas for additional on-site support (non - clinical). Establish 2026 Utilization goals in Q1-2026	Ongoing 03/31/2026

<table>
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<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout the first 6 months of 2026.

<u>Key Indicator Report thru June 2026:</u>
<table>
<tr><th>Metric</th><th>2025</th><th>2026 Q1-Q2</th><th>% Change</th></tr>
<tr><td>Admits PTMPY</td><td>38.1</td><td>41.3</td><td>+8.40%</td></tr>
<tr><td>Bed Days Acute PTMPY</td><td>188.4</td><td>204.3</td><td>+8.44%</td></tr>
<tr><td>ALOS Acute</td><td>4.9</td><td>4.9</td><td>0.00%</td></tr>
<tr><td>Readmit 30 Day</td><td>12.1</td><td>13.5</td><td>+11.57%</td></tr>
</table>
2026 Utilization goals established in Q1-2026:
• Target ALOS below 5.0 days by year-end 2026 through enhanced concurrent review, timely clinical escalation, and improved discharge planning. reduce 30-day inpatient readmissions by 2-3% year-over-year by the end of CY 2026 through strengthened transitions of care and targeted care management, with quarterly monitoring.

Compared with the 2025 averages, Q1 2026 readmissions were elevated for MCE and SPD populations and increased further in Q2, while TANF rates improved in Q2 after a higher Q1 rate.

30-day inpatient readmissions show increase in 2026. Opportunities remain to further strengthen transitions of care, provider engagement, and member adherence to post-discharge plans, which may contribute to increased inpatient utilization and readmission activity.</td>
<td>• Increased inpatient utilization among members with complex medical and behavioral health conditions.
• Limited member engagement with post-discharge care plans and follow-up appointments.
• Challenges coordinating services across multiple providers and care settings for high-risk members.</td>
<td>The Plan partnered with Valley Children’s in Q2 in ongoing effort to support transition to lower level of care through onsite TCS.

• Continue utilization and case management support for care transitions and post-discharge follow-up.

• Require presentation of all inpatient cases with a length of stay greater than 30 days during Discharge Planning (DC) Rounds to identify barriers, escalation opportunities, and facilitate timely transitions of care.

• Implement a mandatory Case Management referral for all members readmitted within 30 days of discharge to support care coordination, post-discharge follow-up, and reduction of avoidable readmissions.

• Maintain collaboration between Utilization Management, Case Management, and facility partners to strengthen discharge planning processes and improve transitions of care.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics are reported quarterly, and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and Plan include SPD, MCE and TANF populations: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All cases readmits. 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. Health Net tracks PHM KPI quarterly including: • Percentage of members who had more ED visits than primary care visits within a 12-month period. • Percentage of members who had a primary care visit within a 12-month period. • Percentage of members with no ambulatory or preventive visit within a 12-month period.	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net (Central Valley) and Health Net Medi-Cal Statewide. PPGs with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPGs identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable, are reviewed at the regional joint operations meetings led by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. Direct network and PPG membership over/under utilization report includes ambulatory care measures (OP visits PTMPY, ED visits PTMPY) and selected surgical procedures PTMPY as markers of over-under utilization and is reported to CalViva MOM semi-annually in the MOM 18 PPG Dashboard. Adjust PHM KPI reporting per DHCS guidance as needed.	Ongoing

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<td>Annual Over-Under Utilization Management Report was presented to CalViva Health Q2-2026.

PPG UM data is shared at CalViva Management Oversight Meetings, every quarter.

Shifts in utilization were reviewed in quarterly JOMs with PPGs.

Specialty referral performance with utilization of top specialty by PPG is compared to regional standards in the quarterly delegation oversight dashboard.

Q4 2025 – Q1-2026 PPG Utilization:
<table>
<tr><th>PPG</th><th>Q</th><th>Admits/K</th><th>Bed Days/K</th><th>ALOS</th><th>% 30-Day Readmit</th><th>ER/K</th></tr>
<tr><td rowspan="2">B</td><td>Q4</td><td>73.7</td><td>337.1</td><td>4.58</td><td>15.2%</td><td>501.5</td></tr>
<tr><td>Q1</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">C</td><td>Q4</td><td>27.1</td><td>145.1</td><td>5.36</td><td>7.1%</td><td>412</td></tr>
<tr><td>Q1</td><td>29.3</td><td>70.4</td><td>2.4</td><td>40.0%</td><td>432</td></tr>
<tr><td rowspan="2">D</td><td>Q4</td><td>54.9</td><td>249.1</td><td>4.54</td><td>11.7%</td><td>445.7</td></tr>
<tr><td>Q1</td><td>64</td><td>279.4</td><td>4.37</td><td>12.7%</td><td>509.3</td></tr>
<tr><td rowspan="2">E</td><td>Q4</td><td>73.4</td><td>315.2</td><td>4.29</td><td>11.6%</td><td>477.1</td></tr>
<tr><td>Q1</td><td>78.5</td><td>350.6</td><td>4.47</td><td>13.2%</td><td>507.3</td></tr>
</table>
</td>
<td>Shifts in utilization patterns and variations in specialty referral performance among PPGs are ongoing challenges.

Variation in utilization among PPGs is partly reflective of demographic differences and access to inpatient care.

Of the four PPGs listed in the adjacent column, only one has instituted an ‘eConsult first’ policy.

To mitigate specialty access challenges, faster adoption of eConsults, greater leveraging of telehealth capabilities, wider provision of high-quality primary care and better triaging of specialty referrals (especially referrals that do not require surgical procedures) is needed.

When operationalized, closed loop referrals will provide better line of sight into referral utilization and reasons for delay.</td>
<td>HN promotes the use of Health Net Empowered Living Program (H.E.L.P.) for assisting providers with timely access to specialists.

HN continues to promote eConsult adoption with Federally Qualified Health Centers (FQHC) and PPGs, for timely access to specialty care.

Regional Medical Director advocates for better care coordination, member experience and value-based care by participating in interdisciplinary care team (ICT) meetings. RMD also convenes discussions with clinical leaders in acute care facilities across the region.

Annual Over/Under Utilization report was presented to CalViva UM/QI Work Group in May 2026.

Utilization data is shared with PPGs on a quarterly basis. In addition to HN generated high-utilizer reports (which have a time lag) PPGs are asked to supplement these with their own ED high utilizer and IP high utilizer reports. PPG reporting is closer to real time.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
3.3 PPG Profile and Vendor List	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM. The MOM 20 vendor list provides audit dates and findings for each vendor. For completed audits an audit summary is shared with the monthly report, detailing audit results. Issues identified during audits or via ongoing performance monitoring are included in the monthly MOM 20 update.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The PPG Profile Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN. The Health Net vendor audit and monitoring process includes annual auditing of delegates' policies and files and ongoing review of delegates' adherence to service level performance.	Ongoing

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<td>PPG monitoring activities are conducted monthly including tracking and trending of performance. Delegation Oversight monitors corrective action plans (CAPs) to ensure actions are implemented, documented and followed to completion. Both PPGs with CAPs have implemented an action plan to ensure compliance with denial letters/template.

Q1 & Q2 UM Authorization Timeliness Results:
- PPG A – Compliant – No CAPs issued.
- PPG B – Showed improved trends on non-compliance, back on track.
- PPG C – Non-Compliant in Q1 & Q2 – CAP issued Remediation/monitoring activities are in progress.
- PPG D – Compliant – No CAPs issued.

Q4 2025-Q1 2026 Prior Authorizations:
Q4-2025 PTMPY
<table>
<tr><th>PPG</th><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th></tr>
<tr><td>Total Auths</td><td>638</td><td>1,439</td><td>706</td><td>1,150</td><td>1,180</td></tr>
<tr><td>I-Net</td><td>508</td><td>1,393</td><td>686</td><td>1115</td><td>1142</td></tr>
<tr><td>OON</td><td>130</td><td>46</td><td>20</td><td>35</td><td>38</td></tr>
<tr><td colspan="6">TAT % Compliance</td></tr>
<tr><td>Urgent</td><td>99.83%</td><td>100.00%</td><td>80.00%</td><td>98.85%</td><td>99.96%</td></tr>
<tr><td>Routine</td><td>99.96%</td><td>99.95%</td><td>87.79%</td><td>99.74%</td><td>99.96%</td></tr>
</table>
Q1-2026 PTMPY
<table>
<tr><th>PPG</th><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th></tr>
<tr><td>Total Auths</td><td>771</td><td>1,734</td><td>935</td><td>1,577</td><td>1,605</td></tr>
<tr><td>I-Net</td><td>716</td><td>1,606</td><td>890</td><td>1518</td><td>1545</td></tr>
<tr><td>OON</td><td>55</td><td>128</td><td>45</td><td>59</td><td>60</td></tr>
<tr><td colspan="6">TAT % Compliance</td></tr>
<tr><td>Urgent</td><td>100.00%</td><td>99.75%</td><td>93.33%</td><td>98.42%</td><td>99.88%</td></tr>
<tr><td>Routine</td><td>99.98%</td><td>100.00%</td><td>99.76%</td><td>92.37%</td><td>99.96%</td></tr>
</table>
</td>
<td>• PPG B – Routine Decision & Member Notification TAT was non-compliant Staffing and workflow issues.
• PPG C - Routine Decision & Member Notification TAT was non-compliant. Delegate has changed MSO relationship. Monitoring and working with new MSO to oversee performance trends.</td>
<td>• The Plan continued monitoring of open PPG CAPs.
• PPG B Workflow is being evaluated to determine root cause and appropriate remediation activities.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
<tr><td>Annual Evaluation</td><td></td><td></td><td></td><td></td></tr>
</table>

☐ MET OBJECTIVES ☐ CONTINUE ACTIVITY IN 2027				

4. Monitoring Coordination with Other Programs

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner, optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report including PHM Key Indicators to track and trend Care Management activities and acuity levels monthly. Utilize stratified health risk assessment data to identify high-risk members and engage them in care management programs. Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction o Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and o Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge.	Dedicated staff of RNs, LCSWs, Care Navigators, Care Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group. Transitional Care Services staff to do onsite bedside enrollment of members into TCS program at Hospital/Facilities. TCS to transition members into Physical Health (PH) or Behavioral Health (BH) CM teams after immediate discharge needs have been met. Collaboration with PPGs, Providers, Facilities on members who would benefit from Care Management to support appropriate interventions and improve member outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The Plan continued monthly new member outreach reports for care management assessment and measures, tracks, and trends care management interventions resulting from triage processes. Number of Health Information Forms (HIFs) completed in January-June by members and returned was 3,178 and 944 members subsequently referred to Care Management through June. Total number of members managed through June across physical, behavioral health, and Transitional Care Services programs was 4,377. Outcome measures include readmission rates, Emergency Department (ED) utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Physical Health, Behavioral Health, & Transitional Care Services & 90 days after enrollment. Results reported in Q1 include members with active or closed cases on or between 1/1/2026 & 3/31/2026 & remained eligible 90 days after case open date. 573 members met criteria. Results of members managed: Number of admissions and readmissions was at 12.4% which is lower than the 5% goal Volume of ED claims/1000/year decreased by 845 (23%) which exceeds our new 20% reduction goal. Total health care costs reduction showed reduction in inpatient costs, outpatient services, and in pharmacy costs. Care Team Satisfaction - Overall members were satisfied with the help they received from Case Management and reported the goals they worked on improved understanding of their health.	Low Member participation in Satisfaction Survey	Launched shortened survey via texting platform in June	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES**				

☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Care Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPGs of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing. • 1st prenatal visit within the 1st trimester and • post-partum visits between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program. • pre-term delivery of high-risk members managed vs high risk members not managed.	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high-risk moms. Dedicated staff of RNs, Care Navigators, and Care Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Provide members with education about and referrals to Doulas throughout their pregnancy. Help members schedule prenatal and postpartum appts. Help members schedule their newborn child first well child exam visit and refer into our First Year of Life Program. Outcome measures are included in the CCM Quarterly reports and reviewed in Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group and QI/UM Committee.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The Plan continued ongoing outreach, assessment and monitoring of high-risk pregnant members in the first half of 2026. Through June 526 members managed in PCM program. Engagement rate for this program remains high at 66.9% through June. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 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 is compared to high-risk members not managed. Results reported in Q1 for 2026 demonstrated greater compliance in managed members for both measures and lower pre-term deliveries of high-risk members managed. • 4 members met the outcome inclusion criteria for prenatal visits; 5 members met preterm delivery criteria and 492 met post-partum visit criteria. • Members enrolled in the High-Risk Pregnancy Program demonstrated: o 14.6% greater compliance in completing the first prenatal visit within their first trimester, which is lower than the 8% goal. o 12.9% greater compliance in completing their post-partum visit which exceeds our 10% goal. o 6.6% less pre-term deliveries in high-risk members, which exceeds our 2% goal.	Low member participation in Satisfaction Survey	Launched shortened survey via texting platform in June.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES**				

☐ CONTINUE ACTIVITY IN 2027				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate and compassionate manner, optimizing emotional health and well-being and improving quality of life. Assisting members with Behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report on track and trend Case Management activities and acuity levels monthly. Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs. Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, and Care Navigators to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Partner with Health Net Behavioral Health Teams to increase referrals to BH CM team to support outreach to follow up with Members who were provided resources. Help members schedule appointments with BH CM providers and connect with resources in the community to meet Member's SDOH needs. Collaborate with ECM and CS providers to ensure warm hand off of members care plan needs. Provide guidance to ECM CM taking over members care related to benefits as appropriate. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI/UM Workgroup and QI/UM Committee.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1. Total number of members managed through June is 456. Calendar Year engagement rate 67.8%. Total Referrals to CM are monitored in the KIR which includes referrals from Impact Pro. Outcome measures include readmission rates, Emergency Department utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Behavioral Health Care Management & 90 days after enrollment. Results reported for Q1 include members with active or closed case on or between 1/1/2026 & 3/31/2026 and remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Care Services programs and are reported in 4.1.	Low member participation in CM Satisfaction Survey	Launched shortened survey via texting platform in June.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as pharmacy, medical claims, and referrals. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing monitoring of the chronic condition management program Annual presentation of disease management outcomes in the Annual Disease Management/chronic Condition Report.	Ongoing Q1 2026

<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The revised Disease Management Program launched in May 2025.

Through Q2 2026, 104 members participated in the Chronic Condition Disease Management Program. Ongoing monitoring activities were completed as planned. Annual disease management outcomes will be presented in Q3 2026.
.
Prevalence of top conditions within the PHM Pyramid as of Q4 2025. This data guides the types of disease management and health coaching programs that are offered.

<table>
<tr><th>Condition</th><th>Rank</th></tr>
<tr><td>Metabolic</td><td>22%</td></tr>
<tr><td>Cardiovascular</td><td>16.5%</td></tr>
<tr><td>Disorders of lipid metabolism</td><td>17.6%</td></tr>
<tr><td>Hypertension</td><td>13.4%</td></tr>
<tr><td>Diabetes</td><td>10.2%</td></tr>
<tr><td>Musculoskeletal pain</td><td>9.2%</td></tr>
<tr><td>Deficiency and other anemia</td><td>8.3%</td></tr>
<tr><td>Respiratory</td><td>8.8%</td></tr>
<tr><td>Liver Disease</td><td>5.7%</td></tr>
<tr><td>Dependency</td><td>5.7%</td></tr>
<tr><td>Mood depression</td><td>5.3%</td></tr>
<tr><td>Alcohol-related/substance-related disorders</td><td>5.0%</td></tr>
<tr><td>Cancer</td><td>4.1%</td></tr>
</table>

Krames on Demand Health Coaching video was developed and launched as an additional resource.</td>
<td>The transition away from MicroStrategy (June 2025) to Power BI caused some data alignment issues in reporting on program engagement, outcomes, and market specific data.

2026 Reporting challenges associated with the transition from MicroStrategy to Power BI continue to impact data alignment and market-specific reporting.

None identified yet.</td>
<td>A job aid is being developed to align data sources. The Plan will be meeting with teams to resolve in Q3/Q4, however, teams are actively collaborating with Shared Services to resolve these issues. In support of these efforts, job aid is being developed to standardize data sources and reporting processes.

Meet with key members of plan; demo video resources and have the plan decide whether to add to their website.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

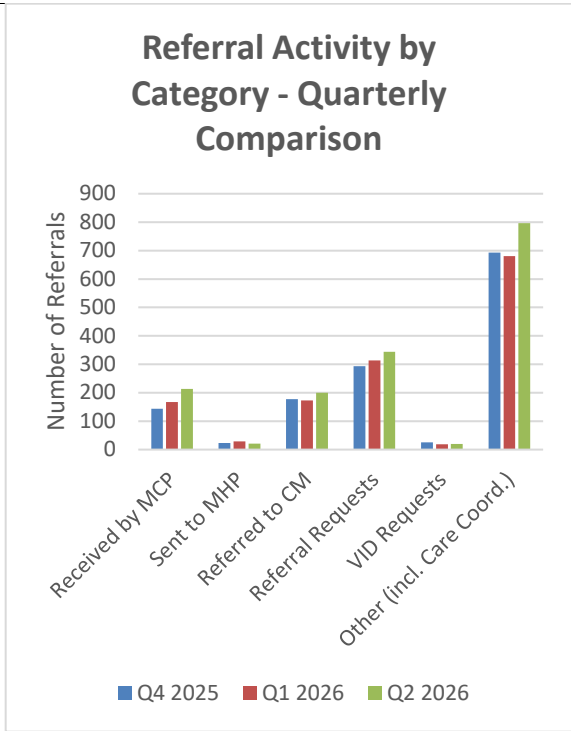
☐ CONTINUE ACTIVITY IN 2027</td>
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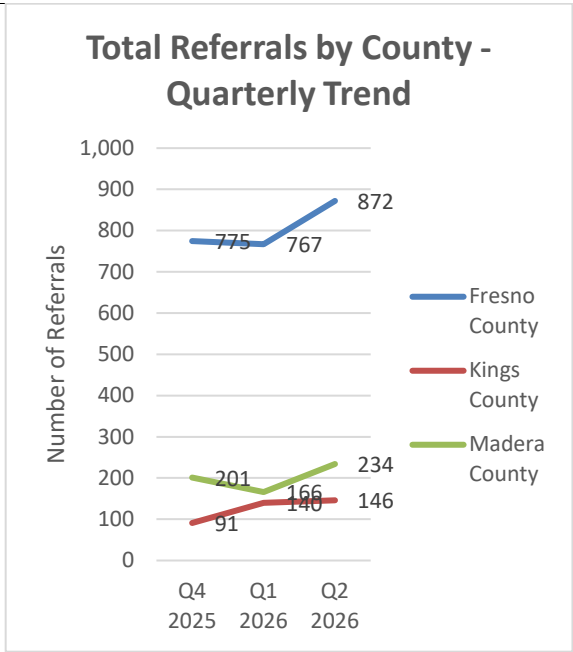
Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2026 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	State Health Program (SHP) MDs, the Health Net Pharmacy Advisory Committee (PAC) and the CalViva Health Chief Medical Officer work with Pharmacy Department to refine the injectable guidelines for medical benefit drugs to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to improve CCS ID using pharmacy data.	Monthly report on PA requests.	Continued active engagement with pharmacy. CVH UM/QI reporting based on Medical Benefit drug review. DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

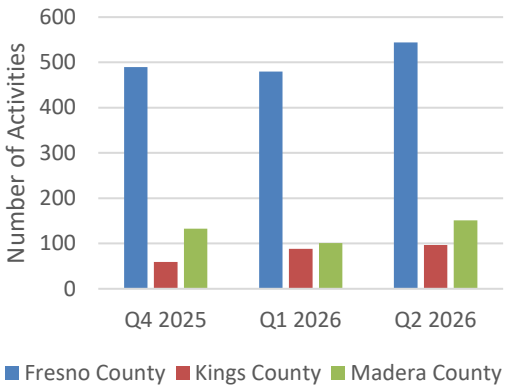
Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	On track/target with all metrics. All QI/UM Committee reporting up to date and above or at threshold. No unusual PA trends or A&G trends of concern. Annual CMS DUR survey submitted and accepted by DHCS June 2026.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

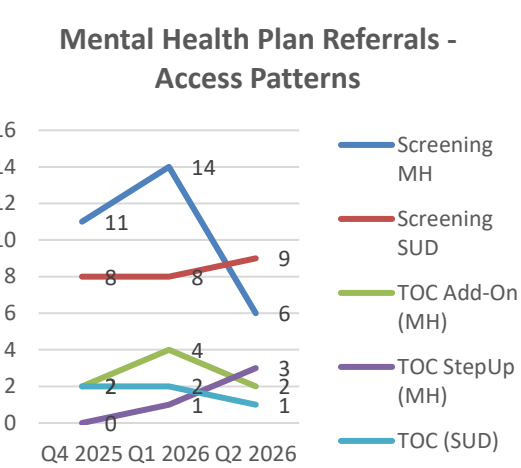
Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that the behavioral health team staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health team provides. BH referrals to/from each county are monitored and reported quarterly to QI UM Work Group	Ongoing

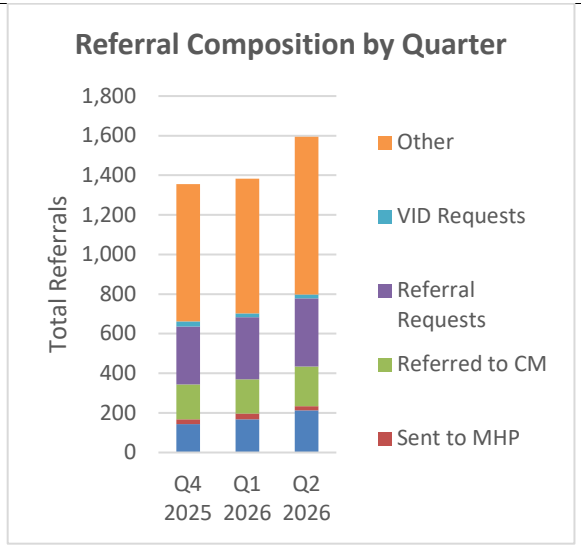
Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	**KEY FINDINGS & ANALYSIS** • POSITIVE: Member Declined cases dropped 55% (11 → 5), suggesting improved engagement • Kings County shows zero 'Member Declined' cases - potential best practice model **OVERALL TRENDS** • Total referral activity increased 17.3% from Q4 2025 (1,067) to Q2 2026 (1,252) • Strongest growth in 'Received by MCP' category: +47.9% (144 → 213) • Referral Requests show steady growth: +17.4% overall (293 → 344) • Care Coordination activities increased 16.1% (682 → 792), indicating active member engagement **COUNTY PERFORMANCE** • Fresno County dominates volume at 69.6% of Q2 2026 referrals (872 of 1,252) • Kings County shows strongest growth: +60.4% (91 → 146), indicating improved access/outreach • Madera County grew 16.4% (201 → 234), with notable Care Coordination increase (+13.5%) **CARE COORDINATION ACTIVITY** • Care Coordination is the largest activity category (63% of 'Other' in Q2 2026) • All counties show growth: Fresno +11%, Kings +64%, Madera +14% • Strong correlation between Care Coordination volume and overall referral success • Kings County's 64% Care Coordination growth aligns with their overall 60% referral increase	MHP referrals declined in Q2 2026 (21) from Q1 peak (29) MH Screening sent to MHP dropped significantly: 14 in Q1 → 6 in Q2 (57% decline)	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

	 Referral Activity by Category - Quarterly Comparison Number of Referrals 900 800 700 600 500 400 300 200 100 0 Received by MCP Sent to MHP Referred to CM Referral Requests VID Requests Other (Incl. Care Coord.) Q4 2025 Q1 2026 Q2 2026			

	 Total Referrals by County - Quarterly Trend Number of Referrals 1,000 900 800 700 600 500 400 300 200 100 0 775 767 872 201 166 234 91 140 146 Q4 2025 Q1 2026 Q2 2026 Fresno County Kings County Madera County			


Care Coordination Activity by County
Number of Activities
600
500
400
300
200
100
0
Q4 2025
Q1 2026
Q2 2026
Fresno County
Kings County
Madera County


Mental Health Plan Referrals - Access Patterns
16
14
12
10
8
6
4
2
0
Q4 2025
Q1 2026
Q2 2026
Screening MH
Screening SUD
TOC Add-On (MH)
TOC StepUp (MH)
TOC (SUD)

				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: ABA Authorization volume Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios --- Authorization Decision Timeliness: goal 100% with corrective action initiated at <95%	Participate in cross functional team to improve quality of behavioral health care. Consistent monitoring of performance measures to ensure continued compliance.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Authorization Decision Timeliness: Q1&Q2: 99.7& in TAT and 5.4 average days to TAT. PQI: 1 non-ABA case for this period. Provider Disputes: **Strong Resolution Rate Maintained** • Both quarters achieved ~99.7% resolution within 45 working days. • Well above the 95% threshold requiring corrective action. Q1 Results: 99.68% resolved within 45 business days. No major variance noted in the data". Will continue to observe and report any significant fluctuations and reasons behind them. Q2 Results: 99.67 % resolved within 45 business days. No major variance noted in the data". Will continue to observe and report any significant fluctuations and reasons behind them.	Auth Decision TAT: None PQI: None Provider Disputes: None	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
	Network Availability: See below. Network Adequacy: Member Ratios: See below. Health Net's PNM Contracting & Network Development team continues to actively expand the network by recruiting: • Newly licensed providers entering the workforce, • Providers working with Health Net on a temporary basis, and • Providers currently contracted with other health plans. This recruitment effort includes providers offering telehealth services, which help mitigate the effects of not meeting geographic access standards and provider-to-member ratio standard.	The provider-to-member ratio standard for Psychiatrists, Psychologist, and Master Level practitioners was not met due to a limited number of providers in CalViva Health counties. There were 3 member grievances regarding network availability in Q1 2026, all 3 grievances were resolved.		

Standards/Performance Goal:

Table 2. DHCS Mental Health Network Adequacy CalViva Health Standards

Provider Type	Network Adequacy Standards	Performance Threshold
Psychiatry (Adult/Pediatric)	Fresno, Kings, Madera: 45 miles/75 min	100%
Non-Specialty Mental Health Providers (Adult/Pediatric)	Fresno, Kings, Madera: 45 miles/75 min	100%

Table 3. DMHC Mental Health Network Adequacy CalViva Health Standards

Provider Type	Network Adequacy Standards	Performance Threshold
Psychiatry	Fresno, Kings (Metro): 20 miles [1] Madera (Micro): 55 miles	90%
Mental Health Professional (MHP)	Fresno, Kings (Metro): 15 miles [2] Madera (Micro): 35 miles	90%

[1] Alternative Low Density Psychiatry ZIP Code Standard 35 miles
[2] Alternative Low Density MHP ZIP Code Standard 20 miles

Table 4. Ratio of Mental Health to Member Standards

Provider Type	Performance Threshold
Member to Psychiatrists	5,000: 1
Member to Psychologist	2,300: 1
Member to Masters Level practitioner	1,150: 1
Member to BCBA	5,000: 1
Member to BCaBA	5,000: 1

Table 5. Mental Health Open Practice Standards

Open Practice Standards	Performance Threshold
Mental Health Providers	85%

[*] Includes masters-level providers, psychologists, and excludes psychiatrists and

Results:

Network Adequacy DHCS:

Network Adequacy results for Psychiatry and Non-Specialty Mental Health Providers. Proportion of members residing within standard.

County	Network Adequacy Standards	Performance Threshold	Adult Psychiatry Access %		Pediatric Psychiatry Access %		Adult Non-Specialty Mental Health Providers Access %		Pediatric Non-Specialty Mental Health Providers Access %	
			Q4 '25	Q1 '26	Q4 '25	Q1 '26	Q4 '25	Q1 '26	Q4 '25	Q1 '26
Fresno	45 miles/75 min	100%	**94.6%**	**99.6%**	**94.6%**	**99.6%**	**100%**	**100%**	**100%**	**100%**
Kings	45 miles/75 min	100%	**92.8%**	**100%**	**92.8%**	**100%**	**100%**	**100%**	**100%**	**100%**
Madera	45 miles/75 min	100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

All Adult and Pediatric Psychiatry and Non-Specialty Mental Health Providers not meeting standards Alternative Access has been requested through the 2025 Annual Network Certification.

Network Adequacy DMHC:

Network Adequacy results for Psychiatry and Mental Health Professional. Proportion of m
standard.

County	Network Adequacy Standards	Performance Threshold	Psychiatry Access %		MHP Access %	
			Q4 '25	Q1 '26	Q4 '25	Q1 '26
Fresno	Psychiatry -20 miles [1] MHP - 15 miles [2]	90%	**91%**	**92.3%**	**83.8%**	**83.8%**
Kings	Psychiatry20 miles [1] MHP - 15 miles [2]	90%	**67.5%**	**96.6%**	**98.6%**	**98.6%**
Madera	Psychiatry 55 miles MHP – 35 miles	90%	**100%**	**100%**	**100%**	**100%**

[1] Alternative Low Density Psychiatry ZIP Code Standard 35 miles
[2] Alternative Low Density MHP ZIP Code Standard 20 miles

MHP in Fresno is below distance standards.

	Ratio of Mental Health to Member: Summarizes Mental Health providers to member ratio results. **Provider Type** / **Performance Threshold** / **Compliance (%)** Q4 '25 / Q1 '26 Member to Psychiatrists: 5,000: 1 / 6,707: 1 / 6,312: 1 Member to Psychologist: 2,300: 1 / 8,623: 1 / 8,679: 1 Member to Master Level practitioner: 1,150: 1 / 2,360: 1 / 1,843: 1 Member to BCBA: 5,000: 1 / 1,033: 1 / 951: 1 Member to BCaBA: 5,000: 1 / 400: 1 / 483: 1 Psychiatrist, Psychologist and Master Level practitioner are below standards. For Q1 2026 improvement in Master Level practitioner due to additional providers added to t ***Mental Health Open Practice:*** Summarizes Mental Health providers open practice results. **Open Practice Standards** / **Performance Threshold** / **Compliance (%)** Q4 '25 / Q1 '26 Mental Health Providers: 85% / 93.7% / 93.5% * Includes master-level providers, psychologists, and excludes psychiatrists and autism providers.			
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
4.8 Enhanced Care Management	☒ Medi-Cal	Demonstrate 12-month growth in percentage of members receiving ECM. Members who do not meet ECM criteria will be referred to alternative programs or care management. Notice of Action Letters (NOA) are distributed to members being disenrolled from ECM	Quarterly monitoring of ECM enrollment including break out of ECM enrollment for adults and children. Achieving 1% enrollment	ECM program enrollment rates by county are reported quarterly CalViva Health (CVH) UM/QI Committee and CVH Medical Operations Management Meeting (MOM). The Plan will implement NOA letters for members being disenrolled from ECM Q1-2026 and implement quarterly audits Q2-2026.	Ongoing Q2-2026 and Ongoing

<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>ECM program enrollment rates by county are reported quarterly CalViva Health (CVH) UM/QI Committee and CVH Medical Operations Management Meeting (MOM).

Since February 2026, Health Net/CVH has advanced a targeted "Getting to 1%" strategy to increase ECM penetration through provider incentives, enhanced referral and outreach processes, community partnerships, and focused enrollment efforts for high-opportunity populations, particularly Children and Youth. These interventions are being implemented throughout 2026 to improve enrollment conversion, increase the percentage of members receiving ECM, and demonstrate sustained 12-month growth consistent with DHCS requirements.

For CVH, adult ECM penetration in Fresno, Kings, and Madera counties have met the DHCS 1% benchmark as of February 2026. Remaining opportunities are concentrated within Children & Youth populations, where all three counties are performing near the target but require additional enrollment growth to consistently meet the 1% threshold.

NOA letters for members being disenrolled from ECM were implemented Q1-2026 and the Plan implemented quarterly audits Q2-2026.

NOA Audit Data, Results (Benchmarks/Thresholds)
Acceptable Compliance Threshold: ≥95%

Target Compliance Rate: 100%
<table>
<tr><th>Audit Month</th><th>Yes</th><th>No</th><th>N/A</th><th>Total Cases</th><th>Score</th></tr>
<tr><td>Feb-26</td><td>10</td><td>0</td><td>0</td><td>10</td><td>100%</td></tr>
<tr><td>Mar-26</td><td>10</td><td>0</td><td>0</td><td>10</td><td>100%</td></tr>
<tr><td>Apr-26</td><td>10</td><td>0</td><td>0</td><td>10</td><td>100%</td></tr>
<tr><td>May-26</td><td>10</td><td>0</td><td>0</td><td>10</td><td>100%</td></tr>
<tr><td>Jun-26</td><td>10</td><td>0</td><td>0</td><td>10</td><td>100%</td></tr>
</table>
</td>
<td>ECM growth has been slower than anticipated due to provider outreach capacity constraints and referral pathway challenges. These barriers increase the time required to identify, contact, engage, and enroll eligible members, particularly among Children and Youth populations, resulting in a longer timeline to achieve measurable increases in ECM penetration and sustain 12-month growth.</td>
<td>None</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
</table>

Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2026 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continue to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, care management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Continue to monitor Aging-out membership, identify 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Teams continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy.

The CCS identification rates for the CVH under 21 population continue to trend above 7% in all counties.

2026 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>8.60%</td><td>7.65%</td><td>8.35%</td><td>8.20%</td></tr>
<tr><td>Feb</td><td>8.60%</td><td>7.75%</td><td>8.42%</td><td>8.26%</td></tr>
<tr><td>Mar</td><td>8.57%</td><td>7.73%</td><td>8.43%</td><td>8.24%</td></tr>
<tr><td>Apr</td><td>8.58%</td><td>7.70%</td><td>8.47%</td><td>8.25%</td></tr>
<tr><td>May</td><td>8.50%</td><td>7.77%</td><td>8.46%</td><td>8.24%</td></tr>
<tr><td>Jun</td><td>8.66%</td><td>7.90%</td><td>8.62%</td><td>8.39%</td></tr>
</table>
</td>
<td>We are seeing some denials from Madera and Kings County related to SAR submissions that do not appear to follow the APL 16-008 related to NICU and other IP Admissions. We are taking advantage of the Reconsideration Process for resolution however we still receive denials. We have engaged DHCS for further support and will continue to monitor for resolution.</td>
<td>Reconsiderations will continue to be submitted. We have recently engaged DHCS for further support and resolution of these denials.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2027</td>
<td></td><td></td><td></td><td></td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2026 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements.	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach.	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Care Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for Integrated Case Management (ICM) as noted under 4.1. 842 Seniors and Persons with Disabilities (SPD) (Supplemental Security Income Dual and Non-Dual). This includes Physical Health Care Management, Behavioral Health Care Management, Transitional Care Services & Obstetrics Care Management, as well as both complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time). 10,367 members were outreached with 904 HRA's completed from January through June 2026. Responded to all requests within the audit process regarding HRA's performance. Continue monthly meetings with the outreach team to review the HRA process and align scripts, process and regulatory reporting requirements.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2027**				

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

Item #11
Attachment 11.A

Member Satisfaction Annual Regulatory
CAHPS Summary Report

Attachment R

PG Forsta

MY 2025 CAHPS® Medicaid Adult 5.1H Survey



CalViva (Centene CA)

Contents

- Overview
- Methodology
- Executive Summary
- Key Driver Analysis of Rating of Health Plan
- Measure Analysis
- Summary of Trend and Benchmarks
- Appendix

Project Manager

Julia Schneider

Julia.Schneider@pressganey.com

Should you have any questions or comments regarding any aspect of the survey or reporting process, please feel free to email your Project Manager.

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Overview

Press Ganey (PG), a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor, was selected by CalViva (Centene CA) to conduct its MY 2025 CAHPS® 5.1H Medicaid Adult Survey.

Survey Objective

The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

NCQA Updates

- NCQA made no significant changes to the survey or program this year.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Methodology

First questionnaire mailed	Second questionnaire mailed	Initiate follow-up calls to non-responders	Last day to accept completed surveys
3/3/2026	**4/7/2026**	**4/28/2026 - 5/12/2026**	**5/13/2026**

QUALIFIED RESPONDENTS

Included beneficiaries who were…

- *18 years and older (as of December 31 of the measurement year)*
- *Continuously enrolled in the plan for at least five of the last six months of the measurement year*

RESPONSE RATE CALCULATION

$$\frac{285 \text{ (Completed)}}{2{,}147 \text{ (Sample)} - 13 \text{ (Ineligible)}} = \frac{285}{2{,}134} = 13.4\%$$

COMPLETES - MODALITY BY LANGUAGE

	Mail	Phone	Internet	*Internet Modes*			Total
				QR Code	Email	URL	
English	81	31	48	38	1	9	**160**
Spanish	66	30	29	28	0	1	**125**
Total	**147**	**61**	**77**	**66**	**1**	**10**	**285**

Total Number of Undeliverables: 135

Note: Respondents were given the option of completing the survey in Spanish. In place of the English survey, a Spanish survey was mailed to members who were identified by the plan as Spanish-speaking. A telephone number was also provided on the survey cover letter for all members to call if they would like to complete the survey in Spanish.

RESPONSE RATE TRENDING

		2024	2025	2026
Completed	**SUBTOTAL**	**--**	**500**	**285**
Ineligible	Does not Meet Eligibility Criteria (01)	--	19	9
	Language Barrier (03)	--	13	2
	Mentally/Physically Incapacitated (04)	--	6	1
	Deceased (05)	--	1	1
	SUBTOTAL	**--**	**39**	**13**
Non-response	Break-off/Incomplete (02)	--	32	12
	Refusal (06)	--	60	16
	Maximum Attempts Made (07)	--	3,554	1,821
	Added to DNC List (08)	--	0	0
	SUBTOTAL	**--**	**3,646**	**1,849**
Total Sample		**--**	**4,185**	**2,147**
Oversampling		**--**	**210.0%**	**59.0%**
Response Rate		**--**	**12.1%**	**13.4%**
PG Response Rate		***11.1%***	***11.7%***	***11.3%***

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Executive Summary



Overview of Terms

Summary Rates (SRS) are defined by NCQA in its HEDIS MY 2025 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

Percentile Rankings Your plan's approximate percentile rankings in relation to the Quality Compass® All Plans benchmark were calculated by Press Ganey using information derived from the NCQA 1-100 Benchmark.



PG Benchmark Information The source for data contained within the PG Book of Business is all submitting plans that contracted with PG for MY 2025. Submission occurred on May 26th, 2026.

NCQA Benchmark Information The source for data contained in this publication is Quality Compass® All Plans 2025. It is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

Small Denominator Threshold NCQA will assign a measure result of NA to overall ratings or composites with a denominator (i.e., the average number of responses across all questions used to calculate the composite) less than 100.

Technical Notes Please refer to the Technical Notes for more information.

Significance Testing All significance testing is performed at the 95% confidence level using a t-test for mean scores and z-test for percentages. The following notation is used to highlight significant differences.

Comparisons to previous year (↑/↓)
Comparisons over 2 years (↕/↕)
Comparisons to benchmarks (▲/▼)

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2026 Dashboard

Medicaid Adult

285

Completed surveys

13.4%

Response Rate

Stars: PG **Estimated** NCQA Rating
NA = Denominator < 100

Scores: All scores displayed are Summary Rate Scores
- Rating: % 9 or 10
- Composites: % Usually or Always
- Smoking: % Always, Usually, or Sometimes

Significance Testing: Current score is significantly higher/lower than 2025 (↑/↓) or 2024 (↕/↕).

Percentiles: Based on the 2026 PG Book of Business

Health Plan Key Driver Classification: Details can be found in the KDA section.

Rating of Health Plan			★★★
Q28. Rating of Health Plan	63.2%	45th	--

Rating of Health Care			★★
Q8. Rating of Health Care	54.3%	23rd	Opportunity

Rating of Personal Doctor			
Q18. Rating of Personal Doctor	71.3%	44th	Opportunity

Advised to Quit Smoking: 2YR			
Q32. Advised to Quit Smoking: 2YR	63.3%	11th	--

Rating of Specialist			
Q22. Rating of Specialist	66.7%	32nd	Opportunity

Coordination of Care			
Q17. Coordination of Care	86.0%	43rd	Opportunity

Customer Service			
Composite	**91.2%**	**72nd**	--
Q24. Provided information or help	86.6%	72nd	Retain
Q25. Treated with courtesy and respect	95.8%	65th	Retain

Getting Needed Care			★★
Composite	**78.8%**	**14th**	--
Q9. Getting care, tests, or treatment	83.4%	27th	Opportunity
Q20. Getting specialist appointment	74.1%	13th	Opportunity

Getting Care Quickly			★★
Composite	**76.7%**	**14th**	--
Q4. Getting urgent care	78.4%	15th	Wait
Q6. Getting routine care	75.0%	18th	Opportunity

Ease of Filling Out Forms			
Q27. Ease of Filling Out Forms	92.3%	5th	Wait

How Well Doctors Communicate			
Composite	**90.5%**	**2nd**	--
Q12. Dr. explained things	90.3%	11th	Wait
Q13. Dr. listened carefully	92.2%	20th	Opportunity
Q14. Dr. showed respect	92.2%	3rd	Wait
Q15. Dr. spent enough time	87.1%	4th	Wait

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Estimated NCQA Health Insurance Plan Ratings

Medicaid Adult

	Score Definition	Base	HPR Score*	HPR 4 Star Threshold	HPR Percentile Band	PG Estimated Rating
PATIENT EXPERIENCE						**2.5**
GETTING CARE						**2**
Getting Needed Care	Usually or Always	135	78.7%	84.5%	10th	**2**
Getting Care Quickly	Usually or Always	132	76.6%	84.3%	10th	**2**
SATISFACTION WITH PLAN AND PLAN SERVICES						**2.5**
Rating of Health Plan	9 or 10	277	63.1%	64.3%	33rd	**3**
Rating of Health Care	9 or 10	162	54.3%	59.7%	10th	**2**

***HPR scores** are **truncated** to three digits (XX.X%) according to the NCQA calculation protocol for Health Plan Ratings. Please note that scores on this slide may differ slightly compared to scores found throughout the rest of the report.

EXPLANATION

NCQA calculates health plan ratings (HPR) by evaluating plans in three categories: consumer satisfaction, clinical quality (includes prevention and treatment) and NCQA Accreditation Standards score.

The overall NCQA star rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization has NCQA Accreditation), rounded to the nearest half point.

The CAHPS measures are classified based on their national percentile (10th, 33rd, 67th and 90th) into scores ranging from 1 to 5 (in increments of 0.5), where 5 is the highest score and 1 is the lowest.

Results are summarized in the table to the left. **Percentiles and ratings are estimated by PG** based on the 2025 NCQA data and benchmarks.

Rating = 1	Rating = 2	Rating = 3	Rating = 4	Rating = 5
<10th Percentile	10th – 32nd Percentile	33rd – 66th Percentile	67th – 89th Percentile	≥90th Percentile

Notes:

- *NCQA will assign a measure result of NA to overall ratings or composites with a denominator (i.e., the average number of responses across all questions used to calculate the composite) less than 100.*
- *Medicaid plans have the option to be scored on either Adult CAHPS or Child CAHPS data.*

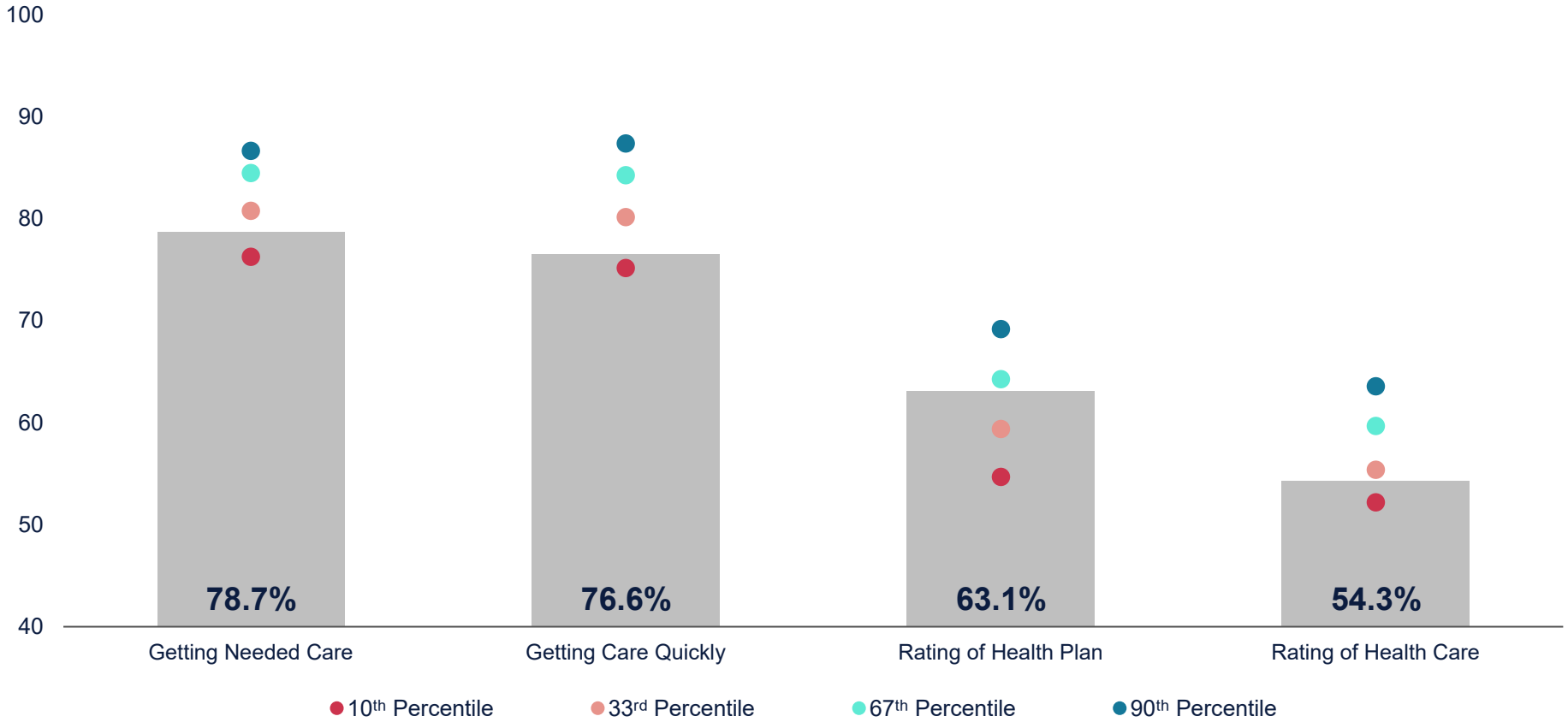
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Performance to Star Cut Points

Medicaid Adult

COMPARISON TO QUALITY COMPASS CUT POINTS

The graph shows how your plan's **Estimated Health Plan Rating (HPR) scores** used for accreditation ratings compare to the most recent Quality Compass thresholds published by NCQA (Fall 2025).



Dark Blue bar = Your plan's performance is at or above the 67th percentile

Light Grey bar = Your plan's performance is below the 67th percentile

HPR scores are **truncated** to three digits (XX.X%) according to the NCQA calculation protocol for Health Plan Ratings. Please note that scores on this slide may differ slightly compared to scores found throughout the rest of the report.

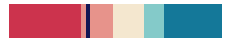
** Scores are % 9 or 10 and % Always or Usually.*

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Key Metric Performance

Medicaid Adult

Measure	Summary Rate Score 2025	Summary Rate Score 2026	Change	2026 Press Ganey BOB Benchmark Percentile Distribution (0 20 40 60 80 100)	Plan Percentile Rank	PG BOB
Health Plan Domain						
Q28. Rating of Health Plan	65.3%	**63.2%**	-2.2%		45th	63.7%
Getting Needed Care	75.9%	**78.8%**	2.9%		14th	83.0%
Customer Service	90.5%	**91.2%**	0.6%		72nd	89.6%
Q27. Ease of Filling Out Forms	93.5%	**92.3%**	-1.2%		5th	94.9% ▼
Health Care Domain						
Q8. Rating of Health Care	52.4%	**54.3%**	1.9%		23rd	58.4%
Getting Care Quickly	78.6%	**76.7%**	-1.9%		14th	82.5% ▼
How Well Doctors Communicate	90.6%	**90.5%**	-0.1%		2nd	93.8% ▼
Q17. Coordination of Care	87.2%	**86.0%**	-1.2%		43rd	87.0%
Q18. Rating of Personal Doctor	64.8%	**71.3%**	6.5%		44th	71.8%
Q22. Rating of Specialist	64.9%	**66.7%**	1.8%		32nd	69.3%

** Scores are % 9 or 10 and % Always or Usually.*

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Key Metric Performance

Medicaid Adult

Measure	Summary Rate Score 2025	Summary Rate Score 2026	Change	2026 Press Ganey BOB Benchmark Percentile Distribution (0 20 40 60 80 100)	Plan Percentile Rank	PG BOB
Effectiveness of Care: 2YR						
Q32. Advised to Quit Smoking: 2YR	67.3%	**63.3%**	-4.0%		11th	75.3% ▼
Q33. Discussing Cessation Meds: 2YR	30.0%	**34.4%**	4.4%		6th	54.9% ▼
Q34. Discussing Cessation Strategies: 2YR	29.2%	**36.0%**	6.8%		12th	50.4% ▼

** Scores are % Always, Usually, or Sometimes.*

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Measure Summary

Medicaid Adult

TOP 3 PERFORMING MEASURES

Your plan's percentile rankings for these measures were the highest compared to the PG Book of Business.

Measure	2026 Valid N	Plan			2025 Quality Compass			2026 Press Ganey BOB		
		2025	2026	Change	Score	Percentile	Gap	Score	Percentile	Gap
Customer Service	118	90.5%	**91.2%**	0.6%	89.3%	71st	1.9%	89.6%	72nd	1.5%
Q28. Rating of Health Plan	277	65.3%	**63.2%**	-2.2%	61.7%	56th	1.5%	63.7%	45th	-0.5%
Q18. Rating of Personal Doctor	202	64.8%	**71.3%**	6.5%	70.7%	53rd	0.6%	71.8%	44th	-0.5%

BOTTOM 3 PERFORMING MEASURES

Your plan's percentile rankings for these measures were the lowest compared to the PG Book of Business.

Measure	2026 Valid N	Plan			2025 Quality Compass			2026 Press Ganey BOB		
		2025	2026	Change	Score	Percentile	Gap	Score	Percentile	Gap
Getting Care Quickly	132	78.6%	**76.7%**	-1.9%	81.6%	16th	-4.9%	82.5% ▼	14th	-5.8%
Q32. Advised to Quit Smoking: 2YR	90^	67.3%	**63.3%**	-4.0%	73.4% ▼	3rd	-10.1%	75.3% ▼	11th	-12.0%
How Well Doctors Communicate	154	90.6%	**90.5%**	-0.1%	93.4%	5th	-2.9%	93.8% ▼	2nd	-3.3%

Scores: All scores displayed are Summary Rate Scores
- Rating: % 9 or 10
- Composites: % Usually or Always
- Smoking: % Always, Usually, or Sometimes

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Health Equity

Medicaid Adult

Group is performing…

- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	Category	Total	Rating of Health Plan		Rating of Health Care		Getting Needed Care		Getting Care Quickly		Rating of Personal Doctor		Rating of Specialist	
			SRS	△	SRS	△	SRS	△	SRS	△	SRS	△	SRS	△
			63.2%		54.3%		78.8%		76.7%		71.3%		66.7%	
Sex	Male	n=118		-3		-1		1		2		-4		-3
	Female	n=165		2		1		0		-1		2		2
Age	18-34	n=60		-14		-8		-11		-13		-14		0
	35-44	n=58		14		17		3		5		10		3
	45-54	n=53		-1		-1		-1		-2		-4		-7
	55+	n=110		1		-2		3		6		3		2
Overall Health	Excellent / Very Good	n=78		14		27		3		2		21		23
	Good	n=86		-5		-19		0		-3		-12		-6
	Fair / Poor	n=117		-5		-4		0		1		-5		-4
Mental Health	Excellent / Very Good	n=112		9		5		-2		-2		7		10
	Good	n=77		5		6		8		0		3		1
	Fair / Poor	n=90		-13		-9		-3		3		-10		-10
Education	High School or Less	n=209		4		1		1		-2		2		4
	Some College or More	n=61		-15		-4		-1		8		-13		-13
Race Ethnicity	White	n=107		-8		-9		1		2		-10		1
	Black / African American	n=16		-13		6		-6		2		20		-42
	Asian	n=18		-19		17		21		-35		-17		-7
	American Indian or Alaska Native	n=10		7		6		9		11		16		8
	Native Hawaiian or other Pacific Islander	n=25		-9		-26		-18		3		-8		-33
	Hispanic	n=192		6		5		0		2		5		2

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Health Equity

Medicaid Adult

Group is performing…

- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	Category	Total	Coordination of Care SRS	Coordination of Care △	Customer Service SRS	Customer Service △	How Well Doctors Communicate SRS	How Well Doctors Communicate △	Ease of Filling Out Forms SRS	Ease of Filling Out Forms △
			86.0%		91.2%		90.5%		92.3%	
Sex	Male	n=118		2		-2		-4		2
	Female	n=165		-1		1		2		-1
Age	18-34	n=60		0		-3		-4		-1
	35-44	n=58		0		3		4		4
	45-54	n=53		-3		0		2		0
	55+	n=110		3		1		0		-1
Overall Health	Excellent / Very Good	n=78		14		3		8		5
	Good	n=86		14		-2		-3		-1
	Fair / Poor	n=117		-11		-1		-3		-3
Mental Health	Excellent / Very Good	n=112		5		3		3		-1
	Good	n=77		7		-2		1		0
	Fair / Poor	n=90		-10		-4		-3		1
Education	High School or Less	n=209		0		-1		0		-2
	Some College or More	n=61		-3		4		-1		4
Race Ethnicity	White	n=107		-1		4		-3		0
	Black / African American	n=16		14		2		10		8
	Asian	n=18		-6		-20		-5		2
	American Indian or Alaska Native	n=10		14		9		10		8
	Native Hawaiian or other Pacific Islander	n=25		2		9		-7		8
	Hispanic	n=192		-1		0		1		-2

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Key Driver Analysis



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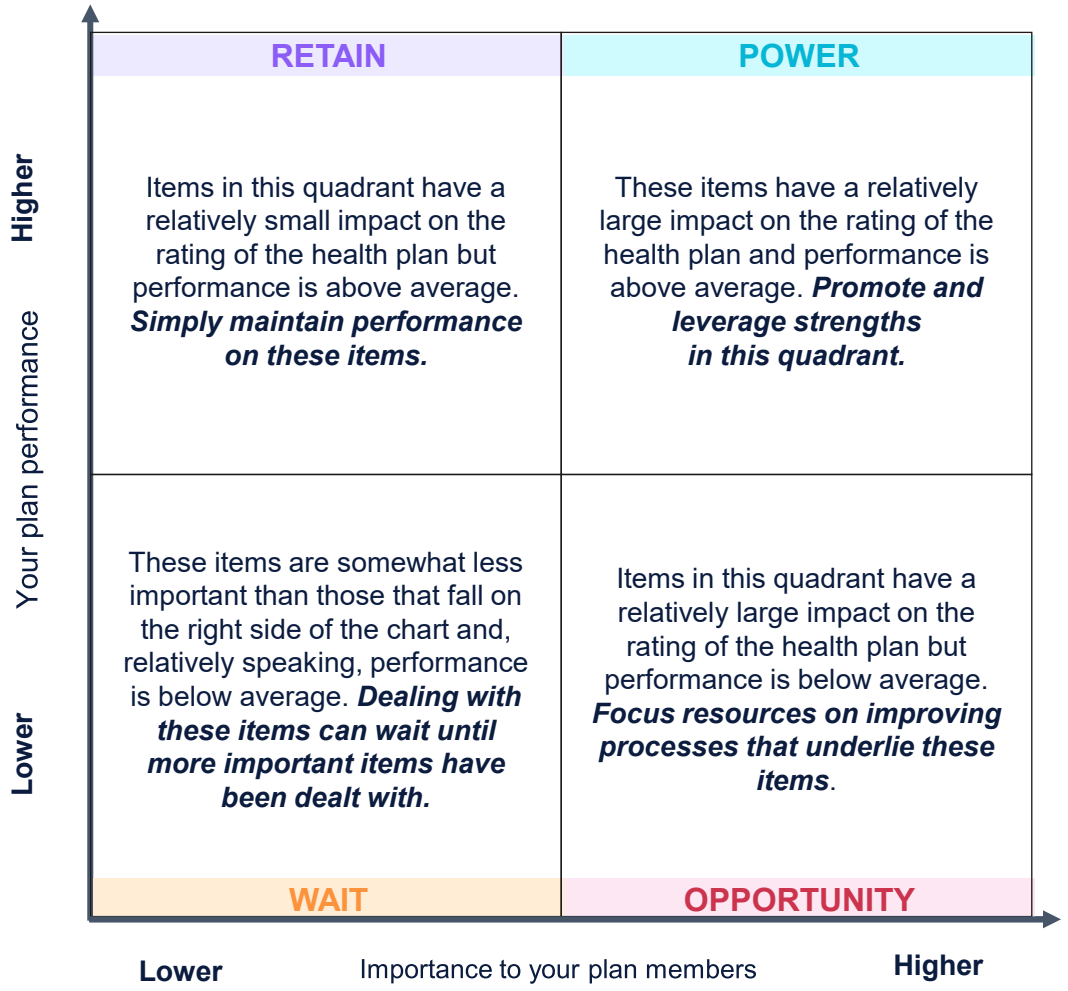
POWeR Chart

POWeR™ CHART CLASSIFICATION MATRIX

Overview. The SatisAction™ key driver statistical model is a powerful, proprietary statistical methodology used to identify the key drivers of the rating of the health plan and provide actionable direction for satisfaction improvement programs. This methodology is the result of a number of years of development and testing using health care satisfaction data.

The model provides the following:

- Identification of the elements that are important in driving of the rating of the health plan.
- Measurement of the relative importance of each of these elements.
- Measurement of how well members think the plan performed on those important elements.
- Presentation of the importance/performance results in a matrix that provides clear direction for member satisfaction improvement efforts by the plan.

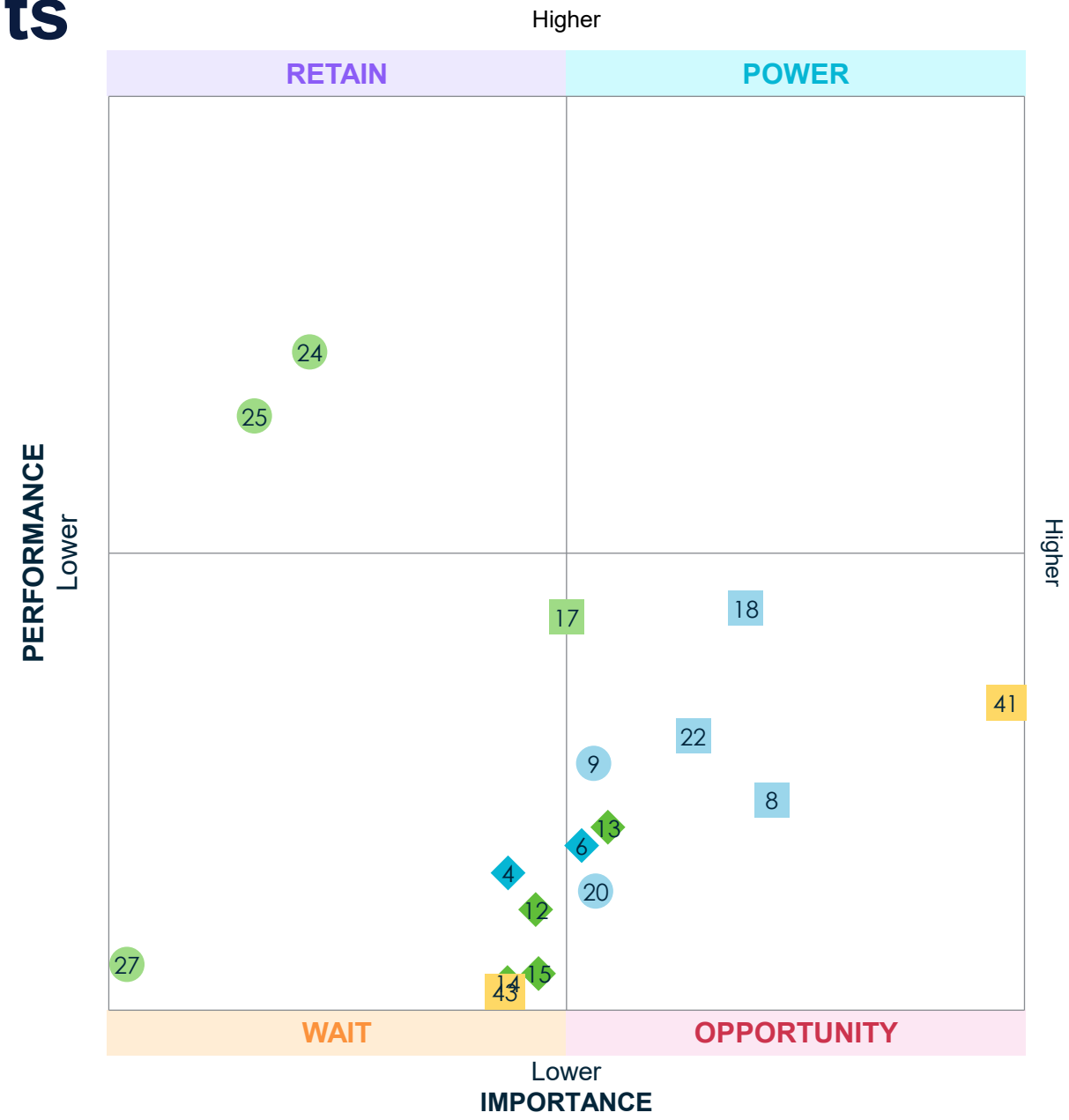


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POWeR Chart – Your Results

			SURVEY MEASURE	2024 SRS	2025 SRS	2026 SRS	2026 %tile
			POWER				
		--	None	--	--	--	--
			OPPORTUNITY				
■	SQ	**Q41**	Rating of provided interpreter overall	--	65.5%	**62.4%**	--
■	RATING	**Q8**	Rating of Health Care	--	52.4%	**54.3%**	23rd
■	RATING	**Q18**	Rating of Personal Doctor	--	64.8%	**71.3%**	44th
■	RATING	**Q22**	Rating of Specialist	--	64.9%	**66.7%**	32nd
◆	HWDC	**Q13**	Dr. listened carefully	--	92.0%	**92.2%**	20th
●	GNC	**Q20**	Getting specialist appointment	--	74.6%	**74.1%**	13th
●	GNC	**Q9**	Getting care, tests, or treatment	--	77.2%	**83.4%**	27th
◆	GCQ	**Q6**	Getting routine care	--	77.4%	**75.0%**	18th
■	CC	**Q17**	Coordination of Care	--	87.2%	**86.0%**	43rd
			WAIT				
◆	HWDC	**Q15**	Dr. spent enough time	--	87.2%	**87.1%**	4th
◆	HWDC	**Q12**	Dr. explained things	--	90.7%	**90.3%**	11th
◆	GCQ	**Q4**	Getting urgent care	--	79.7%	**78.4%**	15th
◆	HWDC	**Q14**	Dr. showed respect	--	92.4%	**92.2%**	3rd
■	SQ	**Q43**	Got appt. in a timely manner	--	67.9%	**64.1%**	--
●	CS	**Q27**	Ease of Filling Out Forms	--	93.5%	**92.3%**	5th
			RETAIN				
●	CS	**Q24**	Provided information or help	--	87.7%	**86.6%**	72nd
●	CS	**Q25**	Treated with courtesy and respect	--	93.3%	**95.8%**	65th

*Percentiles based on the Press Ganey BOB of the listed year.



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Measure Analysis

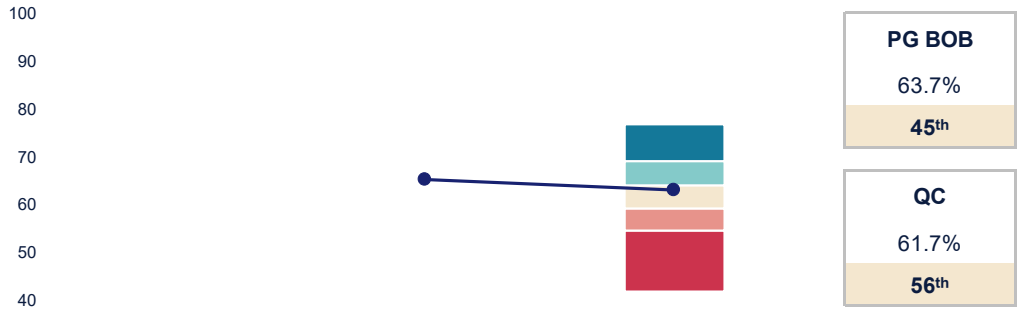


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Ratings

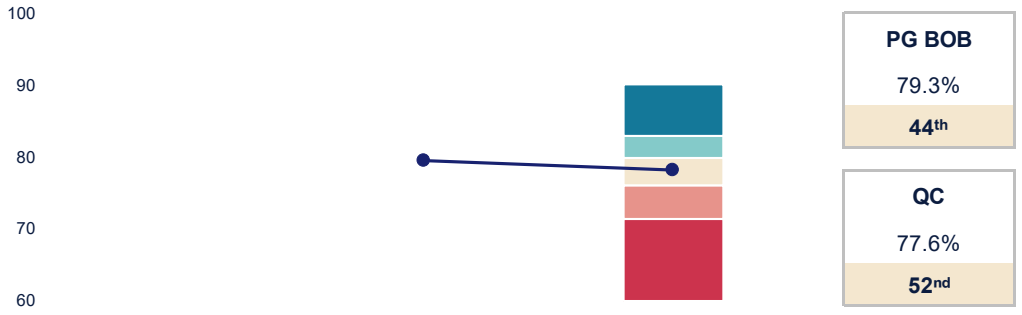
Medicaid Adult

Q28. Rating of Health Plan 9-10%



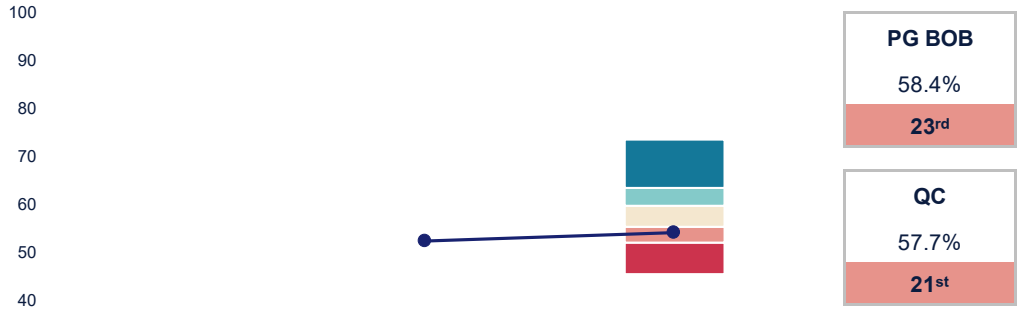
	2024	2025	2026
n	--	479	277
SRS 9-10%	--	65.3%	63.2%

Q28. Rating of Health Plan 8-10%



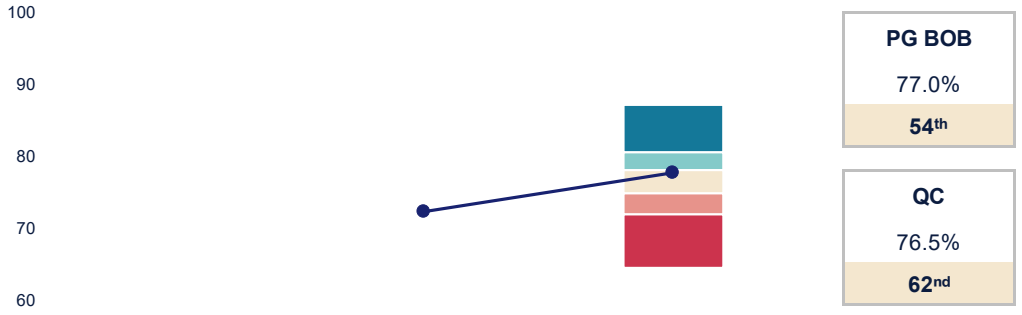
	2024	2025	2026
n	--	479	277
8-10%	--	79.5%	78.3%

Q8. Rating of Health Care 9-10%



	2024	2025	2026
n	--	290	162
SRS 9-10%	--	52.4%	54.3%

Q8. Rating of Health Care 8-10%



	2024	2025	2026
n	--	290	162
8-10%	--	72.4%	77.8%

Percentile Bands are for QC benchmark.

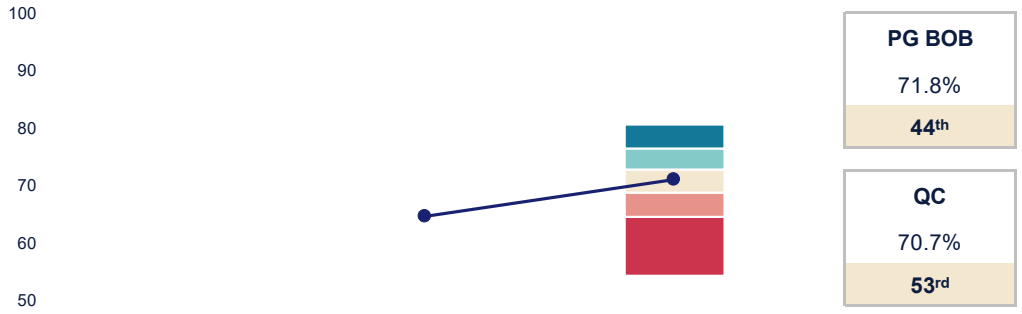
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Ratings

Medicaid Adult

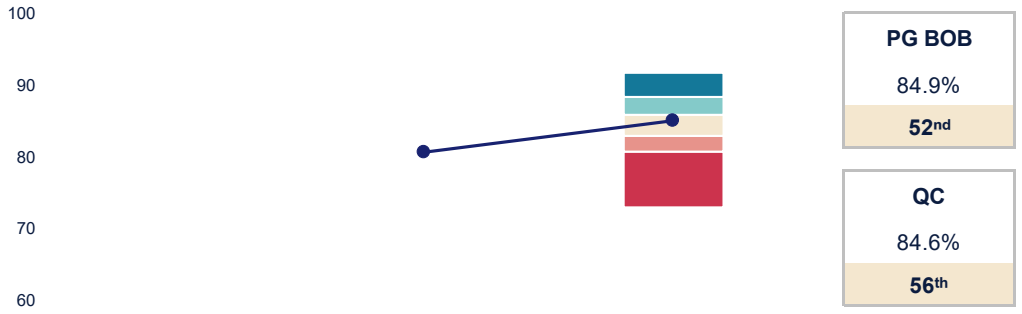
Q18. Rating of Personal Doctor 9-10%



	2024	2025	2026
n	--	358	202
SRS 9-10%	--	64.8%	71.3%

PG BOB	QC
71.8%	70.7%
44th	53rd

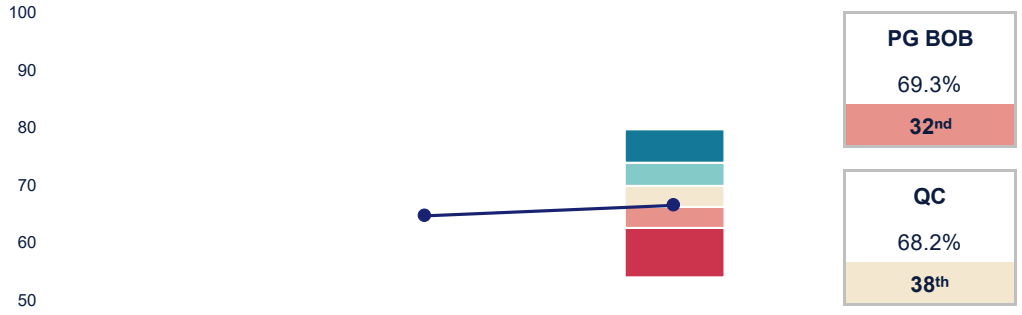
Q18. Rating of Personal Doctor 8-10%



	2024	2025	2026
n	--	358	202
8-10%	--	80.7%	85.1%

PG BOB	QC
84.9%	84.6%
52nd	56th

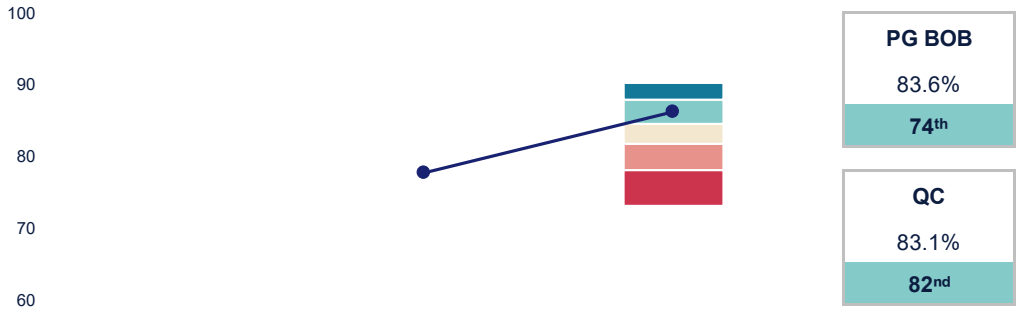
Q22. Rating of Specialist 9-10%



	2024	2025	2026
n	--	185	102
SRS 9-10%	--	64.9%	66.7%

PG BOB	QC
69.3%	68.2%
32nd	38th

Q22. Rating of Specialist 8-10%



	2024	2025	2026
n	--	185	102
8-10%	--	77.8%	86.3%

PG BOB	QC
83.6%	83.1%
74th	82nd

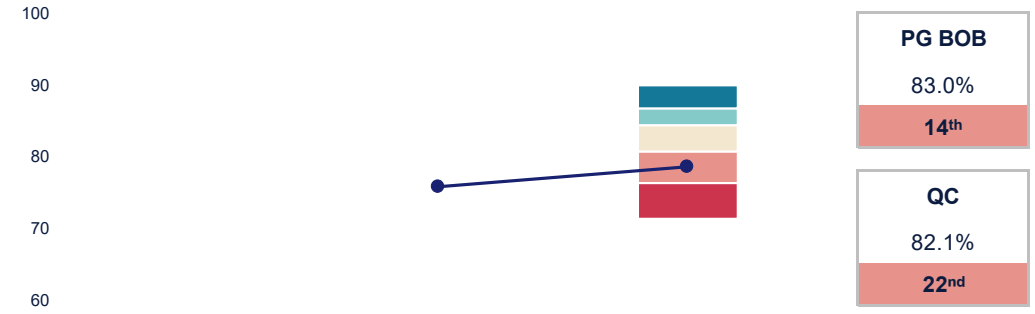
Percentile Bands are for QC benchmark.

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Getting Needed Care

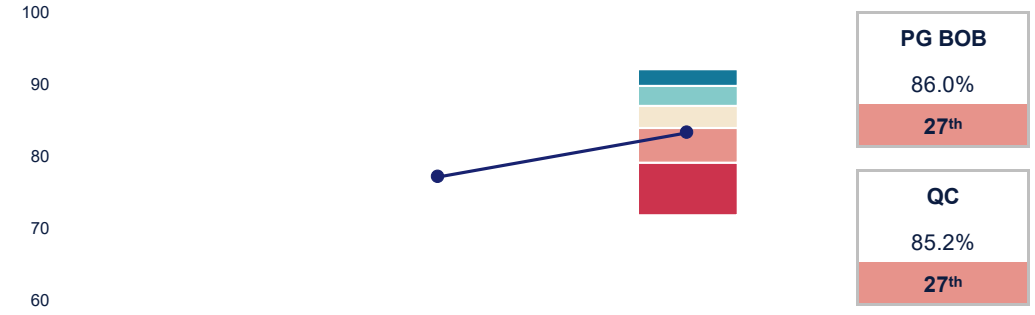
Medicaid Adult

Getting Needed Care



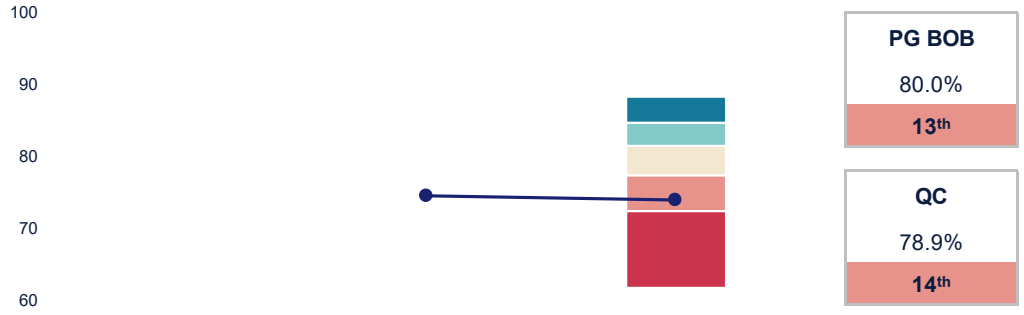
	2024	2025	2026
n	--	239	135
SRS	**--**	**75.9%**	**78.8%**

Q9. Getting care, tests, or treatment



	2024	2025	2026
n	--	285	163
SRS	**--**	**77.2%**	**83.4%**

Q20. Getting specialist appointment



	2024	2025	2026
n	--	193	108
SRS	**--**	**74.6%**	**74.1%**

Percentile Bands are for QC benchmark.

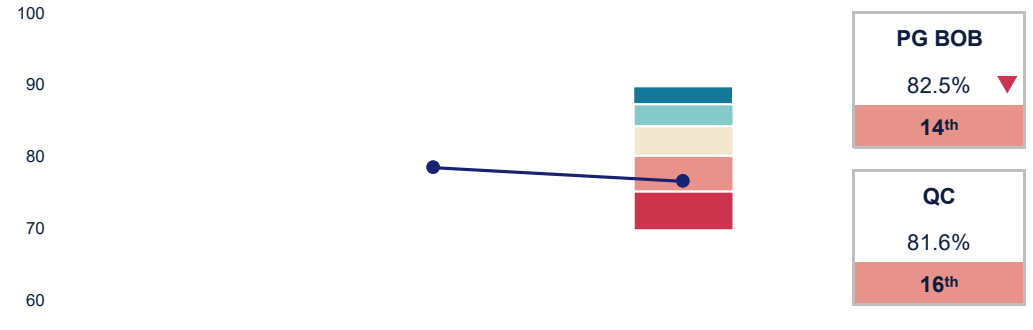
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Getting Care Quickly

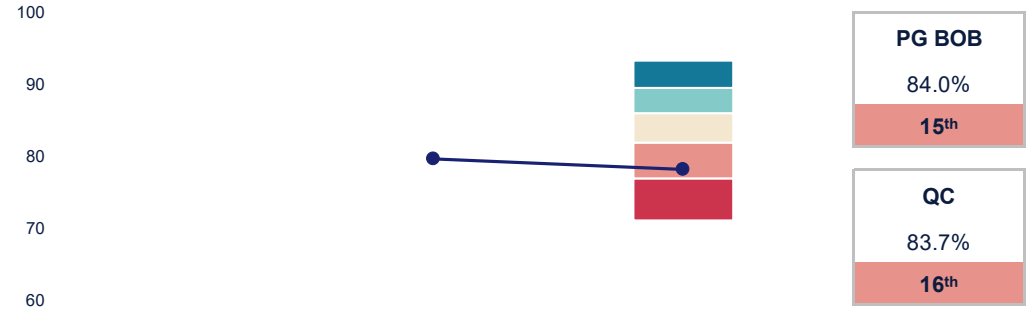
Medicaid Adult

Getting Care Quickly



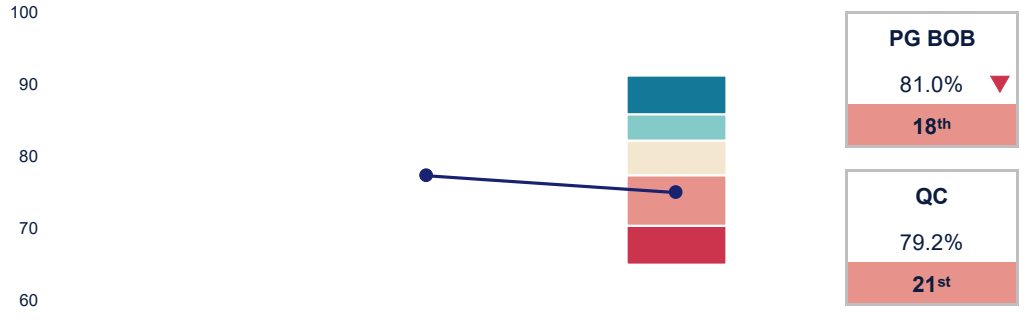
	2024	2025	2026
n	--	222	132
SRS	**--**	**78.6%**	**76.7%**

Q4. Getting urgent care



	2024	2025	2026
n	--	153	97^
SRS	**--**	**79.7%**	**78.4%**

Q6. Getting routine care



	2024	2025	2026
n	--	292	168
SRS	**--**	**77.4%**	**75.0%**

Percentile Bands are for QC benchmark.

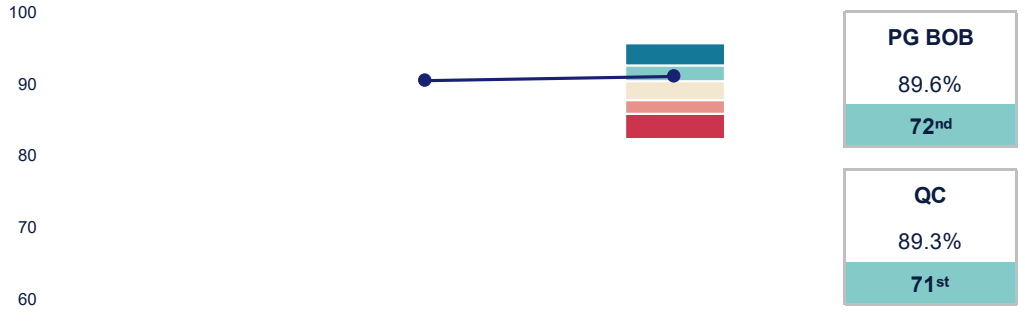
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Customer Service

Medicaid Adult

Customer Service

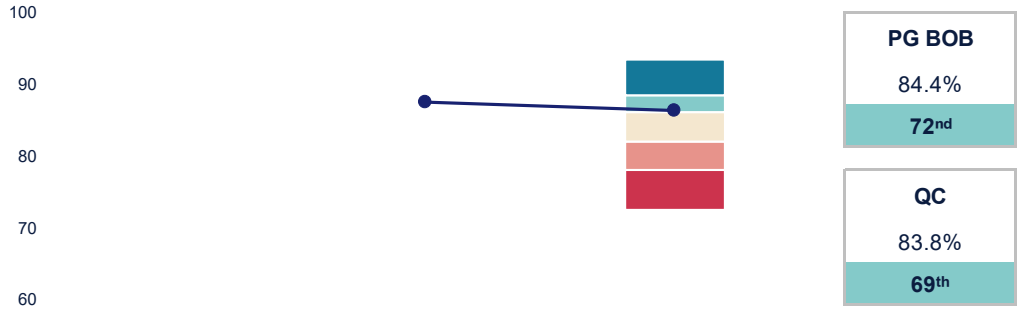


	2024	2025	2026
n	--	195	118
SRS	**--**	**90.5%**	**91.2%**

PG BOB
89.6%
72nd

QC
89.3%
71st

Q24. Provided information or help

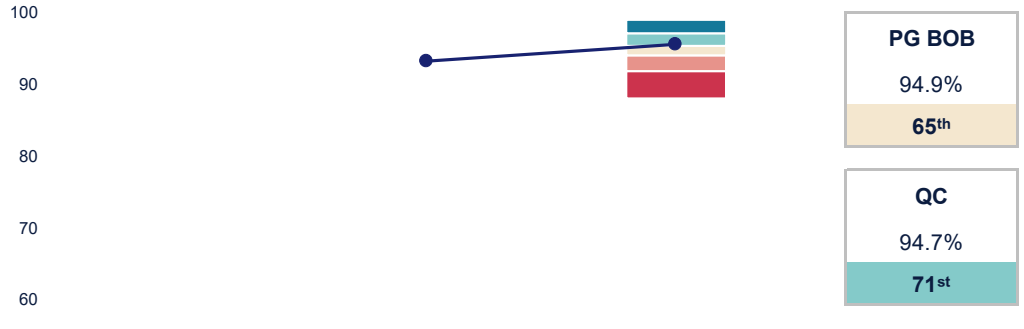


	2024	2025	2026
n	--	195	119
SRS	**--**	**87.7%**	**86.6%**

PG BOB
84.4%
72nd

QC
83.8%
69th

Q25. Treated with courtesy and respect



	2024	2025	2026
n	--	195	118
SRS	**--**	**93.3%**	**95.8%**

PG BOB
94.9%
65th

QC
94.7%
71st

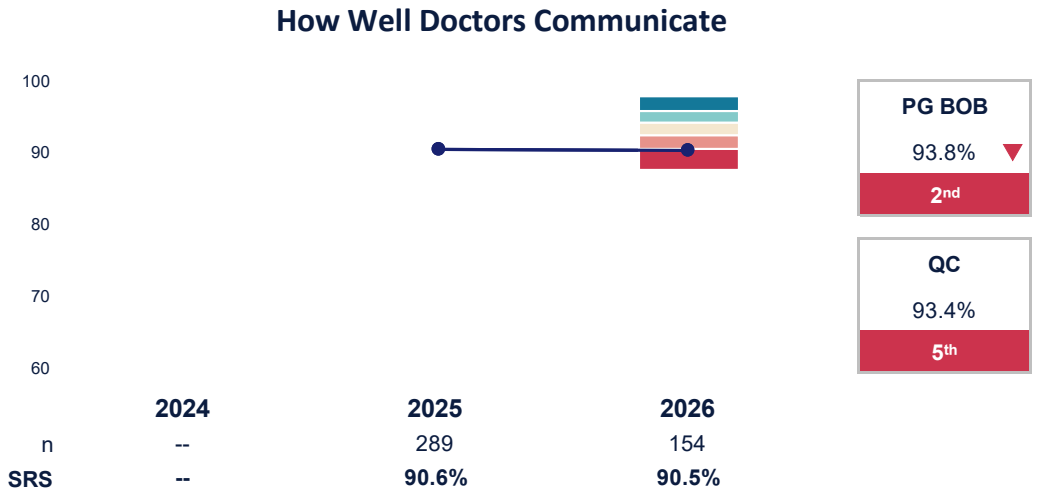
Percentile Bands are for QC benchmark.

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How Well Doctors Communicate

Medicaid Adult



	2024	2025	2026
n	--	289	154
SRS	**--**	**90.6%**	**90.5%**

Percentile Bands are for QC benchmark.

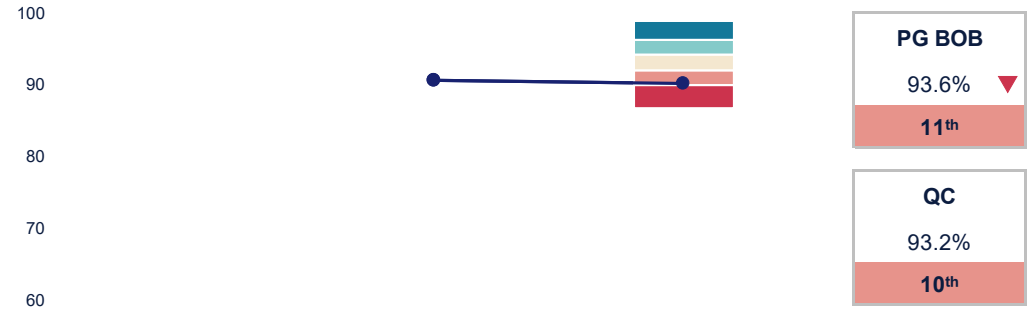
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How Well Doctors Communicate

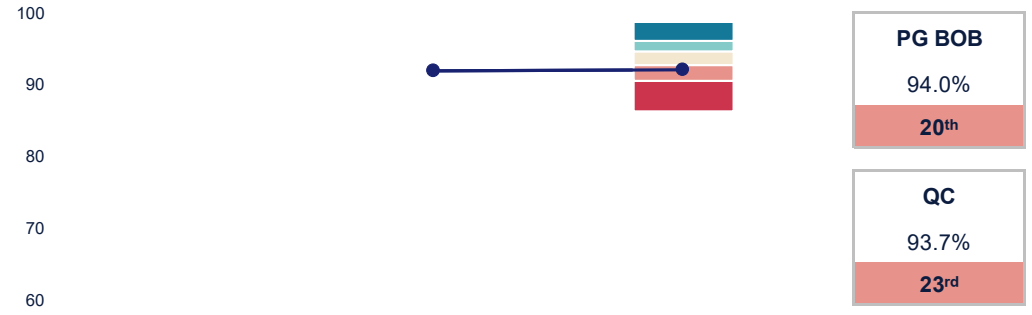
Medicaid Adult

Q12. Dr. explained things



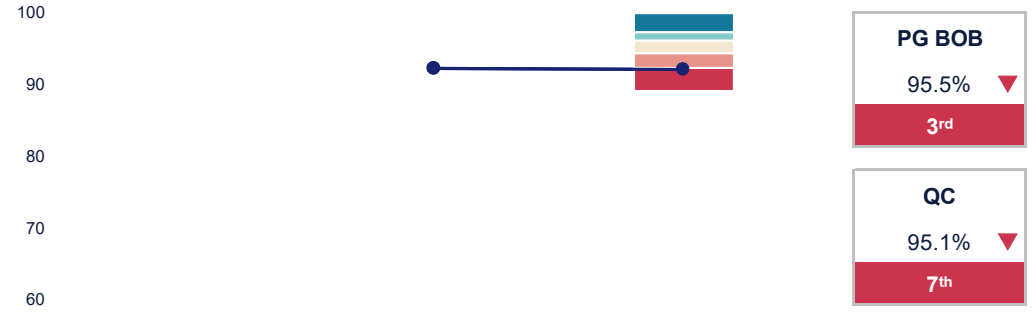
	2024	2025	2026
n	--	291	155
SRS	--	**90.7%**	**90.3%**

Q13. Dr. listened carefully



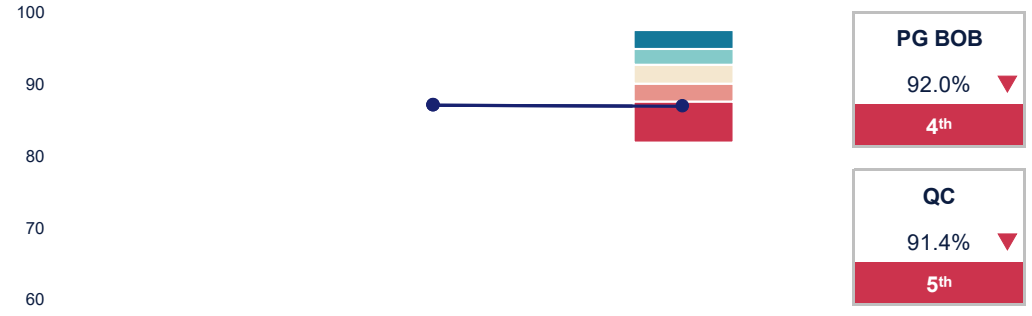
	2024	2025	2026
n	--	289	154
SRS	--	**92.0%**	**92.2%**

Q14. Dr. showed respect



	2024	2025	2026
n	--	288	154
SRS	--	**92.4%**	**92.2%**

Q15. Dr. spent enough time



	2024	2025	2026
n	--	289	155
SRS	--	**87.2%**	**87.1%**

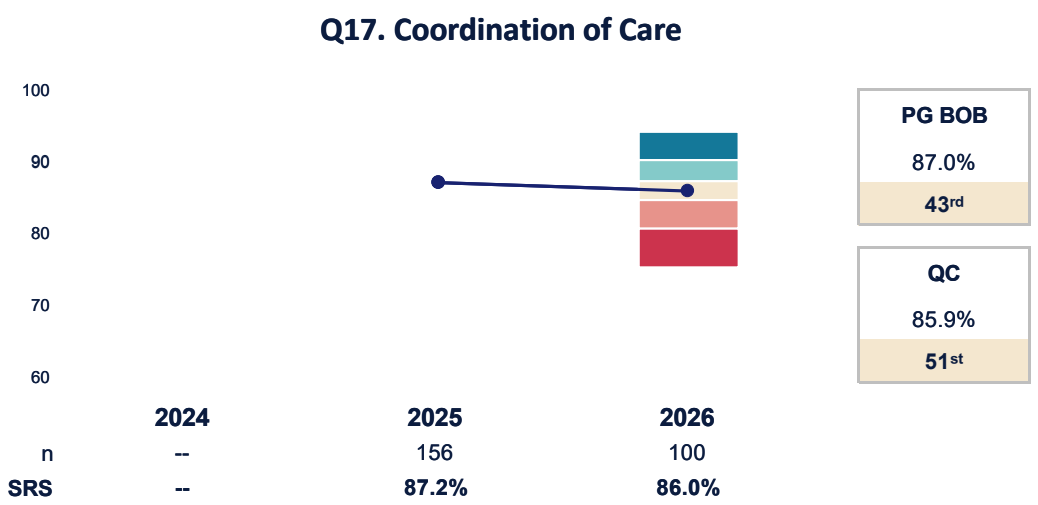
Percentile Bands are for QC benchmark.

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Coordination of Care

Medicaid Adult



Percentile Bands are for QC benchmark.

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Summary of Trend and Benchmark



Summary Rate Scores

Medicaid Adult

	2026 Valid n	2024	2025	2026	2026 Press Ganey BOB	2025 Quality Compass
Rating Questions (% 9 or 10)						
Q28. Rating of Health Plan	277	--	65.3%	**63.2%**	63.7%	61.7%
Q8. Rating of Health Care	162	--	52.4%	**54.3%**	58.4%	57.7%
Q18. Rating of Personal Doctor	202	--	64.8%	**71.3%**	71.8%	70.7%
Q22. Rating of Specialist	102	--	64.9%	**66.7%**	69.3%	68.2%
Rating Questions (% 8, 9 or 10)						
Q28. Rating of Health Plan	277	--	79.5%	**78.3%**	79.3%	77.6%
Q8. Rating of Health Care	162	--	72.4%	**77.8%**	77.0%	76.5%
Q18. Rating of Personal Doctor	202	--	80.7%	**85.1%**	84.9%	84.6%
Q22. Rating of Specialist	102	--	77.8%	**86.3%**	83.6%	83.1%
Getting Needed Care (% Usually or Always)	135	--	75.9%	**78.8%**	83.0%	82.1%
Q9. Getting care, tests, or treatment	163	--	77.2%	**83.4%**	86.0%	85.2%
Q20. Getting specialist appointment	108	--	74.6%	**74.1%**	80.0%	78.9%
Getting Care Quickly (% Usually or Always)	132	--	78.6%	**76.7%**	82.5% ▼	81.6%
Q4. Getting urgent care	97^	--	79.7%	**78.4%**	84.0%	83.7%
Q6. Getting routine care	168	--	77.4%	**75.0%**	81.0% ▼	79.2%
Effectiveness of Care: 2YR (% Sometimes, Usually, or Always)						
Q32. Advised to Quit Smoking: 2YR	90^	--	67.3%	**63.3%**	75.3% ▼	73.4% ▼
Q33. Discussing Cessation Meds: 2YR	90^	--	30.0%	**34.4%**	54.9% ▼	53.2% ▼
Q34. Discussing Cessation Strategies: 2YR	89^	--	29.2%	**36.0%**	50.4% ▼	47.2% ▼

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Summary Rate Scores

Medicaid Adult

	2026 Valid n	2024	2025	2026	2026 Press Ganey BOB	2025 Quality Compass
Customer Service (% Usually or Always)	118	--	90.5%	**91.2%**	89.6%	89.3%
Q24. Provided information or help	119	--	87.7%	**86.6%**	84.4%	83.8%
Q25. Treated with courtesy and respect	118	--	93.3%	**95.8%**	94.9%	94.7%
How Well Doctors Communicate (% Usually or Always)	154	--	90.6%	**90.5%**	93.8% ▼	93.4%
Q12. Dr. explained things	155	--	90.7%	**90.3%**	93.6% ▼	93.2%
Q13. Dr. listened carefully	154	--	92.0%	**92.2%**	94.0%	93.7%
Q14. Dr. showed respect	154	--	92.4%	**92.2%**	95.5% ▼	95.1% ▼
Q15. Dr. spent enough time	155	--	87.2%	**87.1%**	92.0% ▼	91.4% ▼
Q17. Coordination of Care (% Usually or Always)	100	--	87.2%	**86.0%**	87.0%	85.9%
Q27. Ease of Filling Out Forms (% Usually or Always)	274	--	93.5%	**92.3%**	94.9% ▼	95.0% ▼

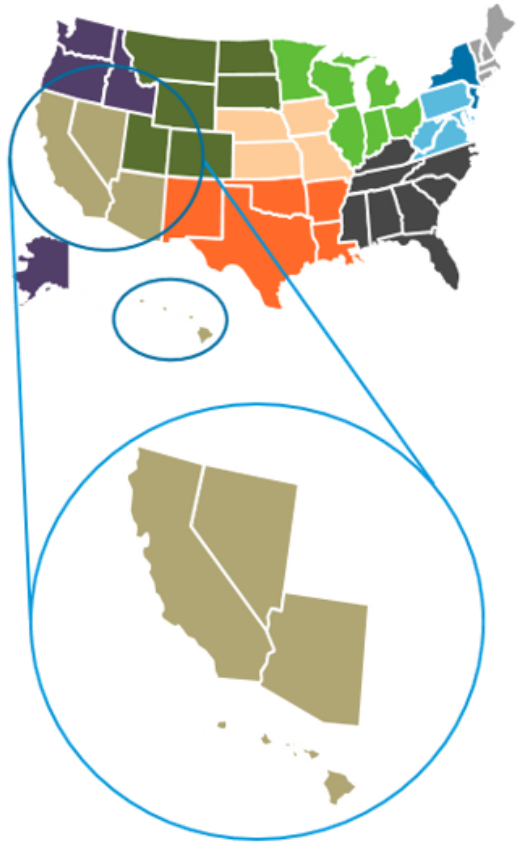
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Regional Performance

Medicaid Adult

	2026	2026 PG BOB Region	
Rating Questions (% 9 or 10)			
Q28. Rating of Health Plan	**63.2%**	64.8%	
Q8. Rating of Health Care	**54.3%**	58.3%	
Q18. Rating of Personal Doctor	**71.3%**	70.2%	
Q22. Rating of Specialist	**66.7%**	68.9%	
Rating Questions (% 8, 9 or 10)			
Q28. Rating of Health Plan	**78.3%**	80.6%	
Q8. Rating of Health Care	**77.8%**	77.1%	
Q18. Rating of Personal Doctor	**85.1%**	84.1%	
Q22. Rating of Specialist	**86.3%**	83.8%	
Getting Needed Care (% Usually or Always)	**78.8%**	80.7%	
Q9. Getting care, tests, or treatment	**83.4%**	83.8%	
Q20. Getting specialist appointment	**74.1%**	77.6%	
Getting Care Quickly (% Usually or Always)	**76.7%**	78.3%	
Q4. Getting urgent care	**78.4%**	81.1%	
Q6. Getting routine care	**75.0%**	75.5%	
Effectiveness of Care: 2YR (% Sometimes, Usually, or Always)			
Q32. Advised to Quit Smoking: 2YR	**63.3%**	69.2%	
Q33. Discussing Cessation Meds: 2YR	**34.4%**	50.3%	▼
Q34. Discussing Cessation Strategies: 2YR	**36.0%**	46.4%	▼

HHS Regions: The regions used align with the U.S. Department of Health and Human Services regions.



Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada

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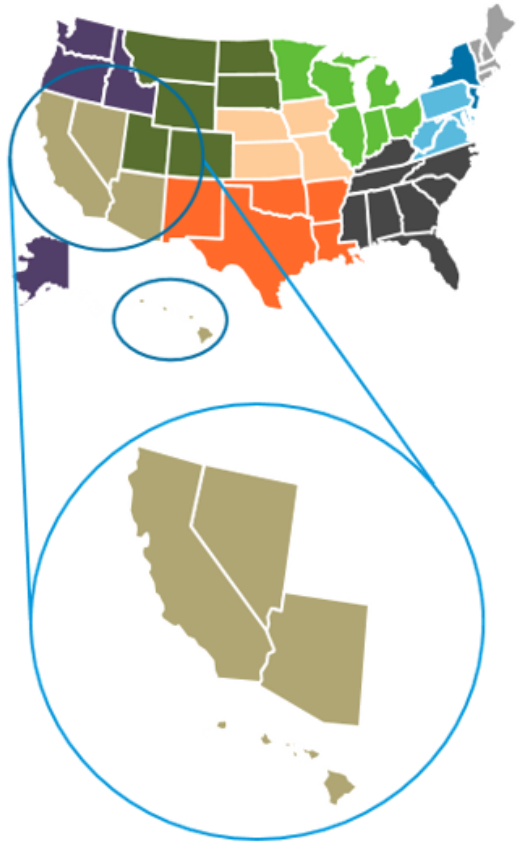
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Regional Performance

Medicaid Adult

	2026	2026 PG BOB Region
Customer Service (% Usually or Always)	**91.2%**	89.0%
Q24. Provided information or help	**86.6%**	83.9%
Q25. Treated with courtesy and respect	**95.8%**	94.2%
How Well Doctors Communicate (% Usually or Always)	**90.5%**	92.4%
Q12. Dr. explained things	**90.3%**	91.7%
Q13. Dr. listened carefully	**92.2%**	93.4%
Q14. Dr. showed respect	**92.2%**	94.9%
Q15. Dr. spent enough time	**87.1%**	89.5%
Q17. Coordination of Care (% Usually or Always)	**86.0%**	84.0%
Q27. Ease of Filling Out Forms (% Usually or Always)	**92.3%**	93.9%

HHS Regions: The regions used align with the U.S. Department of Health and Human Services regions.



Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada

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Percentile Rankings

Medicaid Adult

	Plan Score	QC %tile	2025 Quality Compass - Percentile Ranks									PG %tile	2026 Press Ganey BOB - Percentile Ranks								
			5th	10th	25th	33rd	50th	67th	75th	90th	95th		5th	10th	25th	33rd	50th	67th	75th	90th	95th
Rating Questions (% 9 or 10)																					
Q28. Rating of Health Plan	**63.2%**	56th	52.2	54.8	58.3	59.4	62.2	64.3	65.3	69.2	71.2	45th	53.4	56.3	59.6	60.6	63.6	65.2	66.7	70.2	72.7
Q8. Rating of Health Care	**54.3%**	21st	50.6	52.2	54.7	55.4	57.4	59.7	60.5	63.6	66.0	23rd	46.9	50.6	54.6	55.8	58.4	60.3	62.3	65.0	66.5
Q18. Rating of Personal Doctor	**71.3%**	53rd	63.7	64.7	67.8	68.9	70.9	72.9	74.1	76.6	77.3	44th	62.6	65.0	68.6	69.6	72.1	73.8	74.8	77.8	79.1
Q22. Rating of Specialist	**66.7%**	38th	59.9	62.7	65.7	66.3	67.8	70.0	71.5	74.0	75.6	32nd	57.9	61.4	65.6	66.9	69.2	71.6	73.1	75.8	77.8
Rating Questions (% 8, 9 or 10)																					
Q28. Rating of Health Plan	**78.3%**	52nd	69.4	71.5	75.0	76.1	78.1	80.0	81.0	83.0	84.2	44th	71.3	73.2	76.3	77.2	78.8	81.0	82.5	84.8	86.1
Q8. Rating of Health Care	**77.8%**	62nd	70.3	72.0	74.0	75.0	76.5	78.2	79.0	80.7	82.6	54th	68.6	71.5	74.6	75.2	77.2	78.9	79.9	82.0	84.1
Q18. Rating of Personal Doctor	**85.1%**	56th	79.4	80.9	82.6	83.0	84.7	85.9	86.7	88.4	89.4	52nd	79.1	81.4	83.1	83.9	84.9	85.9	86.9	88.4	89.6
Q22. Rating of Specialist	**86.3%**	82nd	76.2	78.2	80.8	81.8	83.2	84.7	85.7	88.0	89.1	74th	75.2	77.6	81.5	82.0	83.8	85.5	86.4	89.3	90.3
Getting Needed Care (% U/A)	**78.8%**	22nd	75.5	76.4	79.4	80.8	82.2	84.5	85.1	86.8	87.4	14th	75.1	77.5	80.5	81.3	82.9	84.8	85.4	87.2	88.4
Q9. Getting care, tests, or treatment	**83.4%**	27th	77.9	79.2	83.0	84.0	85.8	87.1	87.8	89.9	90.7	27th	78.8	80.5	83.1	84.4	86.3	88.0	88.7	90.8	91.5
Q20. Getting specialist appointment	**74.1%**	14th	71.2	72.4	75.4	77.4	79.2	81.5	82.8	84.7	85.5	13th	70.2	72.6	76.8	78.0	80.1	82.3	83.0	85.2	86.4
Getting Care Quickly (% U/A)	**76.7%**	16th	73.9	75.3	78.9	80.2	81.8	84.4	84.9	87.5	87.9	14th	73.8	75.9	78.9	80.3	82.5	84.5	85.3	87.2	88.5
Q4. Getting urgent care	**78.4%**	16th	75.2	77.1	80.6	82.0	84.0	86.2	86.7	89.6	91.9	15th	74.1	77.4	80.0	81.7	83.9	85.9	86.9	89.3	90.7
Q6. Getting routine care	**75.0%**	21st	68.4	70.5	76.1	77.5	79.7	82.4	83.3	85.9	87.3	18th	70.2	71.9	76.7	78.8	81.7	83.5	84.6	86.8	87.3
Effectiveness of Care: 2YR (% S/U/A)																					
Q32. Advised to Quit Smoking: 2YR	**63.3%**	3rd	63.7	66.5	70.1	71.0	73.5	75.7	76.8	80.2	82.4	11th	57.7	62.6	69.5	71.8	74.3	76.7	78.3	82.4	84.6
Q33. Discussing Cessation Meds: 2YR	**34.4%**	1st	42.7	44.8	49.2	50.6	53.6	55.6	56.9	62.5	65.0	6th	34.1	39.7	48.8	50.9	54.8	57.7	59.4	63.3	65.7
Q34. Discussing Cessation Strategies: 2YR	**36.0%**	4th	37.5	39.3	43.6	44.4	46.8	49.7	50.2	56.0	58.0	12th	31.5	34.9	44.2	46.3	48.5	52.3	54.1	57.0	59.8

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Percentile Rankings

Medicaid Adult

	Plan Score	QC %tile	2025 Quality Compass - Percentile Ranks									PG %tile	2026 Press Ganey BOB - Percentile Ranks								
			5th	10th	25th	33rd	50th	67th	75th	90th	95th		5th	10th	25th	33rd	50th	67th	75th	90th	95th
Customer Service (% U/A)	**91.2%**	71st	84.6	86.0	87.2	87.9	89.5	90.5	91.4	92.8	94.0	72nd	84.7	86.1	87.8	88.5	89.6	90.7	91.3	93.2	93.7
Q24. Provided information or help	**86.6%**	69th	77.0	78.2	81.0	82.2	83.7	86.3	87.1	88.6	90.2	72nd	78.1	79.4	82.0	82.8	84.6	86.0	87.0	88.9	90.2
Q25. Treated with courtesy and respect	**95.8%**	71st	90.7	91.9	93.7	94.2	95.0	95.5	96.1	97.3	97.4	65th	90.6	91.2	93.0	94.2	95.2	95.9	96.5	97.7	98.5
How Well Doctors Communicate (% U/A)	**90.5%**	5th	90.3	90.6	91.9	92.6	93.6	94.4	94.9	96.0	96.5	2nd	90.6	91.6	92.6	92.9	93.7	94.4	94.7	96.1	96.8
Q12. Dr. explained things	**90.3%**	10th	89.0	90.1	91.5	92.1	93.3	94.3	94.9	96.4	97.1	11th	89.2	90.3	91.9	92.5	93.7	94.8	95.4	96.6	97.3
Q13. Dr. listened carefully	**92.2%**	23rd	89.5	90.7	92.4	92.9	93.9	94.8	95.3	96.2	97.0	20th	90.4	91.3	92.7	93.1	93.8	94.8	95.4	96.5	97.3
Q14. Dr. showed respect	**92.2%**	7th	91.8	92.5	93.8	94.4	95.3	96.2	96.6	97.5	98.1	3rd	92.8	93.6	94.3	94.7	95.6	96.2	96.6	97.6	98.0
Q15. Dr. spent enough time	**87.1%**	5th	86.3	87.7	89.7	90.2	91.6	92.9	93.4	95.0	95.6	4th	87.3	88.6	90.3	91.1	92.1	93.1	93.7	94.8	95.5
Q17. Coordination of Care (% U/A)	**86.0%**	51st	80.3	80.9	84.1	84.8	85.8	87.5	88.6	90.3	91.1	43rd	79.2	81.6	84.2	85.1	86.6	88.5	89.3	91.7	92.3
Q27. Ease of Filling Out Forms (% U/A)	**92.3%**	7th	91.9	92.9	93.8	94.2	95.1	96.0	96.3	97.3	97.9	5th	92.3	92.7	94.0	94.5	95.3	95.9	96.2	96.6	97.2

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Appendix



Appendix A: Correlations

Highest Correlations

Below are the key measures with the highest correlations to the Rating measures.

With Rating Of Health Care		
Q18	Rating of Personal Doctor	0.7120
Q28	Rating of Health Plan	0.6779
Q9	Getting care, tests, or treatment	0.5736
Q13	Dr. listened carefully	0.5363
Q15	Dr. spent enough time	0.5204
Q22	Rating of Specialist	0.4814
Q41	Rating of provided interpreter overall	0.4669
Q20	Getting specialist appointment	0.4365
Q14	Dr. showed respect	0.4254
Q4	Getting urgent care	0.4042

With Rating Of Personal Doctor		
Q13	Dr. listened carefully	0.7329
Q8	Rating of Health Care	0.7120
Q14	Dr. showed respect	0.6421
Q15	Dr. spent enough time	0.6044
Q17	Coordination of Care	0.5841
Q28	Rating of Health Plan	0.5260
Q24	Provided information or help	0.5192
Q12	Dr. explained things	0.5191
Q25	Treated with courtesy and respect	0.5158
Q9	Getting care, tests, or treatment	0.4484

With Rating Of Specialist		
Q24	Provided information or help	0.5651
Q28	Rating of Health Plan	0.5066
Q20	Getting specialist appointment	0.4885
Q8	Rating of Health Care	0.4814
Q17	Coordination of Care	0.4438
Q15	Dr. spent enough time	0.2803
Q18	Rating of Personal Doctor	0.2802
Q14	Dr. showed respect	0.2660
Q9	Getting care, tests, or treatment	0.2124
Q13	Dr. listened carefully	0.1883

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Supplemental Questions

Medicaid Adult

	2024	2025	2026
Q40. Got interpreter			
Base (n)	**--**	**490**	**276**
Yes	--	34.1%	34.1%
No	--	65.9%	65.9%
Summary Rate Score (%Yes)	**--**	**34.1%**	**34.1%**
Q41. Rating of provided interpreter overall			
Base (n)	**--**	**284**	**186**
10 Best interpreter possible	--	52.5%	51.6%
9	--	13.0%	10.8%
8	--	12.0%	11.8%
7	--	6.7%	5.9%
6	--	4.2%	4.3%
5	--	4.2%	7.5%
4	--	0.4%	1.1%
3	--	0.7%	0.5%
2	--	0.7%	0.0%
1	--	0.7%	0.0%
0 Worst interpreter possible	--	4.9%	6.5%
Summary Rate Score (%9 or 10 Best interpreter possible)	**--**	**65.5%**	**62.4%**

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Supplemental Questions

Medicaid Adult

	2024	2025	2026
Q42. Wait time to see Dr. for set appt. after arrival			
Opt-out / Exclusion (n)			
Does not apply, I did not have any appointments in the last 6 months	--	71	35
Base (n)	**--**	**410**	**236**
15 minutes or less	--	35.4%	39.8%
16-30 minutes	--	36.1%	34.7%
31-45 minutes	--	15.4%	14.0%
46 minutes to 1 hour	--	6.8%	7.2%
Over 1 hour	--	6.3%	4.2%
Mean Score	**--**	**25.2**	**23.3**
Q43. Got appt. in a timely manner			
Opt-out / Exclusion			
Not Applicable	--	59	41
Base (n)	**--**	**411**	**231**
Always	--	42.6%	41.6%
Usually	--	25.3%	22.5%
Sometimes	--	24.8%	23.4%
Never	--	7.3%	12.6% ↑
Summary Rate Score (%Usually or Always)	**--**	**67.9%**	**64.1%**
Q44. Had to wait for an appointment due to provider's limited availability			
Opt-out / Exclusion			
Not Applicable	--	79	50
Base (n)	**--**	**392**	**221**
Never	--	37.8%	45.7%
Sometimes	--	34.7%	35.3%
Usually	--	15.8%	10.4% ↓
Always	--	11.7%	8.6%
Summary Rate Score (%Never or Sometimes)	**--**	**72.4%**	**81.0%** ↑

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Supplemental Questions

Medicaid Adult

	2024	2025	2026
Q45. Which CS center have contacted most recently			
Opt-out / Exclusion (n)			
I did not contact customer service	--	206	109
Base (n)	**--**	**216**	**142**
Health Plan's Customer Service (Phone number on ID Card)	--	26.4%	32.4%
Provider and/or Doctors Office	--	58.8%	52.1%
Retail Pharmacy Services	--	12.0%	12.0%
Other (Please Specify)	--	2.8%	3.5%
Q46. Info. not received when contacting CS			
Opt-out / Exclusion			
I received the information I wanted	--	149	77
I did not contact customer service	--	219	135
Base (n)	**--**	**72**	**48**
Benefits and covered services	--	45.8%	41.7%
Provider information	--	29.2%	27.1%
Co-payment, co-insurance, and deductible information	--	12.5%	10.4%
Claims information	--	9.7%	8.3%
Membership	--	13.9%	10.4%
Prescription drug information	--	37.5%	39.6%
Other (Please Specify)	--	22.2%	10.4%

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Supplemental Questions

Medicaid Adult

	2024	2025	2026
Q47. Reasons it was difficult to get appt. with specialist			
Opt-out / Exclusion (n)			
I did not have difficulty getting an appointment with a specialist	--	166	120
I did not make an appointment with a specialist	--	118	57
Base (n)	**--**	**118**	**69**
Your doctor did not think you needed to see a specialist	--	21.2%	18.8%
Your health plan approval or authorization was delayed	--	22.9%	26.1%
You could not get a referral	--	11.9%	11.6%
You weren't sure where to find a list of specialists in your health plan or network	--	11.0%	15.9%
The specialists you had to choose from were too far away	--	12.7%	17.4%
You did not have enough specialists to choose from	--	17.8%	7.2% ↓
The specialist you wanted did not belong to your health plan or network	--	16.9%	21.7%
You could not get an appointment at a time that was convenient	--	26.3%	24.6%
Other (Please Specify)	--	25.4%	33.3%

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MY 2025 CAHPS® Medicaid Child 5.1H Survey

CalViva



Contents

- Overview
- Methodology
- Executive Summary
- Key Driver Analysis of Rating of Health Plan
- Measure Analysis
- Summary of Trend and Benchmarks
- Appendix

Project Manager

Julia Schneider

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Should you have any questions or comments regarding any aspect of the survey or reporting process, please feel free to email your Project Manager.

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Overview

Press Ganey (PG), a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor, was selected by CalViva to conduct its MY 2025 CAHPS® 5.1H Medicaid Child Survey.

Survey Objective

The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

NCQA Updates

- NCQA made no significant changes to the survey or program this year.

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CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Methodology

First questionnaire mailed **3/3/2026** → Second questionnaire mailed **4/7/2026** → Initiate follow-up calls to non-responders **4/28/2026 - 5/12/2026** → Last day to accept completed surveys **5/13/2026**

QUALIFIED RESPONDENTS

Included beneficiaries who were…

- *Parents of those 17 years and younger (as of December 31st of the measurement year)*
- *Continuously enrolled in the plan for at least five of the last six months of the measurement year*

RESPONSE RATE CALCULATION

$$\frac{\text{201 (Completed)}}{\text{1,650 (Sample) - 2 (Ineligible)}} = \frac{201}{1{,}648} = 12.2\%$$

COMPLETES - MODALITY BY LANGUAGE

	Mail	Phone	Internet	*Internet Modes*			Total
				QR Code	Email	URL	
English	41	16	44	37	0	7	**101**
Spanish	29	38	33	31	0	2	**100**
Total	**70**	**54**	**77**	**68**	**0**	**9**	**201**

Total Number of Undeliverables: 118

Note: Respondents were given the option of completing the survey in Spanish. In place of the English survey, a Spanish survey was mailed to members who were identified by the plan as Spanish-speaking. A telephone number was also provided on the survey cover letter for all members to call if they would like to complete the survey in Spanish.

RESPONSE RATE TRENDING

		2024	2025	2026
Completed	**SUBTOTAL**	--	--	**201**
Ineligible	Does not Meet Eligibility Criteria (01)	--	--	1
	Language Barrier (03)	--	--	1
	Mentally/Physically Incapacitated (04)	--	--	0
	Deceased (05)	--	--	0
	SUBTOTAL	--	--	**2**
Non-response	Break-off/Incomplete (02)	--	--	14
	Refusal (06)	--	--	9
	Maximum Attempts Made (07)	--	--	1,424
	Added to DNC List (08)	--	--	0
	SUBTOTAL	--	--	**1,447**
Total Sample		--	--	**1,650**
Oversampling		--	--	**0.0%**
Response Rate		--	--	**12.2%**
PG Response Rate		***9.4%***	***10.0%***	***9.1%***

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Executive Summary



Overview of Terms

Summary Rates (SRS) are defined by NCQA in its HEDIS MY 2025 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

Percentile Rankings Your plan's approximate percentile rankings in relation to the Quality Compass® All Plans benchmark were calculated by Press Ganey using information derived from the NCQA 1-100 Benchmark.



PG Benchmark Information The source for data contained within the PG Book of Business is all submitting plans that contracted with PG for MY 2025. Submission occurred on May 26th, 2026.

NCQA Benchmark Information The source for data contained in this publication is Quality Compass® All Plans 2025. It is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

Small Denominator Threshold NCQA will assign a measure result of NA to overall ratings or composites with a denominator (i.e., the average number of responses across all questions used to calculate the composite) less than 100.

Technical Notes Please refer to the Technical Notes for more information.

Significance Testing All significance testing is performed at the 95% confidence level using a t-test for mean scores and z-test for percentages. The following notation is used to highlight significant differences.

Comparisons to previous year (↑/↓)
Comparisons over 2 years (↕/↕)
Comparisons to benchmarks (▲/▼)

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2026 Dashboard

Medicaid Child



201

Completed surveys

12.2%

Response Rate

Stars: PG Estimated NCQA Rating
NA = Denominator < 100

Scores: All scores displayed are Summary Rate Scores
- Rating: % 9 or 10
- Composites: % Usually or Always

Significance Testing: Current score is significantly higher/lower than 2025 (↑/↓) or 2024 (‡/‡).

Percentiles: Based on the 2026 PG Book of Business

Health Plan Key Driver Classification: Details can be found in the KDA section.

Rating of Health Plan			★★★★★
Q31. Rating of Health Plan	80.9%	94th	--

Rating of Health Care			★★★
Q8. Rating of Health Care	69.4%	18th	Opportunity

Rating of Personal Doctor			
Q21. Rating of Personal Doctor	73.5%	8th	Opportunity

Rating of Specialist			
Q25. Rating of Specialist	70.4%	17th	Opportunity

Coordination of Care			
Q20. Coordination of Care	76.8%	5th	Wait

Customer Service			
Composite	**88.5%**	**45th**	--
Q27. Provided information or help	83.6%	50th	Wait
Q28. Treated with courtesy and respect	93.4%	30th	Opportunity

Getting Needed Care			(NA)
Composite	**83.7%**	**30th**	--
Q9. Getting care, tests, or treatment	87.8%	15th	Opportunity
Q23. Getting specialist appointment	79.7%	45th	Wait

Getting Care Quickly			(NA)
Composite	**88.7%**	**55th**	--
Q4. Getting urgent care	96.0%	87th	Retain
Q6. Getting routine care	81.3%	25th	Opportunity

Ease of Filling Out Forms			
Q30. Ease of Filling Out Forms	95.4%	57th	Retain

How Well Doctors Communicate			
Composite	**91.0%**	**5th**	--
Q12. Dr. explained things	93.3%	28th	Opportunity
Q13. Dr. listened carefully	92.5%	4th	Opportunity
Q14. Dr. showed respect	97.7%	60th	Power
Q17. Dr. spent enough time	80.6%	1st	Wait

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Estimated NCQA Health Insurance Plan Ratings

Medicaid Child

	Score Definition	Base	HPR Score*	HPR 4 Star Threshold	HPR Percentile Band	PG Estimated Rating
PATIENT EXPERIENCE						NA
GETTING CARE						NA
Getting Needed Care	Usually or Always	91^	83.7%	86.4%	--	NA
Getting Care Quickly	Usually or Always	86^	88.6%	88.6%	--	NA
SATISFACTION WITH PLAN AND PLAN SERVICES						**4**
Rating of Health Plan	9 or 10	194	80.9%	74.4%	90th	**5**
Rating of Health Care	9 or 10	124	69.3%	73.4%	33rd	**3**

***HPR scores** are **truncated** to three digits (XX.X%) according to the NCQA calculation protocol for Health Plan Ratings. Please note that scores on this slide may differ slightly compared to scores found throughout the rest of the report.

EXPLANATION

NCQA calculates health plan ratings (HPR) by evaluating plans in three categories: consumer satisfaction, clinical quality (includes prevention and treatment) and NCQA Accreditation Standards score.

The overall NCQA star rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization has NCQA Accreditation), rounded to the nearest half point.

The CAHPS measures are classified based on their national percentile (10th, 33rd, 67th and 90th) into scores ranging from 1 to 5 (in increments of 0.5), where 5 is the highest score and 1 is the lowest.

Results are summarized in the table to the left. **Percentiles and ratings are estimated by PG** based on the 2025 NCQA data and benchmarks.

Rating = 1	Rating = 2	Rating = 3	Rating = 4	Rating = 5
<10th Percentile	10th – 32nd Percentile	33rd – 66th Percentile	67th – 89th Percentile	≥90th Percentile

Notes:

- *NCQA will assign a measure result of NA to overall ratings or composites with a denominator (i.e., the average number of responses across all questions used to calculate the composite) less than 100.*
- *Medicaid plans have the option to be scored on either Adult CAHPS or Child CAHPS data.*

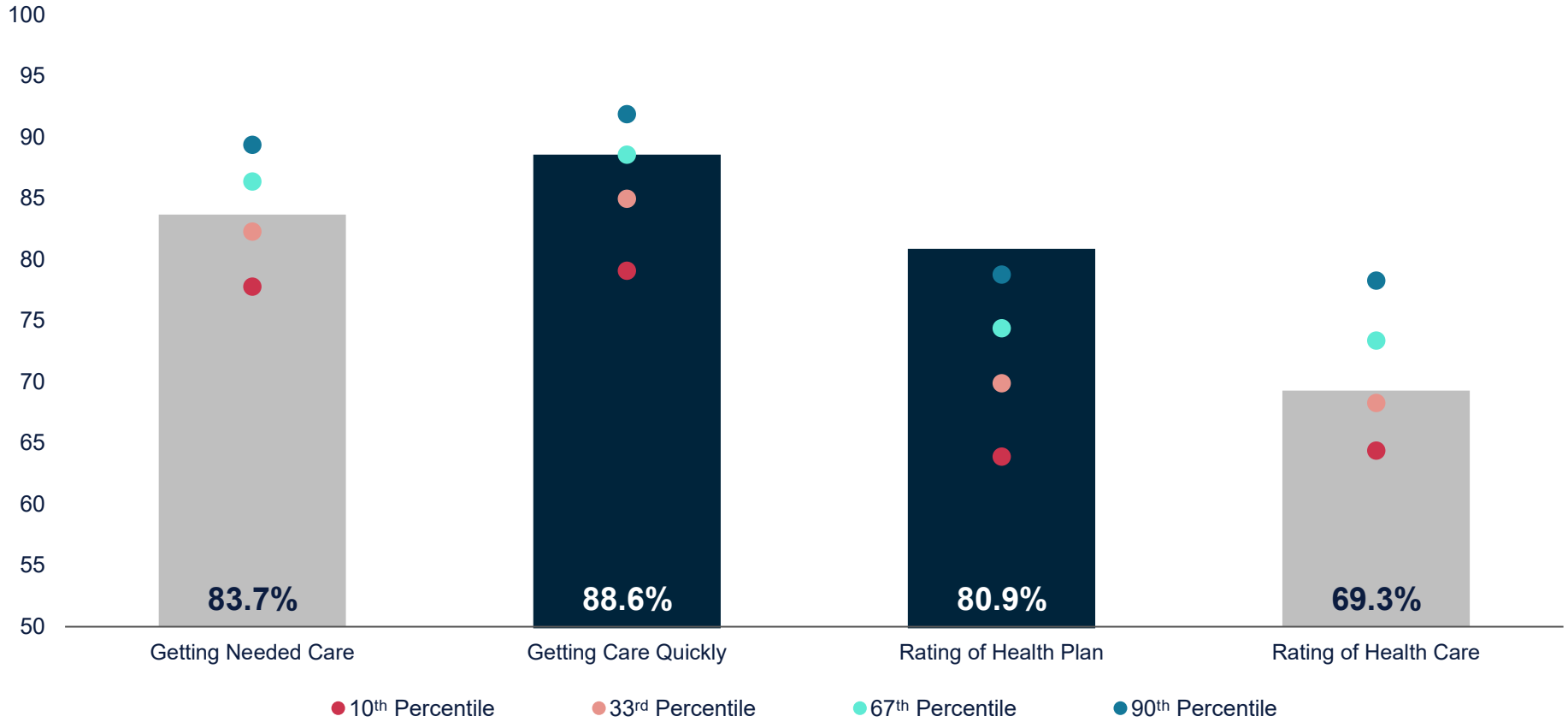
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Performance to Star Cut Points

Medicaid Child

COMPARISON TO QUALITY COMPASS CUT POINTS

The graph shows how your plan's **Estimated Health Plan Rating (HPR) scores** used for accreditation ratings compare to the most recent Quality Compass thresholds published by NCQA (Fall 2025).



Dark Blue bar = Your plan's performance is at or above the 67th percentile

Light Grey bar = Your plan's performance is below the 67th percentile

HPR scores are **truncated** to three digits (XX.X%) according to the NCQA calculation protocol for Health Plan Ratings. Please note that scores on this slide may differ slightly compared to scores found throughout the rest of the report.

** Scores are % 9 or 10, % Always or Usually.*

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Key Metric Performance

Medicaid Child

Measure	Summary Rate Score 2025	Summary Rate Score 2026	Change	2026 Press Ganey BOB Benchmark Percentile Distribution (0 / 20 / 40 / 60 / 80 / 100)	Plan Percentile Rank	PG BOB
Health Plan Domain						
Q31. Rating of Health Plan		**80.9%**			94th	73.0% ▲
Getting Needed Care		**83.7%**			30th	85.8%
Customer Service		**88.5%**			45th	89.0%
Q30. Ease of Filling Out Forms		**95.4%**			57th	95.0%
Health Care Domain						
Q8. Rating of Health Care		**69.4%**			18th	73.2%
Getting Care Quickly		**88.7%**			55th	87.7%
How Well Doctors Communicate		**91.0%**			5th	94.4% ▼
Q20. Coordination of Care		**76.8%**			5th	86.1% ▼
Q21. Rating of Personal Doctor		**73.5%**			8th	78.8% ▼
Q25. Rating of Specialist		**70.4%**			17th	76.4%

** Scores are % 9 or 10, % Always or Usually.*

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Measure Summary

Medicaid Child

TOP 3 PERFORMING MEASURES

Your plan's percentile rankings for these measures were the highest compared to the PG Book of Business.

Measure	2026 Valid N	Plan			2025 Quality Compass			2026 Press Ganey BOB		
		2025	2026	Change	Score	Percentile	Gap	Score	Percentile	Gap
Q31. Rating of Health Plan	194		**80.9%**		71.8% ▲	95th	9.1%	73.0% ▲	94th	7.9%
Getting Care Quickly	86^		**88.7%**		86.2%	67th	2.5%	87.7%	55th	1.0%
Customer Service	61^		**88.5%**		88.2%	52nd	0.3%	89.0%	45th	-0.5%

BOTTOM 3 PERFORMING MEASURES

Your plan's percentile rankings for these measures were the lowest compared to the PG Book of Business.

Measure	2026 Valid N	Plan			2025 Quality Compass			2026 Press Ganey BOB		
		2025	2026	Change	Score	Percentile	Gap	Score	Percentile	Gap
Q21. Rating of Personal Doctor	166		**73.5%**		77.8%	12th	-4.3%	78.8% ▼	8th	-5.4%
How Well Doctors Communicate	132		**91.0%**		94.0%	7th	-2.9%	94.4% ▼	5th	-3.4%
Q20. Coordination of Care	69^		**76.8%**		84.9% ▼	2nd	-8.1%	86.1% ▼	5th	-9.3%

Scores: All scores displayed are Summary Rate Scores
- Rating: % 9 or 10
- Composites: % Usually or Always

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Health Equity

Medicaid Child

Group is performing…

- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	Category	Total	Rating of Health Plan		Rating of Health Care		Getting Needed Care		Getting Care Quickly		Rating of Personal Doctor		Rating of Specialist	
			SRS	△	SRS	△	SRS	△	SRS	△	SRS	△	SRS	△
			80.9%		69.4%		83.7%		88.7%		73.5%		70.4%	
Child's Sex	Male	n=112		1		1		2		0		0		2
	Female	n=82		-2		-3		-4		1		-3		-4
Child's Age	0 to 4	n=51		1		7		-1		-1		-1		-4
	5 to 8	n=43		-11		-9		-3		-1		1		-20
	9 to 13	n=50		7		-6		2		0		-2		3
	14+	n=50		-1		7		1		3		0		13
Overall Health	Excellent / Very Good	n=154		2		2		-5		-2		3		-2
	Good	n=30		-9		-12		9		6		-23		7
	Fair / Poor	n=12		-6		-7		16		1		7		-10
Mental Health	Excellent / Very Good	n=145		3		2		-1		-2		3		0
	Good	n=34		-8		-6		-2		3		-16		13
	Fair / Poor	n=19		-9		-15		11		8		2		-13
Race Ethnicity	White	n=86		0		-1		2		3		-2		-3
	Black / African American	n=12		2		-36		16		3		-7		30
	Asian	n=23		-22		-11		-12		-5		-15		-10
	American Indian or Alaska Native	n=7		-9		-69		-9		11		27		-20
	Native Hawaiian or other Pacific Islander	n=0		--		--		--		--		--		--
	Hispanic	n=146		-1		-1		2		0		-1		-2

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Health Equity

Medicaid Child

Group is performing…

- Above the plan score by 5 or more points
- Above the plan score
- Below the plan score
- Below the plan score by 5 or more points
- Above/below plan score but has low base (<30)

The infographic below highlights disparities in health equity among key demographic groups across the key metrics. Darker shading indicates a larger disparity.

Demographic	*Category*	*Total*	Coordination of Care		Customer Service		How Well Doctors Communicate		Ease of Filling Out Forms	
			SRS	△	SRS	△	SRS	△	SRS	△
			76.8%		88.5%		91.0%		95.4%	
Child's Sex	Male	*n=112*		-6		3		-1		0
	Female	*n=82*		5		-3		1		0
Child's Age	0 to 4	*n=51*		0		-6		-2		3
	5 to 8	*n=43*		16		0		0		-2
	9 to 13	*n=50*		-9		2		4		3
	14+	*n=50*		-5		4		-3		-4
Overall Health	Excellent / Very Good	*n=154*		-2		1		1		1
	Good	*n=30*		-2		-1		-5		-3
	Fair / Poor	*n=12*		12		-5		-2		-12
Mental Health	Excellent / Very Good	*n=145*		-4		-1		1		1
	Good	*n=34*		-10		5		-12		-4
	Fair / Poor	*n=19*		23		0		9		-1
Race Ethnicity	White	*n=86*		-11		-5		1		-5
	Black / African American	*n=12*		-37		11		-8		-4
	Asian	*n=23*		9		11		-5		-4
	American Indian or Alaska Native	*n=7*		-27		11		-8		-10
	Native Hawaiian or other Pacific Islander	*n=0*		--		--		--		--
	Hispanic	*n=146*		-4		-2		1		0

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Key Driver Analysis



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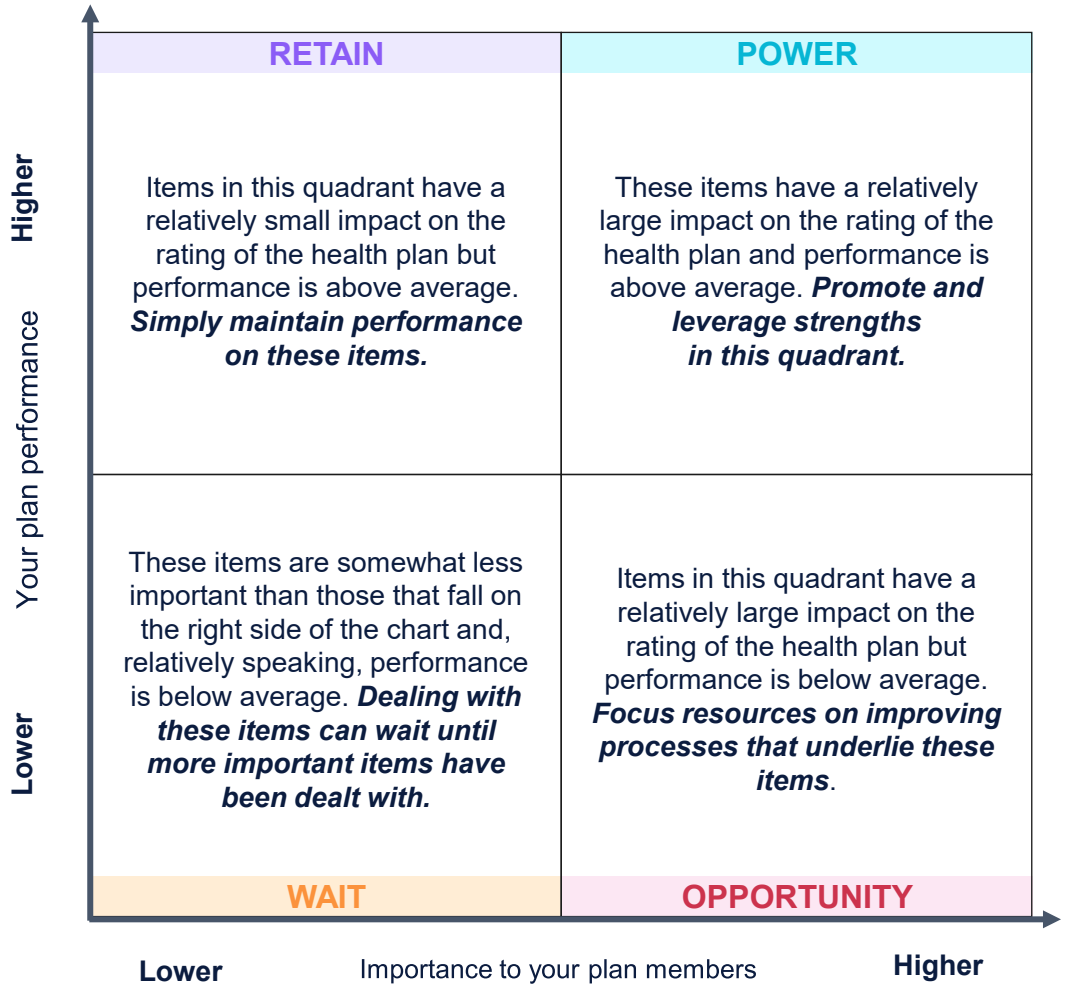
POWeR Chart

POWeR™ CHART CLASSIFICATION MATRIX

Overview. The SatisAction™ key driver statistical model is a powerful, proprietary statistical methodology used to identify the key drivers of the rating of the health plan and provide actionable direction for satisfaction improvement programs. This methodology is the result of a number of years of development and testing using health care satisfaction data.

The model provides the following:

- Identification of the elements that are important in driving of the rating of the health plan.
- Measurement of the relative importance of each of these elements.
- Measurement of how well members think the plan performed on those important elements.
- Presentation of the importance/performance results in a matrix that provides clear direction for member satisfaction improvement efforts by the plan.



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POWeR Chart – Your Results

			SURVEY MEASURE	2024 SRS	2025 SRS	2026 SRS	2026 %tile
			POWER				
◆	HWDC	**Q14**	Dr. showed respect	--	--	**97.7%**	60th
			OPPORTUNITY				
■	RATING	**Q8**	Rating of Health Care	--	--	**69.4%**	18th
■	RATING	**Q21**	Rating of Personal Doctor	--	--	**73.5%**	8th
◆	GCQ	**Q6**	Getting routine care	--	--	**81.3%**	25th
●	GNC	**Q9**	Getting care, tests, or treatment	--	--	**87.8%**	15th
◆	HWDC	**Q13**	Dr. listened carefully	--	--	**92.5%**	4th
◆	HWDC	**Q12**	Dr. explained things	--	--	**93.3%**	28th
●	CS	**Q28**	Treated with courtesy and respect	--	--	**93.4%**	30th
■	RATING	**Q25**	Rating of Specialist	--	--	**70.4%**	17th
			WAIT				
◆	HWDC	**Q16**	Dr. explained things to child	--	--	**89.7%**	--
◆	HWDC	**Q17**	Dr. spent enough time	--	--	**80.6%**	1st
●	CS	**Q27**	Provided information or help	--	--	**83.6%**	50th
■	CC	**Q20**	Coordination of Care	--	--	**76.8%**	5th
■	SQ	**Q44**	Able to reschedule non-urgent care appointment for your child in a timely manner	--	--	**69.8%**	--
●	GNC	**Q23**	Getting specialist appointment	--	--	**79.7%**	45th
			RETAIN				
●	CS	**Q30**	Ease of Filling Out Forms	--	--	**95.4%**	57th
◆	GCQ	**Q4**	Getting urgent care	--	--	**96.0%**	87th

*Percentiles based on the Press Ganey BOB of the listed year.



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Measure Analysis

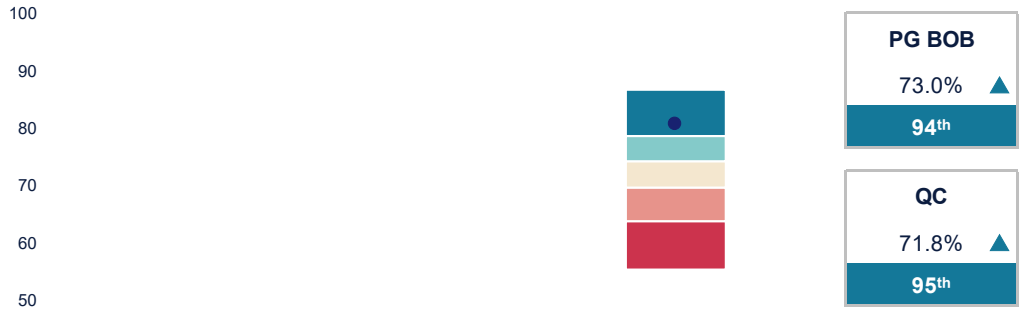


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Ratings

Medicaid Child

Q31. Rating of Health Plan 9-10%



	2024	2025	2026
n	--	--	194
SRS 9-10%	--	--	80.9%

Q31. Rating of Health Plan 8-10%



	2024	2025	2026
n	--	--	194
8-10%	--	--	90.7%

Q8. Rating of Health Care 9-10%



	2024	2025	2026
n	--	--	124
SRS 9-10%	--	--	69.4%

Q8. Rating of Health Care 8-10%



	2024	2025	2026
n	--	--	124
8-10%	--	--	87.1%

Percentile Bands are for QC benchmark.

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Ratings

Medicaid Child

Q21. Rating of Personal Doctor 9-10%



	2024	2025	2026
n	--	--	166
SRS 9-10%	--	--	73.5%

Q21. Rating of Personal Doctor 8-10%



	2024	2025	2026
n	--	--	166
8-10%	--	--	88.6%

Q25. Rating of Specialist 9-10%



	2024	2025	2026
n	--	--	54^
SRS 9-10%	--	--	70.4%

Q25. Rating of Specialist 8-10%



	2024	2025	2026
n	--	--	54^
8-10%	--	--	88.9%

Percentile Bands are for QC benchmark.

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Getting Needed Care

Medicaid Child

Getting Needed Care



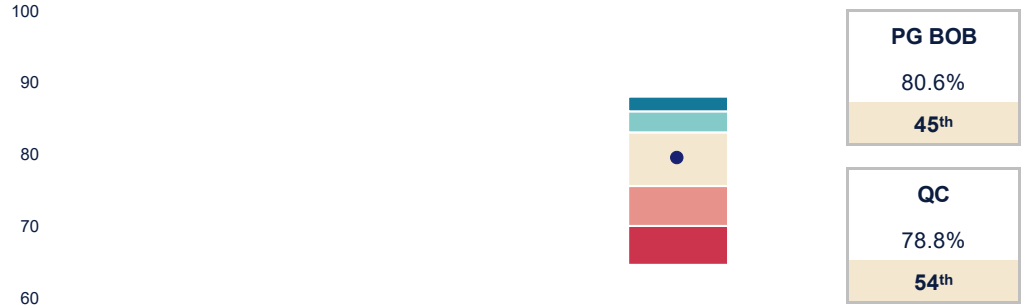
	2024	2025	2026
n	--	--	91^
SRS	--	--	83.7%

Q9. Getting care, tests, or treatment



	2024	2025	2026
n	--	--	123
SRS	--	--	87.8%

Q23. Getting specialist appointment



	2024	2025	2026
n	--	--	59^
SRS	--	--	79.7%

Percentile Bands are for QC benchmark.

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Getting Care Quickly

Medicaid Child

Getting Care Quickly



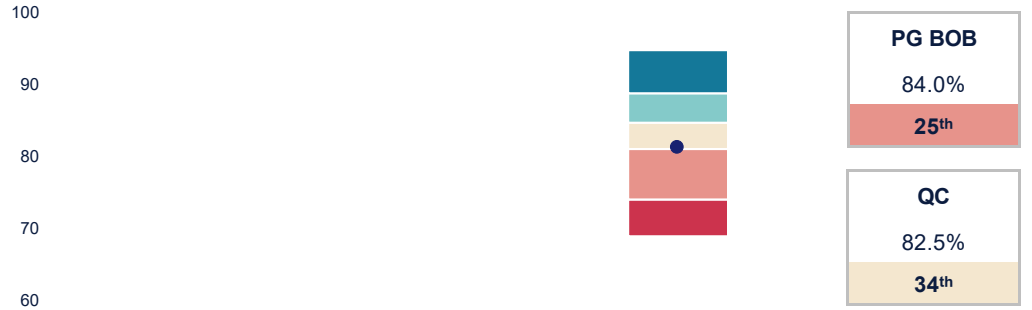
	2024	2025	2026
n	--	--	86^
SRS	--	--	88.7%

Q4. Getting urgent care



	2024	2025	2026
n	--	--	50^
SRS	--	--	96.0%

Q6. Getting routine care



	2024	2025	2026
n	--	--	123
SRS	--	--	81.3%

Percentile Bands are for QC benchmark.

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Customer Service

Medicaid Child

Customer Service



	2024	2025	2026
n	--	--	61^
SRS	--	--	88.5%

PG BOB	
89.0%	
45th	

QC	
88.2%	
52nd	

Q27. Provided information or help



	2024	2025	2026
n	--	--	61^
SRS	--	--	83.6%

PG BOB	
83.4%	
50th	

QC	
82.3%	
64th	

Q28. Treated with courtesy and respect



	2024	2025	2026
n	--	--	61^
SRS	--	--	93.4%

PG BOB	
94.7%	
30th	

QC	
94.1%	
35th	

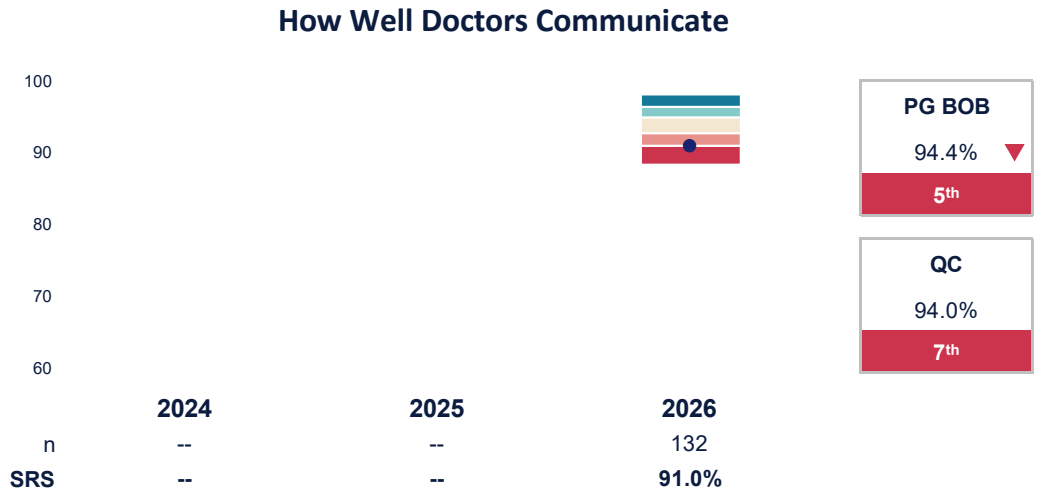
Percentile Bands are for QC benchmark.

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How Well Doctors Communicate

Medicaid Child



Percentile Bands are for QC benchmark.

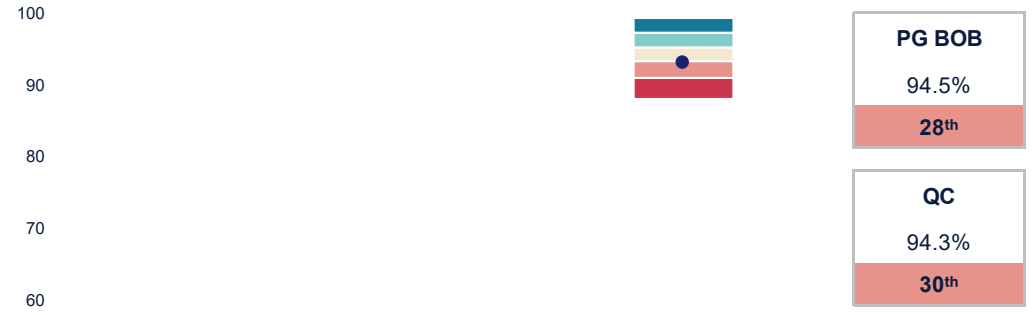
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How Well Doctors Communicate

Medicaid Child

Q12. Dr. explained things



	2024	2025	2026
n	--	--	134
SRS	--	--	93.3%

Q13. Dr. listened carefully



	2024	2025	2026
n	--	--	133
SRS	--	--	92.5%

Q14. Dr. showed respect



	2024	2025	2026
n	--	--	130
SRS	--	--	97.7%

Q17. Dr. spent enough time



	2024	2025	2026
n	--	--	134
SRS	--	--	80.6%

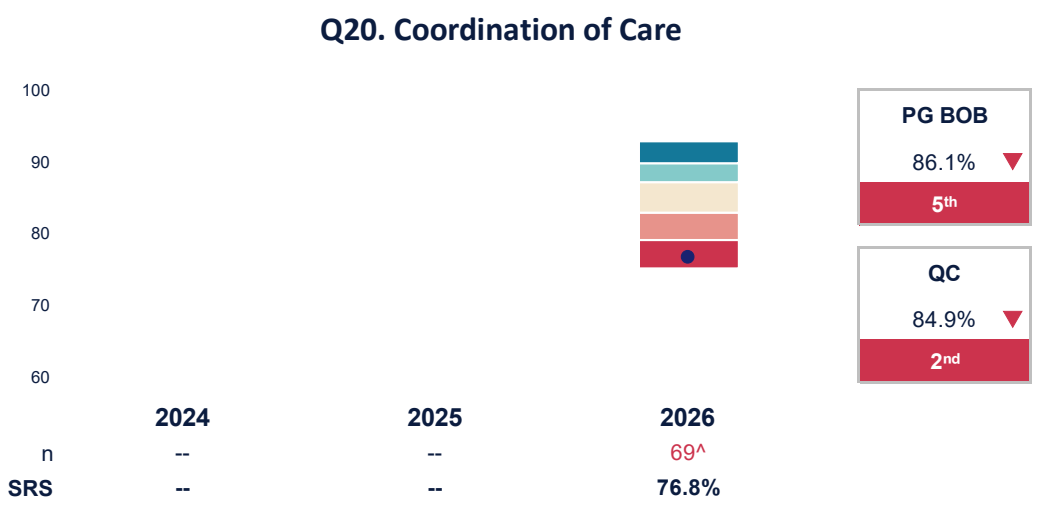
Percentile Bands are for QC benchmark.

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Coordination of Care

Medicaid Child



Percentile Bands are for QC benchmark.

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Summary of Trend and Benchmark



Summary Rate Scores

Medicaid Child

	2026 Valid n	2024	2025	2026	2026 Press Ganey BOB	2025 Quality Compass
Rating Questions (% 9 or 10)						
Q31. Rating of Health Plan	194	--	--	**80.9%**	73.0% ▲	71.8% ▲
Q8. Rating of Health Care	124	--	--	**69.4%**	73.2%	70.9%
Q21. Rating of Personal Doctor	166	--	--	**73.5%**	78.8% ▼	77.8%
Q25. Rating of Specialist	54^	--	--	**70.4%**	76.4%	73.2%
Rating Questions (% 8, 9 or 10)						
Q31. Rating of Health Plan	194	--	--	**90.7%**	86.7% ▲	86.5% ▲
Q8. Rating of Health Care	124	--	--	**87.1%**	88.7%	87.4%
Q21. Rating of Personal Doctor	166	--	--	**88.6%**	91.0%	90.6%
Q25. Rating of Specialist	54^	--	--	**88.9%**	88.6%	87.4%
Getting Needed Care (% Usually or Always)	91^	--	--	**83.7%**	85.8%	84.0%
Q9. Getting care, tests, or treatment	123	--	--	**87.8%**	91.0%	89.8%
Q23. Getting specialist appointment	59^	--	--	**79.7%**	80.6%	78.8%
Getting Care Quickly (% Usually or Always)	86^	--	--	**88.7%**	87.7%	86.2%
Q4. Getting urgent care	50^	--	--	**96.0%**	91.3%	90.2%
Q6. Getting routine care	123	--	--	**81.3%**	84.0%	82.5%
Q20. Coordination of Care (% Usually/Always)	69^	--	--	**76.8%**	86.1% ▼	84.9% ▼
Customer Service (% Usually or Always)	61^	--	--	**88.5%**	89.0%	88.2%
Q27. Provided information or help	61^	--	--	**83.6%**	83.4%	82.3%
Q28. Treated with courtesy and respect	61^	--	--	**93.4%**	94.7%	94.1%

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Summary Rate Scores

Medicaid Child

	2026 Valid n	2024	2025	2026	2026 Press Ganey BOB	2025 Quality Compass
How Well Doctors Communicate (% Usually or Always)	132	--	--	**91.0%**	94.4% ▼	94.0%
Q12. Dr. explained things	134	--	--	**93.3%**	94.5%	94.3%
Q13. Dr. listened carefully	133	--	--	**92.5%**	96.1% ▼	95.5% ▼
Q14. Dr. showed respect	130	--	--	**97.7%**	97.2%	97.0%
Q17. Dr. spent enough time	134	--	--	**80.6%**	89.8% ▼	88.9% ▼
Q30. Ease of Filling Out Forms (% Usually or Always)	195	--	--	**95.4%**	95.0%	95.2%

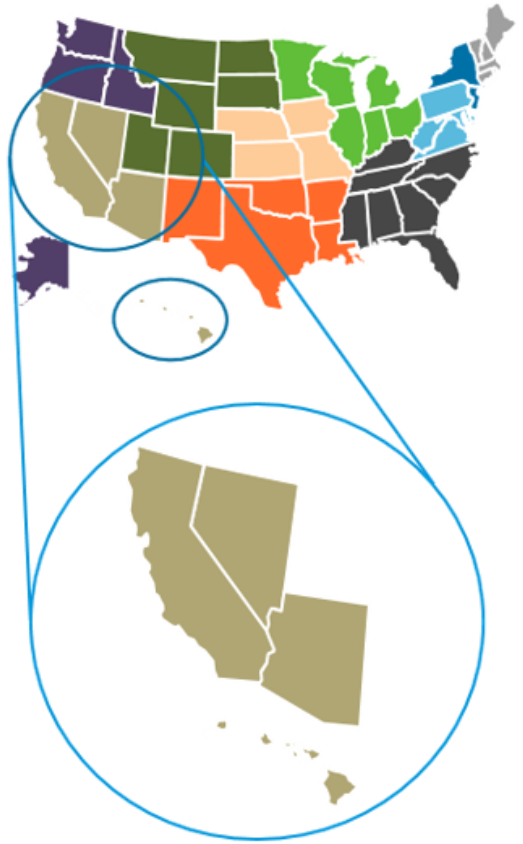
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Regional Performance

Medicaid Child

	2026	2026 PG BOB Region
Rating Questions (% 9 or 10)		
Q31. Rating of Health Plan	**80.9%**	74.1% ▲
Q8. Rating of Health Care	**69.4%**	73.0%
Q21. Rating of Personal Doctor	**73.5%**	78.4%
Q25. Rating of Specialist	**70.4%**	77.6%
Rating Questions (% 8, 9 or 10)		
Q31. Rating of Health Plan	**90.7%**	87.7%
Q8. Rating of Health Care	**87.1%**	88.3%
Q21. Rating of Personal Doctor	**88.6%**	91.2%
Q25. Rating of Specialist	**88.9%**	89.0%
Getting Needed Care (% Usually or Always)	**83.7%**	83.5%
Q9. Getting care, tests, or treatment	**87.8%**	88.7%
Q23. Getting specialist appointment	**79.7%**	78.3%
Getting Care Quickly (% Usually or Always)	**88.7%**	84.4%
Q4. Getting urgent care	**96.0%**	88.4%
Q6. Getting routine care	**81.3%**	80.5%
Q20. Coordination of Care (% Usually or Always)	**76.8%**	84.1%
Customer Service (% Usually or Always)	**88.5%**	89.6%
Q27. Provided information or help	**83.6%**	84.1%
Q28. Treated with courtesy and respect	**93.4%**	95.2%

HHS Regions: The regions used align with the U.S. Department of Health and Human Services regions.



Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada

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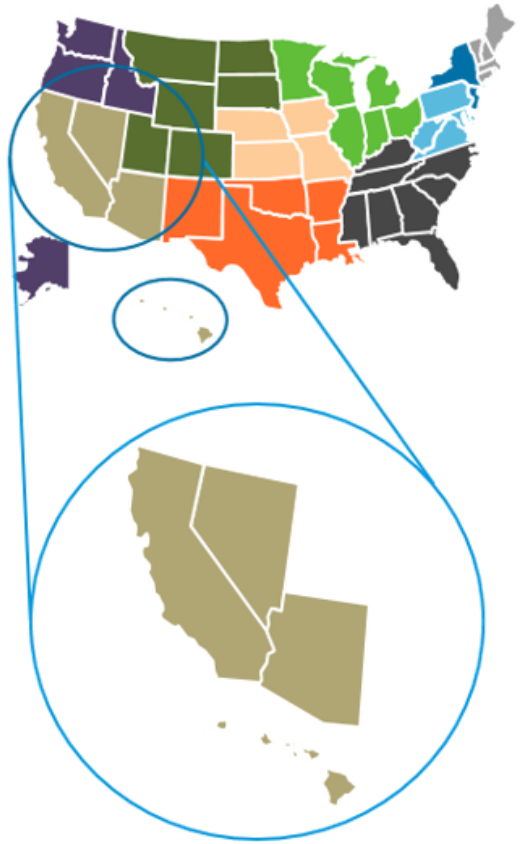
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Regional Performance

Medicaid Child

	2026	2026 PG BOB Region	
How Well Doctors Communicate (% Usually or Always)	**91.0%**	93.1%	
Q12. Dr. explained things	**93.3%**	93.2%	
Q13. Dr. listened carefully	**92.5%**	95.3%	
Q14. Dr. showed respect	**97.7%**	97.0%	
Q17. Dr. spent enough time	**80.6%**	87.0%	▼
Q30. Ease of Filling Out Forms (% Usually or Always)	**95.4%**	95.0%	

HHS Regions: The regions used align with the U.S. Department of Health and Human Services regions.



Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada

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Percentile Rankings

Medicaid Child

	Plan Score	QC %tile	2025 Quality Compass - Percentile Ranks									PG %tile	2026 Press Ganey BOB - Percentile Ranks								
			5th	10th	25th	33rd	50th	67th	75th	90th	95th		5th	10th	25th	33rd	50th	67th	75th	90th	95th
Rating Questions (% 9 or 10)																					
Q31. Rating of Health Plan	**80.9%**	95th	60.7	63.9	69.0	69.9	72.0	74.5	75.6	78.8	80.5	94th	63.7	66.0	69.8	70.6	73.1	75.1	76.7	79.7	81.0
Q8. Rating of Health Care	**69.4%**	39th	61.9	64.5	67.2	68.3	71.1	73.4	74.4	78.3	79.2	18th	66.1	67.6	70.0	71.4	72.9	74.5	75.7	79.0	81.2
Q21. Rating of Personal Doctor	**73.5%**	12th	72.0	72.9	75.9	76.5	78.2	79.4	80.2	82.0	83.3	8th	72.7	73.9	76.2	76.9	78.6	80.4	81.4	83.7	84.8
Q25. Rating of Specialist	**70.4%**	31st	67.3	68.4	69.9	70.5	72.6	75.8	76.4	78.0	80.4	17th	65.7	68.1	72.5	74.1	76.6	79.3	80.7	84.3	85.9
Rating Questions (% 8, 9 or 10)																					
Q31. Rating of Health Plan	**90.7%**	90th	79.1	81.1	84.4	85.5	87.2	88.3	89.0	90.7	91.6	87th	80.4	81.8	84.7	85.3	87.1	88.5	89.1	91.0	92.2
Q8. Rating of Health Care	**87.1%**	44th	81.8	83.2	85.5	86.3	87.5	88.5	89.4	91.4	93.2	28th	82.5	84.1	86.7	87.4	88.9	90.2	90.8	92.5	93.9
Q21. Rating of Personal Doctor	**88.6%**	17th	86.6	87.7	89.3	89.6	90.7	91.5	92.3	93.3	94.1	16th	87.1	87.9	89.1	89.7	91.0	92.1	92.7	94.3	94.8
Q25. Rating of Specialist	**88.9%**	71st	81.5	84.5	85.2	85.6	86.9	88.6	89.1	92.3	93.3	52nd	80.6	82.0	85.1	86.7	88.9	90.7	91.7	94.0	95.3
Getting Needed Care (% U/A)	**83.7%**	46th	76.6	77.9	80.7	82.3	84.1	86.4	87.5	89.5	90.5	30th	78.9	80.6	82.7	84.1	85.6	87.6	88.4	90.9	92.3
Q9. Getting care, tests, or treatment	**87.8%**	26th	82.7	84.7	87.6	88.6	90.3	91.7	92.3	94.6	94.9	15th	85.6	86.9	88.9	89.9	91.0	92.6	93.4	94.8	95.7
Q23. Getting specialist appointment	**79.7%**	54th	68.7	70.1	74.1	75.7	78.7	83.2	84.5	86.1	87.3	45th	69.3	71.4	76.2	77.5	80.6	83.3	84.7	88.5	90.9
Getting Care Quickly (% U/A)	**88.7%**	67th	76.6	79.1	83.6	85.0	86.8	88.6	89.5	92.0	93.4	55th	79.9	81.8	85.4	86.3	88.0	89.7	90.7	92.3	93.5
Q4. Getting urgent care	**96.0%**	89th	82.6	83.8	86.7	88.6	90.5	92.9	93.8	96.1	96.7	87th	83.2	85.4	88.3	89.2	91.4	93.8	94.5	96.5	96.9
Q6. Getting routine care	**81.3%**	34th	70.7	74.1	79.5	81.2	82.8	84.9	86.2	88.9	91.6	25th	74.6	76.5	81.1	82.3	84.6	86.2	87.5	90.4	91.9
Q20. Coordination of Care (% U/A)	**76.8%**	2nd	78.2	79.2	81.9	83.1	84.7	87.3	88.4	89.9	90.7	5th	76.3	78.8	82.4	83.3	86.7	88.5	89.4	91.6	93.0
Customer Service (% U/A)	**88.5%**	52nd	82.6	84.6	86.2	87.3	88.4	89.7	90.4	91.7	92.7	45th	82.6	84.4	86.5	87.5	88.9	90.6	91.4	93.6	95.3
Q27. Provided information or help	**83.6%**	64th	75.5	77.1	79.6	80.6	82.7	84.2	84.6	87.0	89.3	50th	74.0	76.5	79.4	81.2	83.5	85.7	86.9	89.6	92.3
Q28. Treated with courtesy and respect	**93.4%**	35th	89.5	90.9	92.4	93.2	94.4	95.3	96.1	97.1	98.2	30th	88.2	90.8	92.9	93.6	94.9	96.3	96.8	98.6	100.0

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Percentile Rankings

Medicaid Child

	Plan Score	QC %tile	2025 Quality Compass - Percentile Ranks									PG %tile	2026 Press Ganey BOB - Percentile Ranks								
			5th	10th	25th	33rd	50th	67th	75th	90th	95th		5th	10th	25th	33rd	50th	67th	75th	90th	95th
How Well Doctors Communicate (% U/A)	**91.0%**	7th	90.3	91.2	92.3	92.9	94.1	95.1	95.6	96.5	97.1	5th	91.0	91.7	93.1	93.5	94.4	95.2	95.6	97.0	97.4
Q12. Dr. explained things	**93.3%**	30th	90.2	91.1	93.0	93.4	94.4	95.3	96.0	97.4	98.2	28th	90.1	91.0	93.0	93.5	94.6	95.6	95.9	97.3	97.9
Q13. Dr. listened carefully	**92.5%**	4th	92.5	93.0	94.2	94.8	95.7	96.7	96.9	97.6	98.3	4th	92.6	94.0	95.2	95.5	96.2	96.9	97.4	98.4	98.8
Q14. Dr. showed respect	**97.7%**	64th	94.5	95.2	96.1	96.5	97.1	97.8	98.1	98.7	99.2	60th	94.6	95.1	96.3	96.7	97.3	97.9	98.3	99.2	100.0
Q17. Dr. spent enough time	**80.6%**	3rd	81.3	82.7	86.3	87.7	89.3	91.1	91.6	94.0	94.8	1st	82.6	83.9	86.7	87.8	90.1	91.6	92.4	94.6	95.8
Q30. Ease of Filling Out Forms (% U/A)	**95.4%**	51st	92.5	93.0	94.0	94.5	95.3	96.1	96.5	97.3	97.8	57th	92.1	92.7	93.8	94.3	95.0	95.9	96.4	97.5	98.1

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Appendix



Appendix A: Correlations

Highest Correlations

Below are the key measures with the highest correlations to the Rating measures.

With Rating Of Health Care

Q31	Rating of Health Plan	0.6098
Q21	Rating of Personal Doctor	0.5560
Q25	Rating of Specialist	0.4266
Q28	Treated with courtesy and respect	0.4256
Q27	Provided information or help	0.4139
Q13	Dr. listened carefully	0.4124
Q6	Getting routine care	0.3783
Q14	Dr. showed respect	0.3339
Q16	Dr. explained things to child	0.3176
Q44	Able to reschedule non-urgent care appointment for your child in a timely manner	0.2727

With Rating Of Personal Doctor

Q8	Rating of Health Care	0.5560
Q31	Rating of Health Plan	0.5239
Q14	Dr. showed respect	0.5151
Q13	Dr. listened carefully	0.5141
Q9	Getting care, tests, or treatment	0.4769
Q16	Dr. explained things to child	0.4704
Q20	Coordination of Care	0.4271
Q17	Dr. spent enough time	0.4023
Q12	Dr. explained things	0.3932
Q25	Rating of Specialist	0.3461

With Rating Of Specialist

Q31	Rating of Health Plan	0.6626
Q28	Treated with courtesy and respect	0.5283
Q12	Dr. explained things	0.4744
Q9	Getting care, tests, or treatment	0.4728
Q16	Dr. explained things to child	0.4601
Q8	Rating of Health Care	0.4266
Q17	Dr. spent enough time	0.4231
Q21	Rating of Personal Doctor	0.3461
Q27	Provided information or help	0.2948
Q20	Coordination of Care	0.2687

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Supplemental Questions

Medicaid Child

	2024	2025	2026
Q42. Wait time to see child's Dr. for set appt. after arrival			
Opt-out / Exclusion (n)			
Does not apply, my child did not have any appointments in the last 6 months	--	--	18
Base (n)	**--**	**--**	**173**
15 minutes or less	--	--	45.7%
16-30 minutes	--	--	34.1%
31-45 minutes	--	--	12.1%
46 minutes to 1 hour	--	--	6.4%
Over 1 hour	--	--	1.7%
Mean Score	**--**	**--**	**19.3**
Q43. How often child had to wait for an appointment due to provider's limited availability			
Opt-out / Exclusion			
Not Applicable	--	--	28
Base (n)	**--**	**--**	**162**
Never	--	--	46.9%
Sometimes	--	--	39.5%
Usually	--	--	8.0%
Always	--	--	5.6%
Summary Rate Score (%Never or Sometimes)	**--**	**--**	**86.4%**
Q44. Able to reschedule non-urgent care appointment for your child in a timely manner			
Opt-out / Exclusion			
Not Applicable	--	--	28
Base (n)	**--**	**--**	**159**
Always	--	--	42.1%
Usually	--	--	27.7%
Sometimes	--	--	18.2%
Never	--	--	11.9%
Summary Rate Score (%Usually or Always)	**--**	**--**	**69.8%**

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Supplemental Questions

Medicaid Child

	2024	2025	2026
Q45. Reason it was difficult to get an appointment with a specialist for your child			
Opt-out / Exclusion (n)			
None of the above.	--	--	54
I did not have a problem getting an appointment with a specialist for my child.	--	--	78
Base (n)	**--**	**--**	**43**
My child's doctor did not think my child needed to see a specialist.	--	--	32.6%
My child's health plan's approval or authorization was delayed.	--	--	20.9%
I could not get a referral for my child.	--	--	11.6%
I wasn't sure where to find a list of specialists in my child's health plan or network.	--	--	18.6%
The specialists I had to choose from were too far away.	--	--	9.3%
My child's health plan did not have enough specialists to choose from.	--	--	11.6%
The specialist I wanted did not belong to my child's health plan or network.	--	--	9.3%
I could not get a specialist appointment for my child at a time that was good.	--	--	37.2%
Some other reason (Please Specify)	--	--	16.3%

Q46. Which CS center have contacted most recently			
Opt-out / Exclusion			
I did not contact customer service	--	--	96
Base (n)	**--**	**--**	**81**
Health Plan's Customer Service (Phone number on ID Card)	--	--	22.2%
Provider and/or Doctors Office	--	--	53.1%
Retail Pharmacy Services	--	--	17.3%
Other (Please Specify)	--	--	7.4%

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Supplemental Questions

Medicaid Child

	2024	2025	2026
Q47. Info not received when contacting child's customer service			
Opt-out / Exclusion (n)			
I got the information I needed	--	--	120
Base (n)	**--**	**--**	**39**
Transportation services	--	--	15.4%
Interpreter services	--	--	23.1%
Radiology services	--	--	10.3%
Vision services	--	--	20.5%
Mental Health or substance use services	--	--	7.7%
Claims or billing	--	--	2.6%
Help with a complaint or appeal	--	--	2.6%
In-network providers	--	--	10.3%
Referrals or prior authorization	--	--	5.1%
Prescription drug coverage	--	--	23.1%
Durable medical equipment (for example: wheelchair, diabetic supplies, etc.)	--	--	2.6%
Other (Please Specify)	--	--	35.9%

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Item #12

Attachment 12.A

Financials as of August 31, 2026

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of August 31, 2026

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	299,995,175.06
5	Total Bank Accounts	**$299,995,175.06**
6	Accounts Receivable	
7	Accounts Receivable	$588,251,160.26
8	Total Accounts Receivable	**$588,251,160.26**
9	Other Current Assets	
10	Interest Receivable	697,471.37
11	Investments - CDs	$0.00
12	Prepaid Expenses	1,555,490.83
13	Security Deposit	$0.00
14	Total Other Current Assets	**$2,252,962.20**
15	Total Current Assets	**$890,499,297.52**
16	Fixed Assets	
17	Buildings	5,479,147.18
18	Computers & Software	$0.00
19	Construction in Progress	$0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	111,358.69
22	Total Fixed Assets	**$8,751,924.97**
23	Other Assets	
24	Investment -Restricted	305,521.10
25	Lease Receivable	2,353,767.05
26	Total Other Assets	**$2,659,288.15**
27	TOTAL ASSETS	**$901,910,510.64**
28	LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	265,319.85
33	Accrued Admin Service Fee	4,484,293.00
34	Capitation Payable	133,466,537.72
35	Claims Payable	82,542.96
36	Directed Payment Payable	385,055,653.17
37	Total Accounts Payable	**$523,354,346.70**
38	Other Current Liabilities	
39	Accrued Expenses	402,178.05
40	Accrued Payroll	149,484.66
41	Accrued Vacation Pay	456,980.31
42	Amt Due to DHCS	38,214,393.47
43	IBNR	252,987.69
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	**$165,384,761.80**
49	Total Current Liabilities	**$688,739,108.50**
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	**$688,783,036.79**
55	Deferred Inflow of Resources	1,933,013.98
56	Equity	
57	Retained Earnings	208,785,016.49
58	Net Income	2,409,443.38
59	Total Equity	**$211,194,459.87**
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	**$901,910,510.64**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2026 - August 2026 Income Statement

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	Interest Income	1,704,059.23	1,210,000.00	494,059.23
3	Premium/Capitation Income	390,847,189.95	393,349,486.00	(2,502,296.05)
4	**Total Income**	**392,551,249.18**	**394,559,486.00**	**(2,008,236.82)**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	251,670,413.92	253,760,619.00	(2,090,205.08)
7	Medical Claim Costs	702,849.71	833,334.00	(130,484.29)
8	**Total Costs of Medical Care**	**252,373,263.63**	**254,593,953.00**	**(2,220,689.37)**
9	**Gross Margin**	**140,177,985.55**	**139,965,533.00**	**212,452.55**
10	**Expenses**			
11	Admin Service Agreement Fees	8,965,880.00	8,958,708.00	7,172.00
12	Bank Charges	195.66	1,200.00	(1,004.34)
13	Computer & IT Services	29,304.20	48,584.00	(19,279.80)
14	Consulting & Accreditation Fees	10,000.00	90,834.00	(80,834.00)
15	Depreciation Expense	56,485.70	62,000.00	(5,514.30)
16	Dues & Subscriptions	42,622.73	60,000.00	(17,377.27)
17	Grants & Community Reinvestment	1,777,272.73	2,045,455.00	(268,182.27)
18	Insurance	66,457.19	92,402.00	(25,944.81)
19	Labor	802,831.89	951,760.00	(148,928.11)
20	Legal & Professional Fees	46,111.09	62,420.00	(16,308.91)
21	License Expense	262,840.76	296,808.00	(33,967.24)
22	Marketing	212,555.91	250,000.00	(37,444.09)
23	Meals and Entertainment	3,720.83	5,575.00	(1,854.17)
24	Office Expenses	17,634.27	22,500.00	(4,865.73)
25	Parking	0.00	260.00	(260.00)
26	Postage & Delivery	430.00	820.00	(390.00)
27	Printing & Reproduction	494.51	916.66	(422.15)
28	Recruitment Expense	903.53	28,750.00	(27,846.47)
29	Rent	0.00	2,000.00	(2,000.00)
30	Seminars & Training	3,841.98	5,600.00	(1,758.02)
31	Supplies	1,975.22	2,700.00	(724.78)
32	Taxes	125,583,333.34	125,583,334.00	(0.66)
33	Telephone & Internet	3,781.75	8,000.00	(4,218.25)
34	Travel	1,900.22	5,566.66	(3,666.44)
35	**Total Expenses**	**137,890,573.51**	**138,586,193.32**	**(695,619.81)**
36	**Net Operating Income**	**2,287,412.04**	**1,379,339.68**	**908,072.36**
37	**Other Income**			
38	Other Income	122,031.34	84,000.00	38,031.34
39	**Total Other Income**	**122,031.34**	**84,000.00**	**38,031.34**
40	**Net Other Income**	**122,031.34**	**84,000.00**	**38,031.34**
41	**Net Income**	**2,409,443.38**	**1,463,339.68**	**946,103.70**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

CY vs PY Income Statement

		Total	
		July 2026 - Aug 2026 (Current Year)	July 2025 - Aug 2025 (Prior Year)
1	Income		
2	Interest Income	1,704,059.23	1,356,168.42
3	Premium/Capitation Income	390,847,189.95	321,127,201.71
4	**Total Income**	**392,551,249.18**	**322,483,370.13**
5	Cost of Medical Care		
6	Capitation - Medical Costs	251,670,413.92	243,793,725.77
7	Medical Claim Costs	702,849.71	945,253.53
8	**Total Costs of Medical Care**	**252,373,263.63**	**244,738,979.30**
9	**Gross Margin**	**140,177,985.55**	**77,744,390.83**
10	Expenses		
11	Admin Service Agreement Fees	8,965,880.00	9,532,259.00
12	Bank Charges	195.66	0.00
13	Computer & IT Services	29,304.20	44,211.38
14	Consulting/Accreditation Fees	10,000.00	5,460.00
15	Depreciation Expense	56,485.70	57,012.04
16	Dues & Subscriptions	42,622.73	42,559.54
17	Grants & Community Reinvestment	1,777,272.73	1,527,335.35
18	Insurance	66,457.19	63,509.95
19	Labor	802,831.89	671,530.19
20	Legal & Professional Fees	46,111.09	27,481.97
21	License Expense	262,840.76	214,521.14
22	Marketing	212,555.91	180,181.68
23	Meals and Entertainment	3,720.83	1,377.31
24	Office Expenses	17,634.27	15,349.94
25	Parking	0.00	20.00
26	Postage & Delivery	430.00	481.90
27	Printing & Reproduction	494.51	0.00
28	Recruitment Expense	903.53	222.06
29	Rent	0.00	0.00
30	Seminars and Training	3,841.98	150.99
31	Supplies	1,975.22	2,567.26
32	Taxes	125,583,333.34	62,791,666.67
33	Telephone & Internet	3,781.75	3,937.56
34	Travel	1,900.22	2,472.85
35	**Total Expenses**	**137,890,573.51**	**75,184,308.78**
36	**Net Operating Income**	**2,287,412.04**	**2,560,082.05**
37	Other Income		
38	Other Income	122,031.34	105,473.07
39	**Total Other Income**	**122,031.34**	**105,473.07**
40	**Net Other Income**	**122,031.34**	**105,473.07**
41	**Net Income**	**2,409,443.38**	**2,665,555.12**

Item #12

Attachment 12.B

Baker Tilly Audit Proposal

Baker Tilly US, LLP
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San Francisco, CA 94104
United States of America

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September 9, 2026

Fresno Kings Madera Regional Health Authority
dba CalViva Health
c/o Mr. Daniel Maychen Chief Financial Officer
7625 North Palm Ave., Suite 109
Fresno, CA 93711

Subject: Fee Proposal for Audit and Nonattest Services

Dear Daniel,

Thank you for the opportunity to provide services to Fresno Kings Madera Regional Health Authority dba CalViva Health. In our engagement, we will audit the Company's statement of net position as of and for the years ending June 30, 2028; June 30, 2029; and June 20, 2030, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended. In addition, we will provide the Company with the following nonattest services:

Assist management in drafting the financial statements and related footnotes as of and for each of the years ending June 30, 2028; June 30, 2029; and June 20, 2030.

Rianne Suico is responsible for supervising the engagement and authorizing the signing of the report. Our fees for audit services will be:

SERVICE DESCRIPTION	FY 2028	FY 2029	FY 2030
Annual Financial Statement Audit	$76,500	$76,500	$76,500
Presentation of the audit results and Management Letter to the Finance Committee and Board of Commissioners		Included	
Total	**$76,500**	**$76,500**	**$76,500**

You will also be billed for expenses at our cost as they are incurred.

The fee estimates are based on anticipated level of preparation and cooperation from your management and staff, your completion of the year-end closing and adjusting process prior to our arrival to begin fieldwork and the expectation that the records will be in good order. We may experience delays in completing our service due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Our fees are also based on accounting and auditing standards currently in effect and on the assumption there will be minimal changes to the scope of accounting entity.

Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms.

Fresno Kings Madera Regional Health Authority
dba CalViva Health
c/o Mr. Daniel Maychen Chief Financial Officer
September 9, 2026

We appreciate the opportunity to be of service to you. Please let us know if you need additional information.

Baker Tilly US, LLP

Rianne Suico, Principal

CID: C0000028008 | 619112

Item #12

Attachment 12.C

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	25	14	10				163
Member Materials Filed for Approval;	6	3	3	7	3	6	5	10	5				48
Provider Materials Reviewed & Distributed	16	4	19	17	19	29	23	14	12				153
# of DMHC Filings	9	2	8	10	10	12	10	6	3				70

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	4	6	0				24
High-Risk	0	0	1	0	0	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 July 16, 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	2	5	4				29
# of Cases Open for Investigation (Active Number)	29	31	34	33	38	41	40	41	45				

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since July 16, 2026, Compliance Regulatory Report to the Commission, there were 7 new MC609 filings. The filings relate to the following:

- Inappropriate Billing: 5
- SNF Excessive Billing: 2

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: Claims/PDR, Credentialing, ECM, A&G, Access and Availability, Compliance Audit, Pharmacy, Privacy and Security and Behavioral Health. The following audits that have been completed since July 16, 2026, report to the Committee: Health Education (No CAP), Quality Improvement (No CAP), Member Rights (No CAP)

Regulatory Reviews/Audits and CAPS:	Status
Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	On August 4, 2026, DHCS accepted and closed the Focused Audit CAP.
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. The corrective action plan was submitted to DMHC on 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	The HSAG NAV virtual audits were conducted on July 14, 2026, and on August 25, 2026. The Plan is expected to receive audit findings in January 2027.
DHCS 2025 Annual Network Certification (ANC) – Alternative Access Standard (AAS) Determination	On October 2, 2026, the DHCS issued its formal determination regarding CalViva Health's 2025 Annual Network Certification (ANC) Alternative Access Standard (AAS) requests. DHCS approved 109 of the submitted AAS requests across Fresno, Kings, and Madera counties and issued zero (0) denials. CalViva Health is thus deemed compliant and has passed the 2025 ANC.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Unsatisfactory Immigration Status (US)	Effective January 1, 2027, Medi-Cal members with Unsatisfactory Immigration Status (UIS) will transition from Medi-Cal managed care to the Fee-for-Service (FFS) delivery system in accordance with federal requirements. DHCS has established implementation requirements and associated deliverables for MCPs to support an orderly transition of affected members, including activities related to member communications, continuity of care, data, and transition readiness. The Plan submitted the first deliverable on September 1, 2026. The Plan will continue to submit the required documents through the end of the year.

Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has executed the following MOUs: • Public Health (LHD) Kings County • First 5 Fresno County • Child Welfare Fresno County • First 5 Madera County
Plan Administration:	**Status**
2027 EOC Member Handbook	On July 15, 2026, DHCS released the 2027 EOC Member Handbook Template. The Plan submitted both clean and redline copies to DHCS and DMHC for approval on August 26, 20265. The EOC must be mailed or posted by January 1, 2027.
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 September 2, 2026. The following reports were presented: Q2 2026 Appeal and Grievance Report Review and Discussion of A&G trends from Dr Marabella Member Incentive Program-Semi-Annual Report Q1 and Q2 2026 The next PPC meeting will be held on December 3, 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 25-015 IMMUNIZATION REQUIREMENTS
- APL 26-001 IHA (supersedes APL 22-030)
- APL 26-002 NSMHS Rsponsibilities (supersedes APL 22-006)
- APL 26-003 QMED (supersedes APL 14-020)
- APL 26-004 MCP Responsibilities for BH Data Sharing
- APL 26-005 Maternity Serv for Preg and Postp Mbrs (superseds APLs 00-012, 18-022)
- APL 26-006 Skilled Nursing Facility Workforce Quality Incentive Program (supersedes APL 25-002)
- APL 26-007 Guidance on Network Provider Agreements (supersedes APL 19-001)
- APL 26-008 Interoperability Final Rules, Incl Prior Authorizations (supersedes APL 22-026)
- APL 26-009 PRIVATE DUTY NURSING CASE MANAGEMENT RESPONSIBILITIES (supersedes APL 20-012)
- APL 26-010 SKILLED NURSING FACILITIES (supersedes APL 24-009)
- APL 26-011 SUBACUTE CARE FACILITIES (supersedes APL 24-010)
- APL 26-012 ICFs FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (supersedes APL 24-011_
- APL 26-013 H.R. 1 Federal Payment to Prohibited Entities Important Update End of One Year Restriction on Federal Payments
- APL 26-014 Responsibilities for Ann. Cognitive Assessment (supersedes APL 22-025)
- APL 26-015 Immunization Requirements

2026 DMHC All Plan Letters:

- APL 26-016 CALIFORNIA CHILDREN'S SERVICES MEMBERS WITH UNSATISFACTORY IMMIGRATION STATUS
- APL 26-017 PROVIDER DISPUTE RESOLUTION MECHANISM AND REPORTING REQUIREMENTS
- APL 26-018 FEDERAL REIMBURSEMENT LIMITATION ON GENDER-AFFIRMING CARE
- APL 26-019 DYADIC SERVICES
- APL 26-005 Maternal and Infant Health Equity
- APL 26-002 - Delegation of Risk for COVID-19 Testing or Immunizations. Applicability of SB 510
- APL 26-007 – 2026 Health Plan Annual Assessments (4.15.2026)
- APL 26-013-ProvisionalLicensesofSubstanceUseDisorderFacilities(8_21_26)

Item #12
Attachment 12.D

Medical Management

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2026

Current as of End of the Month: August
Revised Date: 09/16/2026

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	18	50	23	32	0	55	0	0	0	0	146	111
Standard Grievances Received	200	191	221	612	206	195	229	630	278	273	0	551	0	0	0	0	1793	2295
Total Grievances Received	**207**	**206**	**240**	**653**	**220**	**213**	**247**	**680**	**301**	**305**	**0**	**606**	**0**	**0**	**0**	**0**	**1939**	**2406**
Grievance Ack Letters Sent Noncompliant	1	1	1	3	0	2	1	3	2	1	0	3	0	0	0	0	9	8
Grievance Ack Letter Compliance Rate	**99.5%**	**99.5%**	**99.5%**	**99.5%**	**100.0%**	**99.0%**	**99.6%**	**99.5%**	**99.3%**	**99.6%**	**0.0%**	**99.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.50%**	**99.65%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Expedited Grievances Resolved Compliant	7	14	19	40	14	18	17	49	24	31	0	55	0	0	0	0	144	110
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**95.8%**	**100.0%**	**0.0%**	**98.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.3%**	**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	206	639	224	254	0	478	0	0	0	0	1662	2292
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**170**	**196**	**219**	**585**	**231**	**234**	**223**	**688**	**249**	**285**	**0**	**534**	**0**	**0**	**0**	**0**	**1807**	**2403**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**158**	**186**	**211**	**555**	**215**	**221**	**193**	**629**	**229**	**263**	**0**	**492**	**0**	**0**	**0**	**0**	**1676**	**2259**
Access - Other - DMHC	29	30	36	95	36	42	36	114	60	50	0	110	0	0	0	0	319	431
Access - PCP - DHCS	4	9	13	26	11	25	12	48	10	13	0	23	0	0	0	0	97	153
Access - Physical/OON - DHCS	0	0	0	0	1	0	0	1	0	2	0	2	0	0	0	0	3	1
Access - Spec - DHCS	1	6	4	11	6	5	8	19	1	7	0	8	0	0	0	0	38	73
Administrative	31	36	29	96	27	22	35	84	32	38	0	70	0	0	0	0	250	438
Balance Billing	19	26	42	87	36	30	20	86	26	35	0	61	0	0	0	0	234	313
Community Supports	6	8	4	18	12	9	10	31	14	9	0	23	0	0	0	0	72	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	27	16	74	21	22	0	43	0	0	0	0	180	213
Behavioral Health	6	2	2	10	4	6	6	16	13	22	0	35	0	0	0	0	61	1
Other	14	14	11	39	8	3	5	16	6	13	0	19	0	0	0	0	74	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	2	4	3	1	0	4	0	0	0	0	13	15
Transportation - Access	6	11	12	29	16	15	12	43	10	11	0	21	0	0	0	0	93	126
Transportation - Behavior	1	6	7	14	2	4	3	9	2	5	0	7	0	0	0	0	30	49
Transportation - Other	20	19	22	61	24	32	28	84	31	35	0	66	0	0	0	0	211	209
Quality Of Care Grievances	**12**	**10**	**8**	**30**	**16**	**13**	**30**	**59**	**20**	**22**	**0**	**42**	**0**	**0**	**0**	**0**	**131**	**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	1	1	0	0	0	0	0	0	0	0	1	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	1	2	1	2	0	3	0	0	0	0	6	2
Other	3	2	2	7	5	3	8	16	5	5	0	10	0	0	0	0	33	26
PCP Care	8	4	2	14	6	4	8	18	5	8	0	13	0	0	0	0	45	58
PCP Delay	1	0	1	2	4	4	6	14	5	2	0	7	0	0	0	0	23	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	5	6	4	3	0	7	0	0	0	0	18	20
Specialist Delay	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	2	7
SNF-Long Term Care	0	1	0	1	1	0	0	1	0	1	0	1	0	0	0	0	3	4
Exempt Grievances Received	**171**	**154**	**154**	**479**	**126**	**116**	**138**	**380**	**191**	**184**	**0**	**375**	**0**	**0**	**0**	**0**	**1234**	**1798**
Access - Avail of Appt w/ PCP	3	5	2	**10**	1	3	2	**6**	3	5	0	**8**	0	0	0	**0**	**24**	**27**
Access - Avail of Appt w/ Specialist	0	0	0	**0**	1	1	0	**2**	0	1	0	**1**	0	0	0	**0**	**3**	**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**	1	1	0	**2**	0	0	0	**0**	**4**	**10**
Access - Wait Time - in office for appt	1	0	0	**1**	2	0	1	**3**	0	0	0	**0**	0	0	0	**0**	**4**	**2**
Access - Panel Disruption	0	2	7	**9**	0	1	2	**3**	0	0	0	**0**	0	0	0	**0**	**12**	**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**	1	1	0	**2**	0	0	0	**0**	**4**	**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	1	**1**	0	1	0	**1**	0	0	0	**0**	**2**	**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**	1	0	0	**1**	0	0	0	**0**	**2**	**0**
Attitude/Service - Health Plan Staff	0	7	3	**10**	1	4	1	**6**	0	2	0	**2**	0	0	0	**0**	**18**	**15**
Attitude/Service - Provider	9	4	11	**24**	9	5	3	**17**	6	22	0	**28**	0	0	0	**0**	**69**	**93**
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	2	1	0	**3**	0	0	0	**0**	**3**	**3**
Attitude/Service - Vendor	0	3	2	**5**	2	1	1	**4**	0	3	0	**3**	0	0	0	**0**	**12**	**36**
Attitude/Service - Health Plan	3	2	1	**6**	0	0	1	**1**	2	0	0	**2**	0	0	0	**0**	**9**	**8**
Authorization - Authorization Related	2	2	1	**5**	0	1	1	**2**	3	2	0	**5**	0	0	0	**0**	**12**	**17**
Eligibility Issue - Member not eligible per Health Plan	1	1	2	**4**	0	1	3	**4**	0	1	0	**1**	0	0	0	**0**	**9**	**40**
Eligibility Issue - Member not eligible per Provider	10	9	14	**33**	8	8	6	**22**	10	16	0	**26**	0	0	0	**0**	**81**	**100**
Health Plan Materials - ID Cards-Not Received	36	25	20	**81**	19	12	17	**48**	32	27	0	**59**	0	0	0	**0**	**188**	**238**
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	1	**1**	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	**3**	**10**

Health Plan Materials - Other	0	0	2	**2**	0	3	1	**4**	2	0	0	**2**	0	0	0	**0**	**8**	**7**
Behavioral Health Related	2	3	1	**6**	1	2	4	**7**	1	2	0	**3**	0	0	0	**0**	**16**	**16**
PCP Assignment/Transfer - Health Plan Assignment - Change Request	42	36	36	**114**	24	22	27	**73**	47	36	0	**83**	0	0	0	**0**	**270**	**533**
PCP Assignment/Transfer - HCO Assignment - Change Request	13	9	5	**27**	7	3	10	**20**	15	23	0	**38**	0	0	0	**0**	**85**	**131**
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**1**	**0**
PCP Assignment/Transfer - PCP Transfer not Processed	2	0	0	**2**	1	0	2	**3**	2	2	0	**4**	0	0	0	**0**	**9**	**24**
PCP Assignment/Transfer - Rollout of PPG	3	0	0	**3**	3	0	0	**3**	1	0	0	**1**	0	0	0	**0**	**7**	**3**
PCP Assignment/Transfer - Mileage Inconvenience	5	3	2	**10**	2	0	2	**4**	2	2	0	**4**	0	0	0	**0**	**18**	**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	2	**12**	3	0	0	**3**	0	0	0	**0**	**19**	**4**
Transportation - Access - Provider Late	0	1	1	**2**	2	3	1	**6**	1	0	0	**1**	0	0	0	**0**	**9**	**3**
Transportation - Behaviour	0	0	1	**1**	1	2	0	**3**	1	1	0	**2**	0	0	0	**0**	**6**	**5**
Transportation - Other	14	9	14	**37**	18	17	22	**57**	18	6	0	**24**	0	0	0	**0**	**118**	**85**
OTHER - Other	4	3	3	**10**	1	2	2	**5**	4	2	0	**6**	0	0	0	**0**	**21**	**27**
Claims Complaint - Balance Billing from Provider	18	26	23	**67**	21	17	26	**64**	32	25	0	**57**	0	0	0	**0**	**188**	**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	5	13	9	7	0	16	0	0	0	0	37	49
Standard Appeals Received	51	63	75	189	72	81	71	224	77	57	0	134	0	0	0	0	547	564
Total Appeals Received	**55**	**64**	**78**	**197**	**76**	**85**	**76**	**237**	**86**	**64**	**0**	**150**	**0**	**0**	**0**	**0**	**584**	**613**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	1	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.2%**	**0.0%**	**99.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.82%**	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	5	**13**	7	9	0	**16**	0	0	0	0	36	49
Expedited Appeals Compliance Rate	**66.7%**	**100.0%**	**100.0%**	**85.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**97.3%**	**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	85	216	80	66	0	146	0	0	0	0	529	562
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100%**
Total Appeals Resolved	**54**	**50**	**71**	**175**	**66**	**73**	**90**	**229**	**87**	**75**	**0**	**162**	**0**	**0**	**0**	**0**	**566**	**611**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**54**	**48**	**69**	**171**	**65**	**73**	**89**	**227**	**87**	**75**	**0**	**162**	**0**	**0**	**0**	0	**560**	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	1	6	2	2	0	4	0	0	0	0	**18**	16
Community Supports	13	16	15	44	22	11	26	59	31	17	0	48	0	0	0	0	**151**	95
DME	12	9	13	34	14	18	24	56	14	10	0	24	0	0	0	0	**114**	111
Experimental/Investigational	1	4	3	8	3	2	1	6	0	2	0	2	0	0	0	0	**16**	34
Mental Health	0	0	0	0	0	1	5	6	7	4	0	11	0	0	0	0	**17**	5
Advanced Imaging	9	7	13	29	11	8	14	33	8	10	0	18	0	0	0	0	**80**	127
Other	2	4	9	15	3	22	10	35	8	20	0	28	0	0	0	0	**78**	75
Pharmacy/RX Medical Benefit	7	3	6	16	2	2	4	8	12	3	0	15	0	0	0	0	**39**	61
Surgery	8	3	5	16	8	4	3	15	4	5	0	9	0	0	0	0	**40**	58
SNF-Long Term Care	0	1	0	1	0	2	1	3	1	2	0	3	0	0	0	0	**7**	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**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**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	1	1	0	0	0	0	0	0	0	0	**1**	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	40	92	31	19	0	50	0	0	0	0	217	272
Uphold Rate	**44.4%**	**50.0%**	**36.6%**	**42.9%**	**33.3%**	**41.1%**	**44.4%**	**40.2%**	**35.6%**	**25.3%**	**0.0%**	**30.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**38.3%**	**44.5%**
Overturns - Full	18	14	25	**57**	32	32	35	**99**	45	46	0	**91**	0	0	0	**0**	247	272
Overturn Rate - Full	**33.3%**	**28.0%**	**35.2%**	**32.6%**	**48.5%**	**43.8%**	**38.9%**	**43.2%**	**51.7%**	**61.3%**	**0.0%**	**56.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**43.6%**	**44.5%**
Overturns - Partials	12	6	12	**30**	11	10	11	**32**	10	8	0	**18**	0	0	0	**0**	80	42
Overturn Rate - Partial	**22.2%**	**12.0%**	**16.9%**	**17.1%**	**16.7%**	**13.7%**	**12.2%**	**14.0%**	**11.5%**	**10.7%**	**0.0%**	**11.1%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**14.1%**	**6.9%**
Withdrawal	0	5	8	**13**	1	1	4	**6**	1	2	0	**3**	0	0	0	0	22	25
Withdrawal Rate	**0.0%**	**10.0%**	**11.3%**	**7.4%**	**1.5%**	**1.4%**	**4.4%**	**2.6%**	**1.1%**	**2.7%**	**0.0%**	**1.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.9%**	**4.1%**
Membership	420,475	418,423	416,089		412,652	410,203	406,906		406795	402922	0		0	0	0			
Appeals - PTMPM	0.13	0.12	0.17	**0.42**	0.16	0.18	0.22	**0.56**	0.21	0.19	-	**0.60**	-	-	-	-	**0.52**	0.24
Grievances - PTMPM	0.40	0.47	0.53	**1.40**	0.56	0.57	0.55	**1.68**	0.61	0.71	-	**1.98**	-	-	-	-	**1.65**	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	13	43	20	22	0	42	0	0	0	0	**120**	87
Standard Grievances Received	171	158	185	**514**	170	167	179	516	231	233	0	464	0	0	0	0	**1494**	1870
Total Grievances Received	**177**	**171**	**201**	**549**	**182**	**185**	**192**	**559**	**251**	**255**	**0**	**506**	**0**	**0**	**0**	**0**	**1614**	**1957**
Grievance Ack Letters Sent Noncompliant	1	1	1	**3**	0	1	1	2	2	1	0	3	0	0	0	0	**8**	7
Grievance Ack Letter Compliance Rate	**99.4%**	**99.4%**	**99.5%**	**99.4%**	**100.0%**	**99.4%**	**99.4%**	**99.6%**	**99.1%**	**99.6%**	**0.0%**	**99.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.5%**	**99.63%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	**1**	0
Expedited Grievances Resolved Compliant	6	12	17	35	11	18	13	42	20	21	0	41	0	0	0	0	**118**	87
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**95.0%**	**100.0%**	**0.0%**	**97.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.2%**	**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	172	534	184	206	0	390	0	0	0	0	**1379**	1864
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**140**	**166**	**184**	**490**	**192**	**199**	**185**	**576**	**205**	**227**	**0**	**432**	**0**	**0**	**0**	**0**	**1498**	**1951**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**129**	**157**	**177**	**463**	**179**	**187**	**160**	**526**	**189**	**206**	**0**	**395**	**0**	**0**	**0**	**0**	**1384**	**1832**
Access - Other - DMHC	25	26	30	81	29	37	28	94	55	36	0	91	0	0	0	0	**266**	358
Access - PCP - DHCS	4	7	10	21	11	21	12	44	6	8	0	14	0	0	0	0	**79**	124
Access - Physical/OON - DHCS	0	0	0	0	1	0	0	1	0	2	0	2	0	0	0	0	**3**	1
Access - Spec - DHCS	1	4	4	9	6	5	7	18	1	4	0	5	0	0	0	0	**32**	54
Administrative	25	34	26	85	22	15	30	67	26	34	0	60	0	0	0	0	**212**	353
Balance Billing	14	20	39	73	30	26	13	69	20	28	0	48	0	0	0	0	**190**	251
Community Supports	4	6	4	14	11	8	9	28	13	8	0	21	0	0	0	0	**63**	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	25	15	66	17	16	0	33	0	0	0	0	**153**	173
Behavioral Health	5	2	1	8	0	4	5	9	9	17	0	26	0	0	0	0	**43**	1
Other	12	12	8	32	8	2	4	14	4	12	0	16	0	0	0	0	**62**	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	2	3	3	1	0	4	0	0	0	0	**11**	15
Transportation - Access	4	10	10	24	13	11	9	33	7	7	0	14	0	0	0	0	**71**	104
Transportation - Behaviour	1	4	6	11	1	3	3	7	2	3	0	5	0	0	0	0	**23**	37
Transportation - Other	16	15	15	46	21	29	23	73	26	30	0	56	0	0	0	0	**175**	159
Quality Of Care Grievances	**11**	**9**	**7**	**27**	**13**	**12**	**25**	**50**	**16**	**21**	**0**	**37**	**0**	**0**	**0**	**0**	**114**	**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	1	1	0	0	0	0	0	0	0	0	**1**	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	1	1	1	2	0	3	0	0	0	0	**5**	2
Other	3	2	2	7	4	3	5	12	4	5	0	9	0	0	0	0	**28**	20
PCP Care	7	3	2	12	6	4	7	17	4	8	0	12	0	0	0	0	**41**	46
PCP Delay	1	0	1	2	3	4	5	12	3	1	0	4	0	0	0	0	**18**	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	5	6	4	3	0	7	0	0	0	0	**17**	17
Specialist Delay	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	**2**	7
SNF-Long Term Care	0	1	0	1	0	0	0	0	0	1	0	1	0	0	0	0	**2**	**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	4	9	7	5	0	12	0	0	0	0	**27**	36
Standard Appeals Received	39	49	55	143	57	65	54	176	54	45	0	99	0	0	0	0	**418**	444
Total Appeals Received	**42**	**50**	**57**	**149**	**59**	**68**	**58**	**185**	**61**	**50**	**0**	**111**	**0**	**0**	**0**	**0**	**445**	**480**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	**1**	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.8%**	**0.0%**	**99.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.8%**	**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	4	9	5	7	0	12	0	0	0	0	**26**	36
Expedited Appeals Compliance Rate	**50.0%**	**100.0%**	**100.0%**	**80.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**96.2%**	**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	67	169	63	46	0	109	0	0	0	**0**	**405**	444
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**42**	**37**	**54**	**133**	**49**	**58**	**71**	**178**	**68**	**53**	**0**	**121**	**0**	**0**	**0**	**0**	**432**	**480**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**36**	**53**	**131**	**48**	**58**	**70**	**176**	**68**	**53**	**0**	**121**	**0**	**0**	**0**	**0**	**428**	**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	1	3	2	1	0	3	0	0	0	0	**14**	14
Community Supports	11	13	11	35	20	9	21	50	26	13	0	39	0	0	0	0	**124**	73
DME	11	8	11	30	10	14	23	47	10	6	0	16	0	0	0	0	**93**	91
Experimental/Investigational	1	3	2	6	3	2	0	5	0	2	0	2	0	0	0	0	**13**	27
Behavioral Health	0	0	0	0	0	1	4	5	7	4	0	11	0	0	0	0	**16**	5
Advanced Imaging	5	5	9	19	8	7	8	23	7	8	0	15	0	0	0	0	**57**	105
Other	2	1	7	10	2	17	8	27	5	11	0	16	0	0	0	0	**53**	50
Pharmacy/RX Medical Benefit	7	3	5	15	2	2	2	6	9	1	0	10	0	0	0	0	**31**	52
Surgery	3	2	3	8	3	3	2	8	1	5	0	6	0	0	0	0	**22**	40
SNF-Long Term Care	0	0	0	0	0	1	1	2	1	2	0	3	0	0	0	0	**5**	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**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**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	1	1	0	0	0	0	0	0	0	0	**1**	**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	33	**68**	25	14	0	39	0	0	0	**0**	**161**	204
Uphold Rate	**38.1%**	**54.1%**	**33.3%**	**40.6%**	**26.5%**	**37.9%**	**46.5%**	**38.2%**	**36.8%**	**26.4%**	**0.0%**	**32.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.3%**	**42.5%**
Overturns - Full	16	10	21	**47**	27	29	25	**81**	34	29	0	63	0	0	0	**0**	**191**	223
Overturn Rate - Full	**38.1%**	**27.0%**	**38.9%**	**35.3%**	**55.1%**	**50.0%**	**35.2%**	**45.5%**	**50.0%**	**54.7%**	**0.0%**	**52.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**44.2%**	**46.5%**
Overturns - Partials	10	4	10	**24**	8	6	10	**24**	8	8	0	16	0	0	0	**0**	**64**	33
Overturn Rate - Partial	**23.8%**	**10.8%**	**18.5%**	**18.0%**	**16.3%**	**10.3%**	**14.1%**	**13.5%**	**11.8%**	**15.1%**	**0.0%**	**13.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**14.8%**	**6.9%**
Withdrawal	0	3	5	**8**	1	1	3	**5**	1	2	0	3	0	0	0	**0**	**16**	20
Withdrawal Rate	**0.0%**	**8.1%**	**9.3%**	**6.0%**	**2.0%**	**1.7%**	**4.2%**	**2.8%**	**1.5%**	**3.8%**	**0.0%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**	**4.2%**
Membership	332,462	330,913	329,090		326,488	324,541	321,785		321,974	318,347								
Appeals - PTMPM	0.13	0.11	0.16	**0.40**	0.15	0.18	0.22	**0.55**	0.21	0.17	-	**0.13**	-	-	-	0.00	**0.27**	0.29
Grievances - PTMPM	0.42	0.50	0.56	**1.48**	0.59	0.61	0.57	**1.78**	0.64	0.71	-	**0.45**	-	-	-	0.00	**0.93**	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	2	2	3	2	0	5	0	0	0	0	12	11
Standard Grievances Received	16	11	13	40	18	13	17	48	20	14	0	34	0	0	0	0	122	196
Total Grievances Received	**17**	**13**	**15**	**45**	**18**	**13**	**19**	**50**	**23**	**16**	**0**	**39**	**0**	**0**	**0**	**0**	**134**	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	2	4	2	0	6	0	0	0	0	12	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%**	**100.0%**	**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	12	45	16	20	0	36	0	0	0	0	122	196
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**16**	**16**	**13**	**45**	**17**	**17**	**13**	**47**	**20**	**22**	**0**	**42**	**0**	**0**	**0**	**0**	**134**	**207**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**16**	**12**	**43**	**16**	**17**	**12**	**45**	**18**	**21**	**0**	**39**	**0**	**0**	**0**	**0**	**127**	**197**
Access - Other - DMHC	2	2	1	5	2	2	2	6	4	5	0	9	0	0	0	0	20	32
Access - PCP - DHCS	0	1	0	1	0	0	0	0	2	2	0	4	0	0	0	0	5	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	1	11	3	1	0	4	0	0	0	0	21	35
Balance Billing	2	4	1	7	3	2	2	7	1	3	0	4	0	0	0	0	18	26
Community Supports	1	2	0	3	1	1	1	3	0	0	0	0	0	0	0	0	6	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	1	6	1	5	0	6	0	0	0	0	16	24
Behavioral Health	0	0	0	0	1	0	0	1	3	0	0	3	0	0	0	0	4	0
Other	1	1	0	2	0	0	0	0	2	0	0	2	0	0	0	0	4	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	2	4	0	3	0	3	0	0	0	0	9	8
Transportation - Behaviour	0	1	1	2	0	0	0	0	0	1	0	1	0	0	0	0	3	7
Transportation - Other	4	3	3	10	1	2	3	6	2	1	0	3	0	0	0	0	19	26
Quality Of Care Grievances	**1**	**0**	**1**	**2**	**1**	**0**	**1**	**2**	**2**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**7**	**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	1	0	0	1	0	0	0	0	1	3
PCP Care	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	2	4
PCP Delay	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0	2	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	1	0	0	1	0	0	0	0	2	7
Standard Appeals Received	3	3	5	11	6	7	8	21	8	6	0	14	0	0	0	0	46	36
Total Appeals Received	**3**	**3**	**5**	**11**	**6**	**8**	**8**	**22**	**9**	**6**	**0**	**15**	**0**	**0**	**0**	**0**	48	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	0	0	1	0	0	0	0	2	7
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	9	20	6	7	0	13	0	0	0	0	40	37
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Appeals Resolved	**0**	**3**	**4**	**7**	**4**	**8**	**9**	**21**	**7**	**7**	**0**	**14**	**0**	**0**	**0**	**0**	**42**	**44**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**3**	**3**	**6**	**4**	**8**	**9**	**21**	**7**	**7**	**0**	**14**	**0**	**0**	**0**	**0**	**41**	**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	1	0	1	0	0	0	0	2	2
Community Supports	0	1	2	3	2	2	4	8	5	3	0	8	0	0	0	0	19	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	1	1	0	0	0	0	0	0	0	0	1	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	3	3	0	0	0	0	0	0	0	0	4	4
Other	0	1	0	1	0	1	1	2	1	3	0	4	0	0	0	0	7	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	1	0	0	1	0	0	0	0	4	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	3	**8**	2	2	0	4	0	0	0	**0**	17	23
Uphold Rate	**0.0%**	**66.7%**	**75.0%**	**71.4%**	**25.0%**	**50.0%**	**33.3%**	**38.1%**	**28.6%**	**28.6%**	**0.0%**	**28.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.5%**	**52.3%**
Overturns - Full	0	1	1	**2**	1	1	4	**6**	5	5	0	10	0	0	0	**0**	18	13
Overturn Rate - Full	**0.0%**	**33.3%**	**25.0%**	**28.6%**	**25.0%**	**12.5%**	**44.4%**	**28.6%**	**71.4%**	**71.4%**	**0.0%**	**71.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.9%**	**29.5%**
Overturns - Partials	0	0	0	**0**	2	3	1	**6**	0	0	0	0	0	0	0	**0**	6	7
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**37.5%**	**11.1%**	**28.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**14.3%**	**15.91%**
Withdrawal	0	0	0	**0**	0	0	1	**1**	0	0	0	0	0	0	0	**0**	1	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**11.1%**	**4.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.4%**	**2.3%**
Membership	**38,237**	**38,072**	**37,909**		37,590	37,474	37,262		37,085	36,989						**0**		
Appeals - PTMPM	-	0.08	0.11	**0.06**	0.11	0.21	0.24	**0.19**	0.19	0.19	-	**0.13**	-	0	-	0.00	**0.09**	**0.16**
Grievances - PTMPM	0.42	0.42	0.34	**0.39**	0.45	0.45	0.35	**0.42**	0.54	0.59	-	**0.38**	-	0	-	0.00	**0.30**	**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	3	5	0	8	0	8	0	0	0	0	14	13
Standard Grievances Received	13	22	23	58	18	15	33	66	27	26	0	53	0	0	0	0	177	229
Total Grievances Received	**13**	**22**	**24**	**59**	**20**	**15**	**36**	**71**	**27**	**34**	**0**	**61**	**0**	**0**	**0**	**0**	**191**	**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%**	**93.3%**	**100.0%**	**98.5%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.4%**	**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	3	5	0	8	0	8	0	0	0	0	14	13
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**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	22	60	24	28	0	52	0	0	0	0	161	232
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**14**	**14**	**22**	**50**	**22**	**18**	**25**	**65**	**24**	**36**	**0**	**60**	**0**	**0**	**0**	**0**	**175**	**245**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**13**	**22**	**49**	**20**	**17**	**21**	**58**	**22**	**36**	**0**	**58**	**0**	**0**	**0**	**0**	**165**	**230**
Access - Other - DMHC	2	2	5	9	5	3	6	14	1	9	0	10	0	0	0	0	33	41
Access - PCP - DHCS	0	1	3	4	0	4	0	4	2	3	0	5	0	0	0	0	13	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	1	1	0	3	0	3	0	0	0	0	6	11
Administrative	2	1	2	5	1	1	4	6	3	3	0	6	0	0	0	0	17	50
Balance Billing	3	2	2	7	3	2	5	10	5	4	0	9	0	0	0	0	26	36
Community Supports	1	0	0	1	0	0	0	0	1	1	0	2	0	0	0	0	3	4
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	1	2	5	2	0	0	2	3	1	0	4	0	0	0	0	11	16
Behavioral Health	1	0	1	2	3	2	1	6	1	5	0	6	0	0	0	0	14	0
Other	1	1	3	5	0	1	1	2	0	1	0	1	0	0	0	0	8	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	1	6	3	1	0	4	0	0	0	0	13	14
Transportation - Behaviour	0	1	0	1	1	1	0	2	0	1	0	1	0	0	0	0	4	5
Transportation - Other	0	1	4	5	2	1	2	5	3	4	0	7	0	0	0	0	17	24
Quality Of Care Grievances	**0**	**1**	**0**	**1**	**2**	**1**	**4**	**7**	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**10**	**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	3	4	0	0	0	0	0	0	0	0	4	3
PCP Care	0	1	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	8
PCP Delay	0	0	0	0	1	0	1	2	1	0	0	1	0	0	0	0	3	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	1	3	1	2	0	3	0	0	0	0	8	4
Standard Appeals Received	9	11	15	35	9	9	9	27	15	6	0	21	0	0	0	0	83	59
Total Appeals Received	**10**	**11**	**16**	**37**	**11**	**9**	**10**	**30**	**16**	**8**	**0**	**24**	**0**	**0**	**0**	**0**	91	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	1	3	1	2	0	3	0	0	0	0	8	4
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	9	27	11	13	0	24	0	0	0	**0**	84	63
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**12**	**10**	**13**	**35**	**13**	**7**	**10**	**30**	**12**	**15**	**0**	**27**	**0**	**0**	**0**	**0**	**92**	**87**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**12**	**9**	**13**	**34**	**13**	**7**	**10**	**30**	**12**	**15**	**0**	**27**	**0**	**0**	**0**	**0**	**91**	**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	1	1	0	1	0	1	0	0	0	0	0	0
DME	1	1	2	4	4	2	1	7	4	4	0	8	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	1	1	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	4	2	3	9	3	1	3	7	1	2	0	3	0	0	0	0	0	5
Other	0	2	2	4	1	4	1	6	2	6	0	8	0	0	0	0	0	16
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	2	2	3	2	0	5	0	0	0	0	0	0
Surgery	5	1	2	8	3	0	1	4	2	0	0	2	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	4	16	4	3	0	7	0	0	0	**0**	**39**	**45**
Uphold Rate	**66.7%**	**30.0%**	**38.5%**	**45.7%**	**61.5%**	**57.1%**	**40.0%**	**53.3%**	**33.3%**	**20.0%**	**0.0%**	**25.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.4%**	**51.7%**
Overturns - Full	2	3	3	**8**	4	2	6	12	6	12	0	18	0	0	0	**0**	**38**	36
Overturn Rate - Full	**16.7%**	**30.0%**	**23.1%**	**22.9%**	**30.8%**	**28.6%**	**60.0%**	**40.0%**	**50.0%**	**80.0%**	**0.0%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**41.3%**	**41.4%**
Overturns - Partials	2	2	2	**6**	1	1	0	2	2	0	0	2	0	0	0	**0**	**10**	2
Overturn Rate - Partial	**16.7%**	**20.0%**	**15.4%**	**17.1%**	**7.7%**	**14.3%**	**0.0%**	**6.7%**	**16.7%**	**0.0%**	**0.0%**	**7.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.9%**	**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%**	**5.4%**	**4.6%**
Membership	49,776	49,438	49,090		48,574	48,188	47,859		47,736	47,586						-		
Appeals - PTMPM	0.24	0.20	0.26	**0.71**	0.27	0.15	0.21	**0.62**	0.25	0.32	-	0.19	-	0	-	0.00	**0.38**	**0.38**
Grievances - PTMPM	0.28	0.28	0.45	**1.01**	0.45	0.37	0.52	**1.35**	0.50	0.76	-	0.42	-	0	-	0.00	**0.69**	**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	5	13	4	11	0	15	0	0	0	0	39	31
Standard Grievances Received	26	21	78	125	62	66	82	210	75	92	0	167	0	0	0	0	502	658
Total Grievances Received	**29**	**25**	**82**	136	**64**	**72**	**87**	**223**	**79**	**103**	**0**	**182**	**0**	**0**	**0**	**0**	**541**	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.8%**	**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	6	13	4	10	0	14	0	0	0	0	39	34
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	71	211	76	70	0	146	0	0	0	0	517	718
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**53**	**64**	**55**	**172**	**73**	**74**	**77**	**224**	**80**	**80**	**0**	**160**	**0**	**0**	**0**	**0**	**556**	**752**
Grievance Descriptions - Resolved Cases	**53**	**64**	**55**	**172**	**73**	**74**	**77**	**224**	**80**	**80**	**0**	**160**	**0**	**0**	**0**	**0**	**556**	**752**
Access to primary care	1	1	2	4	0	4	3	7	3	1	0	4	0	0	0	0	15	43
Access to specialists	0	4	1	5	2	2	2	6	0	4	0	4	0	0	0	0	15	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	22	55	21	33	0	54	0	0	0	0	156	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	6	10	7	2	0	9	0	0	0	0	29	29
QOS Non Access	30	37	36	103	53	49	44	146	49	40	0	89	0	0	0	0	338	428
Exempt Grievances Received	**22**	**24**	**25**	**71**	**7**	**14**	**13**	**34**	**19**	13	0	**32**	**0**	**0**	**0**	**0**	**137**	**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**	1	2	0	**3**	0	0	0	**0**	6	13
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	2	0
Attitude/Service - Vendor	0	1	0	**1**	1	1	1	**3**	0	1	0	**1**	0	0	0	**0**	5	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	1	**1**	1	2	0	**3**	0	0	0	**0**	5	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	1	0	**1**	0	0	0	**0**	7	15
Health Plan Materials - ID Cards-Not Received	10	2	4	**16**	3	1	1	**5**	1	0	0	**1**	0	0	0	**0**	22	31
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	1	2
Health Plan Materials - Other	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	2	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	4	**6**	4	2	0	**6**	0	0	0	**0**	21	44
PCP Assignment/Transfer - HCO Assignment - Change Request	0	0	0	**0**	0	1	0	**1**	1	1	0	**2**	0	0	0	**0**	3	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	1	0	**1**	0	0	0	**0**	2	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**	1	0	0	**1**	0	0	0	**0**	2	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	3	**5**	6	0	0	**6**	0	0	0	**0**	28	34

OTHER - Other	1	1	1	**3**	2	1	0	**3**	1	0	0	**1**	0	0	0	**0**	7	7
Claims Complaint - Balance Billing from Provider	0	3	3	**6**	0	4	3	**7**	1	1	0	**2**	0	0	0	**0**	15	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	2	3	1	1	0	2	0	0	0	0	7	16
Standard Appeals Received	9	9	21	39	28	43	25	96	15	20	0	35	0	0	0	0	170	159
Total Appeals Received	**9**	**9**	**23**	**41**	**29**	**43**	**27**	**99**	**16**	**21**	**0**	**37**	**0**	**0**	**0**	**0**	177	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**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	2	3	1	1	0	2	0	0	0	0	7	17
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**-100.0%**	**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	41	95	24	16	0	40	0	0	0	**0**	196	164
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**17**	**24**	**22**	**63**	**22**	**33**	**43**	**98**	**25**	**17**	**0**	**42**	**0**	**0**	**0**	**0**	**203**	**181**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**17**	**24**	**22**	**63**	**22**	**22**	**43**	**87**	**25**	**17**	**0**	**42**	**0**	**0**	**0**	**0**	**192**	**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	1	1	1	0	0	1	0	0	0	0	4	6
Community Supports	6	12	4	22	8	5	12	25	10	4	0	14	0	0	0	0	61	34
DME	4	6	6	16	8	11	16	35	7	5	0	12	0	0	0	0	63	40
Experimental/Investigational	0	0	2	2	1	1	1	3	0	1	0	1	0	0	0	0	6	6
Behavioral Health	0	0	0	0	0	0	4	4	1	1	0	2	0	0	0	0	6	1
Advanced Imaging	2	1	3	6	2	1	6	9	0	0	0	0	0	0	0	0	15	25
Other	0	2	6	8	0	2	1	3	2	5	0	7	0	0	0	0	18	20
Pharmacy/RX Medical Benefit	2	2	0	4	0	1	0	1	2	0	0	2	0	0	0	0	7	13
Surgery	2	0	0	2	3	1	1	5	2	1	0	3	0	0	0	0	10	7
SNF-Long Term Care	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0	2	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	24	**37**	8	4	0	**12**	0	0	0	**0**	**83**	85
Uphold Rate	**47.1%**	**70.8%**	**40.9%**	**54.0%**	**31.8%**	**18.2%**	**55.8%**	**37.8%**	**32.0%**	**23.5%**	**0.0%**	**28.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.9%**	**47.0%**
Overturns - Full	6	5	5	**16**	9	11	15	**35**	17	9	0	**26**	0	0	0	**0**	**77**	70
Overturn Rate - Full	**35.3%**	**20.8%**	**22.7%**	**25.4%**	**40.9%**	**33.3%**	**34.9%**	**35.7%**	**68.0%**	**52.9%**	**0.0%**	**61.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.9%**	**38.67%**
Overturns - Partials	3	0	4	**7**	6	5	4	**15**	0	3	0	**3**	0	0	0	**0**	**25**	15
Overturn Rate - Partial	**17.6%**	**0.0%**	**18.2%**	**11.1%**	**27.3%**	**15.2%**	**9.3%**	**15.3%**	**0.0%**	**17.6%**	**0.0%**	**7.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**12.3%**	**8.3%**
Withdrawal	0	2	4	**6**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**7**	11
Withdrawal Rate	**0.0%**	**8.3%**	**18.2%**	**9.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**5.9%**	**0.0%**	**2.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.4%**	**6.1%**
Membership	43,916	43,978	43,870		43,309	43,418	43,439		43,320	43,317								
Appeals - PTMPM	0.39	0.55	0.50	**1.43**	0.51	0.76	0.99	**2.26**	0.58	0.39	-	**0.32**	0	-	-	0.00	**1.00**	**0.79**
Grievances - PTMPM	1.21	1.46	1.25	**3.92**	1.69	1.70	1.77	**5.16**	1.85	1.85	-	**1.23**	0	-	-	0.00	**2.58**	**3.22**

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative	Grievances related to health plan benefit, paln authorization or access issues
Balance Billing	Member billing for Par and Nonpar providers.
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/RX Medical Benefit	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Behavioral Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy/RX Medical Benefit	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist

APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT

Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).

Exempt Grievance tab key – Calviva Dashboard	
Column Definitions.	
Date Opened	The date the case was received
SF #	The internal HealthNet system ID code for the CCC representative who documented the call
Rep Name	Name of the CCC associate who took the call
Sup Name	Supervisor of the CCC associate who took the call
Mbr ID	The Calviva Health ID number of the member
SPD	Marked “yes” if the member is part of the “Seniors & Persons with Disabilities” population
Date of Birth	Date of birth of the member
Mbr Name	Name of the member
Reason	The case was categorized as a Calviva Exempt Grievance, hence the reason it’s on the report
Preventable	Used if an Exempt Grievance was determined to be preventable
Access to Care	Used if determined Exempt Grievance was related to Access to Care
Issue Main Classification	Case is categorized by type of complaint
Issue Sub Classification	Case is subcategorized by type of complaint
DMHC Complaint Category	Case is categorized based on the DMHC TAR template complaint category
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here

Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it's an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligibilty or lackthereof.
Health Care Benefits	When it's an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
The Outlier Tab	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.

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

Item #12
Attachment 12.E

Medical Management

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 8/1/2026 to 8/31/2026

Report created 9/17/2026

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

Exhibits:

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

Contact Information

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

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 8/1/2026 to 8/31/2026
Report created 9/17/2026

ER utilization based on Claims data	2025-08	2025-09	2025-10	2025-11	2025-12	2025-Trend	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06	2026-07	2026-08	2026-Trend	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Qtr Trend	CY- 2025	YTD-2026	YTD-Trend
MEMBERSHIP																**Quarterly Averages**							**Annual Averages**		
Expansion Mbr Months	122,392	121,296	121,003	120,883	120,655		119,264	118,394	117,406	116,197	114,780	113,710	112,871	112,337		121,576	122,898	122,530	120,847	118,355	114,896		121,963	115,620	
Adult/Family/O TLIC Mbr Mos	260,399	258,290	257,463	257,291	257,397		255,067	253,880	252,988	251,878	250,132	247,101	245,580	244,158		261,819	262,076	260,234	257,384	253,978	249,704		260,378	250,098	
Aged/Disabled Mbr Mos	48,562	48,579	48,705	48,603	48,463		47,702	47,574	46,195	46,988	46,712	46,325	46,121	46,130		47,683	48,039	48,558	48,590	47,157	46,675		48,218	46,718	
COUNTS																									
Admits - Count	2,159	2,034	2,143	2,127	2,226		2,176	2,100	2,225	2,121	2,077	1,999	2,107	2,060		2,130	2,067	2,108	2,165	2,167	2,066		2,117	2,151	
Expansion	812	741	837	767	768		803	746	793	799	811	740	812	793		774	756	780	791	781	783		775	802	
Adult/Family/O TLIC	887	868	889	909	981		907	915	958	855	829	842	871	836		901	859	886	926	927	842		893	896	
Aged/Disabled	460	425	417	451	477		466	439	474	467	437	417	424	431		455	452	442	448	460	440		449	453	
Admits Acute - Count	1,385	1,241	1,349	1,361	1,402		1,461	1,394	1,495	1,431	1,384	1,290	1,374	1,427		1,411	1,372	1,323	1,371	1,450	1,368		1,369	1,438	
Expansion	641	574	677	613	614		655	595	659	664	660	610	655	668		613	610	606	635	636	645		616	658	
Adult/Family/O TLIC	388	359	361	408	416		439	479	470	402	370	345	370	381		447	411	384	395	463	372		409	419	
Aged/Disabled	356	308	311	340	372		367	320	366	365	354	335	349	378		351	351	333	341	351	351		344	361	
Readmit 30 Day - Count	260	241	280	272	276		284	265	303	312	313	257	281	318		241	250	255	276	284	294		256	295	
Expansion	99	99	129	119	118		126	114	121	147	150	117	136	136		97	102	101	122	120	138		105	133	
Adult/Family/O TLIC	67	64	66	68	56		65	68	70	62	57	47	50	72		58	59	67	63	68	55		62	62	
Aged/Disabled	94	78	85	85	102		93	83	112	103	106	93	95	110		86	89	87	91	96	101		88	100	
**ER Visits - Count	17,046	17,483	17,177	16,701	17,898		18,351	17,485	19,236	17,591	18,504	16,878	15,482	5,847		17,047	17,028	16,876	17,259	18,357	17,658		17,052	16,172	
Expansion	5,605	5,554	5,311	5,076	5,484		5,674	5,116	5,820	5,167	5,592	5,476	5,236	2,065		4,861	5,222	5,528	5,290	5,537	5,412		5,225	5,018	
Adult/Family/O TLIC	9,186	9,841	9,638	9,471	10,171		10,419	10,194	11,047	10,181	10,594	9,124	8,146	3,130		10,158	9,664	9,161	9,760	10,553	9,966		9,686	9,104	
Aged/Disabled	2,255	2,088	2,228	2,154	2,243		2,258	2,175	2,369	2,243	2,318	2,278	2,100	652		2,028	2,142	2,187	2,208	2,267	2,280		2,141	2,049	
PER/K																									
Admits Acute - PTMPY	38.5	34.8	37.9	38.3	39.4		41.5	39.8	43.1	41.4	40.3	38.0	40.8	42.5		39.3	38.0	36.8	38.5	41.5	39.9		38.2	41.8	
Expansion	62.8	56.8	67.1	60.9	61.1		65.9	60.3	67.4	68.6	69.0	64.4	69.6	71.4		60.5	59.6	59.3	63.0	64.5	67.3		60.6	68.3	
Adult/Family/O TLIC	17.9	16.7	16.8	19.0	19.4		20.7	22.6	22.3	19.2	17.8	16.8	18.1	18.7		20.5	18.8	17.7	18.4	21.9	17.9		18.9	20.1	
Aged/Disabled	88.0	76.1	76.6	83.9	92.1		92.3	80.7	95.1	93.2	90.9	86.8	90.8	98.3		88.3	87.8	82.3	84.2	89.3	90.3		85.6	92.7	
Bed Days Acute - PTMPY	176.2	171.8	175.1	192.7	201.6		203.5	196.2	204.5	211.7	201.8	200.6	196.5	216.9		204.3	192.3	172.3	189.8	201.4	204.7		189.7	207.8	
Expansion	303.5	292.8	327.5	319.7	333.7		328.9	308.2	334.3	415.4	354.9	341.2	348.7	380.0		348.2	301.5	288.5	327.0	323.8	370.8		316.2	355.9	
Adult/Family/O TLIC	66.5	64.8	60.4	66.1	74.5		74.3	75.7	76.5	67.3	72.3	84.4	71.1	78.6		75.4	76.0	68.5	67.0	75.5	74.6		71.8	77.5	
Aged/Disabled	443.8	438.7	403.1	547.1	548.0		580.9	560.5	575.4	482.4	518.7	475.6	491.7	552.0		545.4	547.3	435.9	499.3	572.2	492.3		506.7	539.1	
ALOS Acute	4.6	4.9	4.6	5.0	5.1		4.9	4.9	4.7	5.1	5.0	5.3	4.8	5.1		5.2	5.1	4.7	4.9	4.9	5.1		5.0	5.0	
Expansion	4.8	5.2	4.9	5.3	5.5		5.0	5.1	5.0	6.1	5.1	5.3	5.0	5.3		5.8	5.1	4.9	5.2	5.0	5.5		5.2	5.2	
Adult/Family/O TLIC	3.7	3.9	3.6	3.5	3.8		3.6	3.3	3.4	3.5	4.1	5.0	3.9	4.2		3.7	4.0	3.9	3.6	3.5	4.2		3.8	3.9	
Aged/Disabled	5.0	5.8	5.3	6.5	5.9		6.3	6.9	6.1	5.2	5.7	5.5	5.4	5.6		6.2	6.2	5.3	5.9	6.4	5.4		5.9	5.8	
Readmit % 30 Day	12.0%	11.8%	13.1%	12.8%	12.4%		13.1%	12.6%	13.6%	14.7%	15.1%	12.9%	13.3%	15.4%		11.3%	12.1%	12.1%	12.7%	13.1%	14.2%		12.1%	13.7%	
Expansion	12.2%	13.4%	15.4%	15.5%	15.4%		15.7%	15.3%	15.3%	18.4%	18.5%	15.8%	16.7%	17.2%		12.5%	13.5%	12.9%	15.4%	15.4%	17.6%		13.6%	16.5%	
Adult/Family/O TLIC	7.6%	7.4%	7.4%	7.5%	5.7%		7.2%	7.4%	7.3%	7.3%	6.9%	5.6%	5.7%	8.6%		6.5%	6.9%	7.6%	6.8%	7.3%	6.6%		6.9%	7.0%	
Aged/Disabled	20.4%	18.4%	20.4%	18.8%	21.4%		20.0%	18.9%	23.6%	22.1%	24.3%	22.3%	22.4%	25.5%		18.8%	19.7%	19.7%	20.2%	20.9%	22.9%		19.6%	22.0%	
**ER Visits - PTMPY	474.2	490.0	482.5	469.6	503.6		521.8	499.8	554.1	508.6	539.4	497.5	459.2	174.3		474.5	471.9	469.5	485.2	525.1	515.2		475.3	470.5	
Expansion	549.5	549.5	526.7	503.9	545.4		570.9	518.5	594.9	533.6	584.6	577.9	556.7	220.6		479.8	509.9	541.4	525.3	561.4	565.2		514.1	520.8	
Adult/Family/O TLIC	423.3	457.2	449.2	441.7	474.2		490.2	481.8	524.0	485.0	508.2	443.1	398.0	153.8		465.6	442.5	422.4	455.0	498.6	479.0		446.4	436.8	
Aged/Disabled	557.2	515.8	548.9	531.8	555.4		568.0	548.6	615.4	572.8	595.5	590.1	546.4	169.6		510.4	535.0	540.6	545.4	577.0	586.1		532.9	526.3	

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-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)	98%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	98%		100%	98%	98%	97%		100%		NA	NA	
Routine Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	93%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%		97%	69%	96%	100%		100%		NA	NA	
Expedited Pre-Service Authorization TAT (non-BH)	94%	94%	100%	100%	94%		96%	100%	100%	98%	94%	90%	100%	98%		100%	100%	89%	98%		98.46%		NA	NA	
Expedited Pre-Service Authorization w/ Extension/Deferral TAT (non-BH)	100%	NA	100%	100%	100%		NA	100%	100%	100%	100%	67%	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%	98%	100%	100%	100%		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 %	8.47	8.39	8.48	8.49	8.51		8.48	8.50	8.48	8.49	8.43	8.59	8.57	8.54		8.47	8.38	8.40	8.49		8.49		8.44	8.49	

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-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	204	272	236	216	233		222	241	343	322	295	192	286	294		777	907	750	685		806	809		3,119	2,195	
Pending	-	-	1	-	13		-	-	-	-	-	-	-	2		-	-	-	14		-	-		14	2	
Ineligible	12	13	6	7	8		19	7	10	17	8	5	7	12		50	53	44	21		36	30		168	85	
Total Outreached	192	259	229	209	212		203	234	333	305	287	187	279	280		727	854	706	650		770	779		2,937	2,108	
Engaged	127	182	164	141	157		154	151	219	197	177	135	204	171		441	544	471	462		524	509		1,918	1,408	
Engagement Rate	66%	70%	72%	67%	74%		76%	65%	66%	65%	62%	72%	73%	61%		61%	64%	67%	71%		68%	65%		65%	67%	
Total Screened and Declined	1	6	4	2	12		3	2	4	1	1	2	1	1		9	14	10	18		9	4		51	15	
Unable to Reach	64	71	61	66	43		46	81	110	107	109	50	74	108		277	296	225	170		237	266		968	685	
Total Cases Managed	359	385	372	364	359		321	295	304	293	278	265	275	264		477	494	530	448		430	344		1,089	595	
Total Cases Closed	61	61	63	58	69		71	55	56	41	38	33	37	28		185	221	203	190		182	112		799	359	
Cases Remained Open	289	311	303	289	284		225	169	131	97	81	74	48	34		277	270	311	284		131	74		284	34	
Physical Health Case Management																**Physical Health Case Management**								**Physical Health Case**		
Total Number Of Referrals	403	397	337	267	351		481	579	535	505	401	470	454	424		771	1,445	1,134	955		1,595	1,376		4,305	3,849	
Pending	1	3	2	3	55		1	1	1	-	2	1	6	43		-	-	4	60		3	3		64	55	
Ineligible	15	18	6	16	10		36	20	8	5	2	7	5	2		10	54	51	32		64	14		147	85	
Total Outreached	387	376	329	248	286		444	558	526	500	397	462	443	379		761	1,391	1,079	863		1,528	1,359		4,094	3,709	
Engaged	227	226	206	136	182		266	339	308	301	269	278	295	262		413	780	628	524		913	848		2,345	2,318	
Engagement Rate	59%	60%	63%	55%	64%		60%	61%	59%	60%	68%	60%	67%	69%		54%	56%	58%	61%		60%	62%		57%	62%	
Total Screened and Refused/Decline	30	18	17	18	19		24	34	44	22	10	8	11	12		87	122	76	54		102	40		339	165	
Unable to Reach	130	132	106	94	85		154	185	174	177	118	176	137	105		261	489	375	285		513	471		1,410	1,226	
Total Cases Closed	90	95	96	74	112		118	129	108	142	126	142	162	129		240	273	289	282		355	410		1,084	1,056	
Cases Remained Open	295	314	345	355	329		342	345	407	413	422	415	399	400		277	308	314	329		407	415		329	400	
Total Cases Managed	401	440	464	437	458		500	526	548	579	585	595	592	558		528	572	634	558		796	858		1,430	1,485	
Complex Case	49	59	76	73	78		92	95	96	103	98	106	108	99		48	42	70	81		129	135		148	222	
Non-Complex Case	352	381	388	364	380		408	431	452	476	487	489	484	459		480	530	564	477		667	723		1,282	1,263	
Transitional Care Services																**Transitional Care Services**								**Transitional Care Services**		
Total Number Of Referrals	640	710	801	591	563		719	714	623	609	618	739	776	630		1,590	1,639	2,010	1,955		2,056	1,966		7,194	5,428	
Pending	-	-	2	-	15		-	-	-	-	-	-	2	20		-	-	-	17		-	-		17	22	
Ineligible	4	5	3	14	6		48	22	9	3	8	7	3	1		10	7	13	23		79	18		53	101	
Total Outreached	636	705	796	577	542		671	692	614	606	610	732	771	609		1,580	1,632	1,997	1,915		1,977	1,948		7,124	5,305	
Engaged	519	602	637	462	470		604	624	554	573	533	630	654	543		1,437	1,466	1,702	1,569		1,782	1,736		6,174	4,715	
Engagement Rate	82%	85%	80%	80%	87%		90%	90%	90%	95%	87%	86%	85%	89%		91%	90%	85%	82%		90%	89%		87%	89%	
Total Screened and Refused/Decline	8	6	18	9	6		4	9	7	2	9	12	19	6		21	12	20	33		20	23		86	68	
Unable to Reach	109	97	141	106	66		63	59	53	31	68	90	98	60		122	154	275	313		175	189		864	522	
Total Cases Closed	323	348	399	340	387		327	281	431	338	355	344	390	364		837	841	992	1,126		1,039	1,037		3,796	2,830	
Cases Remained Open	418	445	478	450	386		392	488	436	490	459	526	563	528		324	364	445	386		436	526		386	528	
Total Cases Managed	793	850	938	840	789		781	836	928	883	891	976	1,021	959		1,207	1,227	1,493	1,164		1,535	1,670		4,198	3,425	

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	2025-Trend	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-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	120	129	241	95	106		130	161	155	173	164	159	202	145		387	423	363	442		446	496		1,615	1,289	
Pending	-	1	-	-	15		-	-	-	-	-	-	-	7		-	-	1	15		-	-		16	7	
Ineligible	2	4	-	1	1		11	4	1	-	-	-	-	-		7	11	6	2		16	-		26	16	
Total Outreached	118	124	241	94	90		119	157	154	173	164	159	202	138		380	412	356	425		430	496		1,573	1,266	
Engaged	74	86	152	65	65		82	109	111	110	110	102	128	91		267	308	239	282		302	322		1,096	843	
Engagement Rate	63%	69%	63%	69%	72%		69%	69%	72%	64%	67%	64%	63%	66%		70%	75%	67%	66%		70%	65%		70%	67%	
Total Screened and Refused/Decline	-	2	2	3	1		4	-	1	2	4	2	1	-		2	1	2	6		5	8		11	14	
Unable to Reach	44	36	87	26	24		33	48	42	61	50	55	73	47		111	103	115	137		123	166		466	409	
Total Cases Closed	29	27	42	28	25		37	36	37	63	55	62	61	59		159	209	85	95		110	180		548	410	
Cases Remained Open	97	110	88	93	104		114	136	158	168	160	158	138	127		169	70	110	104		158	158		104	127	
Total Cases Managed	132	149	139	127	135		163	187	216	237	237	230	213	202		338	282	209	168		287	346		658	553	
Complex Case	10	11	10	10	11		15	18	20	26	35	37	40	36		22	16	15	12		24	45		39	60	
Non-Complex Case	122	138	129	117	124		148	169	196	211	202	193	173	166		316	266	194	156		263	301		619	493	
	First Year of Life Care Management															**First Year of Life Care Management**								**First Year of Life Care**		
Total Number Of Referrals	40	45	55	40	47		51	37	61	45	44	38	48	49		124	149	147	142		149	127		562	373	
Pending	2	-	-	-	2		-	-	-	-	-	-	3	-		1	2	5	2		-	-		10	3	
Ineligible	-	1	2	1	4		7	2	-	-	-	-	-	-		1	1	2	7		9	-		11	9	
Total Outreached	38	44	53	39	41		44	35	61	45	44	38	45	49		122	146	140	133		140	127		541	361	
Engaged	37	41	51	39	40		43	31	59	42	43	36	45	47		117	146	129	130		133	121		522	346	
Engagement Rate	97%	93%	96%	100%	98%		98%	89%	97%	93%	98%	95%	100%	96%		96%	100%	92%	98%		95%	95%		96%	96%	
Total Screened and Refused/Decline	-	1	-	-	1		-	-	-	-	-	1	-	-		-	-	1	1		-	1		2	1	
Unable to Reach	1	2	2	-	-		1	4	2	3	1	1	-	2		5	-	10	2		7	5		17	14	
Total Cases Closed	28	27	20	23	33		29	41	49	37	47	51	47	44		78	87	101	76		119	135		342	345	
Cases Remained Open	400	405	432	450	449		452	441	435	450	440	419	419	422		327	395	405	449		435	419		449	422	
Total Cases Managed	428	437	455	474	483		489	482	497	489	490	476	471	466		424	479	510	503		567	560		792	767	

Item #12
Attachment 12.F

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: October 29th, 2026

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 3 2026(Oct 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 3 of 2026.

I. Meetings

Two QI/UM meetings were held in Quarter 3, in July and September. On July 16th and September 17th, 2026, the QI/UM Committee met, and the following **guiding documents** were approved:

1. 2025 Care Management Program Evaluation
2. 2026 QI & Health Education Work Plan Mid-Year Evaluation
3. 2026 UMCM Work Plan Mid-Year Evaluation
4. 2026 UM Program Description – DMHC Updates
5. Health Disparities Analysis and Actions Report 2026
6. Health Equity Social Risks and Social Needs Analysis and Prioritization Report
7. Health Equity Social Risks and Social Needs Resource Assessment Analysis Report 2026
8. Health Equity 2026 Annual Referral Tracking Disparity Report
9. Population Health Management Program Effectiveness Report 2026
10. RY2026 HEDIS® Results & QI Update

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

1. Medical Policies
2. Pharmacy Provider Updates
3. Clinical Practice Guidelines
4. Quality Improvement Policies & Procedures Annual Review
5. DHCS Community Reinvestment Presentation

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** provide a summary of all grievances in order to track volumes, turn-around times, case classifications, and use of clear and concise language in member letters. A year-over-year and Quarterly Analysis was presented in September to identify trends over time and evaluate the effectiveness of actions taken for improvement.
   a. Quality of Service Grievances (QOS), particularly Access to Care/DMHC, remained the highest grievance category, largely related to prior authorization.

b. Exempt grievances have generally improved compared with last year, especially assignment and ID card issues, due to increased automation and digital card access.
c. Appeals volume is increasing, with 430 resolved mid-year compared with 600 total for 2025.
d. Uphold and overturn rates out of desired ratio due to need for continued education related to new benefits and changes to existing benefits.

2. **Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.
PQI reviews may be initiated by a member, non-member, or peer review-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.
    - There were two (2) non-member-generated Fresno County Physical Health (PH) PQIs in Q2.
    - Member-generated PQIs increased based on previous quarters, with a total of 57 PH cases and two (2) Behavioral Health (BH) cases. All cases were scored level zero (0) to two (2).
    - Thirteen (13) Peer Review cases were generated (one was BH). Five (5) cases were closed, and eight (8) cases were open.
    - Five (5) Peer Review cases reviewed from April through June needed Further Action. All cases scored level zero to two (0-2).

3. The **Facility Site & Medical Records and PARS Report** displays completed activity and results of the DHCS required PCP Facility Site (FSR) and Medical Record Reviews (MRR) for CVH. The new FSR/MRR tools and standards began on 7/1/22, including revised Physical Accessibility Review Survey (PARS) assessment of provider offices. The results are analyzed for the purpose of monitoring and improving the performance of PCPs against DHCS and CVH standards.
Sixteen (16) FSRs and thirteen (13) MRRs were completed during Q3-Q4 2025.
    - The FSR mean rate for Q3-Q4 2025 was 98%.
    - The MRR mean rate for Q3-Q4 2025 was 91%.
    - Thirteen (13) PARS were completed with eight of the thirteen (8/13) PARS having Basic level access.
    - PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal to 90% do not have to submit a CAP (exempt pass). For all the counties, the CE CAP submission mean compliance rate within 10 business days was 100% for the last two quarters of 2025. FSR CAP compliance within 30 days of the FSR data mean rate was 100%. MRR CAP compliance within 30 days for MRR data mean rate was 100%.

4. The **Behavioral Health Performance Indicator Report Q1 2026** was substantially revised to improve visibility for CVH, the QI/UM Committee, and the Commission. The consolidated report covers behavioral health activities, performance data, county coordination, care management, access, grievances, satisfaction, MOU-related information, membership and utilization trends, turnaround time compliance, approval and denial rates, mental health parity, care coordination referrals, case management activity, access standards, transportation utilization, county behavioral health updates, and member/provider education efforts.
    a. Turnaround time compliance was 100%, with average turnaround time increasing from 4.1 days in 2025 to 5.4 days in 2026.
    b. Case management volume declined by 782 cases, or 52%, while engagement remained approximately 70% and case complexity increased.
    c. Care coordination included 922 screenings; Fresno County had the highest volume, adults represented about 78% of activity, and youth volume remained stable at 65.
    d. Access availability standards were 100% compliant.

e. Transportation totaled approximately 12,000 behavioral health-related trips; SUD trips accounted for about 8,500 trips, or 67%, and Fresno County represented 92% of utilization.
f. Behavioral health grievances remained low at eleven (11) total; satisfaction results are pending, with ECHO survey results expected in November.

5. The **Lead Screening Quarterly Report** is a Quarterly Assessment of Blood Lead Screening compliance in Children to ensure that CalViva members receive blood lead level testing and follow-up when indicated and that parents/caregivers receive anticipatory guidance from providers related to blood lead poisoning prevention. Improvement has been noted in HEDIS® rates for this measure in RY2025, but challenges still exist.

- In Q1 2026, the **overall compliance** was twenty-point nine five percent (20.95%), which is lower when compared to Q4 2025. Due to this measure's cumulative effect, a decline is expected at the start of each calendar year. Q1 2026 FSR/MRR data shows 57% of member records are compliant for both lead screening and anticipatory guidance and 36% of the primary care physician (PCP) sites are in compliance.
- To further assess provider performance, CalViva Health conducted a special audit of timely blood lead level (BLL) testing and anticipatory guidance during March-April 2026. The audit included 178 member records across six clinic sites.
- The audit findings demonstrated strong performance for 12-month blood lead level (BLL) testing, with a compliance rate of 95.50% (170 of 178 member records reviewed).
- Anticipatory guidance documentation compliance was 67.42% (120 of 178 member records).
- The special audit also identified higher anticipatory guidance documentation rates among clinic sites utilizing electronic medical record (EMR) prompts.
- **Next Step:** Expand Quality EDGE funding opportunities to allow providers to request support for EMR prompts, reminders, or workflow enhancements that promote the delivery and documentation of anticipatory guidance.

6. **Additional Quality Improvement Reports** approved include Initial Health Appointment Quarterly Report, Provider Preventable Conditions, County Relations Report, Member Incentives Program report, Performance Improvement Updates (PIPs), Skilled Nursing Facility Quality Assurance Performance Improvement Report, ECM & Community Supports Performance Report, and others scheduled for presentation at the QI/UM Committee during Q3.

III. Access Reports – The following is a summary of the access related reports and topics reviewed. These reports may be submitted by the Access Work Group or other access-related monitoring functions.

1. Access Work Group minutes from March 31st and May 26th were reviewed and approved.

2. The **Access Work Group Q3 Summary Report** was presented. This report provides the QI/UM Committee with an update on the CVH Access Workgroup activities since the last QI/UM Committee report. A variety of reports were presented and discussed at the workgroup including, but not limited to, reports on access related grievances, network adequacy and capacity, Call Center metrics, Triage & Screening results, Telehealth and more. Several standing reports related to the annual DMHC Timely Access Reporting (TAR) filing were discussed and brought back for final approval due to their length and complexity. Updates were provided on Network Certifications and other regulatory filings.

Some of the key reports presented this quarter included:

- **MY 2025 Integrated Accessibility Report**: Access metrics fall under two categories: metrics for the access "Rate of Compliance", as required by the Department of Managed Health Care (DMHC), such as the Provider Appointment Availability (PAAS) Survey and the Department of Health Care Services

(DHCS) standards, and other metrics CVH uses to monitor access to care that are not part of the Rate of Compliance.

- **Timely Access Metrics**: MY 2025 PAAS results show that the seventy percent (70%) DMHC compliance threshold was met for both Urgent Care (70%) and Non-Urgent (77%) appointments across all survey types **when combined across all counties,** even though individual providers may not have met the compliance threshold.
- **After-Hours Survey**: The Provider After-Hours Survey was fielded via telephone to CVH PCPs. Two metrics were used to measure performance with Access to After-Hours:
  - Appropriate After-Hours Emergency Instructions: percent of providers who give clear and appropriate instructions for emergency issues. **Goal met. 93% overall compliance rate**
  - Ability to contact on-call physician after-hours – percent of providers that can be contacted within thirty (30) minutes for urgent issues. **Goal not met. 86.9% overall compliance rate.**
- **Provider Satisfaction Survey**: Overall results indicate satisfaction rates ranged between 49% and 62%, which was a decrease from the prior year's results, which ranged between 66% and 72%.
- **Enrollee Experience Survey (EES)**: Results of the 2025 EES show that 67% of members indicate that they had no problems getting a timely appointment for routine care, an improvement when compared to the 2025 rate of 54%.

3. **Additional Access Related Reports** approved include the Specialty Referral Report, Provider Office Wait Time Report, Accessibility of Service Report (Primary, BH, & Specialty Care), Assessment of Network Adequacy Report, the Standing Referral Report and other reports scheduled in Q3.

IV. UMCM Reports -

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

1. **The Key Indicator Report (KIR) & Concurrent Review Report** provided data through July 31st, 2026, and Q2 respectively. A presentation analyzing key UM and CM metrics at the mid-year was presented with the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through Q2 2026. Annual and quarterly comparisons were presented with the following highlights:
   - The Q2 2026 readmissions data show mixed performance across populations. TANF improved compared to the 2025 average, while MCE and SPD increased above the 2025 average. Continued focus on discharge planning, care coordination, and post-discharge support remains important to help reduce avoidable readmissions, especially for populations trending above prior-year performance.
2. **The Care Management and CCM Report** provides a summary of the various case management and care coordination services offered to CalViva members. The programs include physical health case management, perinatal case management, behavioral health case management, transitional care services (the entry point for most CM programs) and the First Year of Life. Reports for Q1 and Q2 were presented in July and September respectively. The **outcome measures** include Readmission rates, ED utilization, Pre-term deliveries for the OB population, Member satisfaction, and Overall Healthcare costs. Positive results were seen for most outcome measures with the following results:
   a. **PH and BH outcomes:** Readmissions and emergency department (ED) utilization declined after care management; BH and PH readmissions decreased by 12%, and ED claims by 845, above our new 20% goal.
   b. **TCS outcomes:** Readmissions improved by 8%, exceeding the goal; the reduction in ED visits was just below the new 20% goal.
   c. **PCM outcomes:** Timely prenatal visits improved by 14%, preterm births decreased by 6%, and postpartum visits improved by 12%; each measure met or exceeded its goal.
   d. Member survey participation remained below target. The team plans to use a shorter survey delivered by text messages to improve response rates.

3. **Additional UMCM Reports** include Concurrent Review IRR Report, TurningPoint, Evolent Report (NIA), CCS Report, SPD HRA Report, Top 10 Inpatient Diagnoses MY2025, PA Member Letter Monitoring report, ECM and Community Supports, and others scheduled for presentation at the QI/UM Committee during Q3.

V. Pharmacy Quarterly Reports

The following is a summary of the reports and topics reviewed: Pharmacy reports include Executive Summary, Operation Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR) which were all reviewed. Since the implementation of Medi-Cal Rx in January of 2022, pharmacy activities are focused on Medical Benefit drugs.

1. Pharmacy Prior Authorization metrics were within 5% of standard for the second quarter.
2. PA volumes remained consistent in Q2 compared to Q1 with volumes consistent in all three months.
3. Overall Turn-around Time was 99.6% compliant in Q2.
4. Second quarter's Top Medication Requests were consistent with quarter 1.
5. Inter-rater Reliability results met the 90% threshold for action, and the 95% goal was also met; the overall score was 95%. Three (3) sample cases were determined to have a questionable denial or approval after Plan review. A more detailed review and QA of cases in Q2 2026 has been performed, and results will be shared with PA management to address concerns.

VI. HEDIS® Activity

In Q3, HEDIS® related activities were focused on analyzing the results for MY2025 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. CalViva saw improvement in most measures in MY25 when compared to MY24.

A review of final HEDIS® results for CalViva for MY 2025 (RY26) reveals the following:

- **Fresno County** did not meet the Minimum Performance Level (MPL) for MY25 in **three (3) Domains** (**BH** (2/2 *same as last year*), **Children's Health** (1/8 *improvement*) and **Reproductive Health/Cancer Prevention** (1/5 *decline*).

- **Kings County** did not meet the MPL for MY25 in the **Children's Domain** (4/8 improvement).

- **Madera County** did not meet the MPL for MY25 in the **BH Domain** (2/2 same as last year) and Reproductive Health/Cancer Prevention (1/5 decline).

The number of MCAS measures required to meet the MPL for MY26 IS **21 core MCAS measures; 20 held to MPL and 1 report only.**

VII. Quality Improvement Activities

1. Two Performance Improvement Projects:

- **Clinical Disparity PIP** - Improve Infant Well-Child Visits in the Black/African American(B/AA) Population in Fresno County.
- Two interventions:
  1. **Refer all caregivers/mothers of B/AA children to Black Infant Health** to encourage and facilitate WCV.
  2. **Promote use of the CDC Milestone Tracker App** to engage parents in WCV and encourage appointment attendance.
     - Statistically significant improvement noted for B/AA Children Completion of six (6) Well Child Visits by 15 months for remeasurement period 1 (MY24) and remeasurement period two (2) (MY25).
     - Successful rollout of CDC Milestone Tracker App to provide caregiver education on developmental milestones & promote timely WCVs.

- **PIP Closed:** HSAG final scoring 100% High Confidence for methodology. Moderate confidence in significant improvement.

A. **Non-Clinical PIP** - Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue with three interventions.

1. **Educational Intervention** for Hospital staff on Use of Smart Phrases in EMR to document services & referrals provided for BH/SUD in the ED (SUNs, CHWs, LCSWs, etc.) to represent codes that meet FUM/FUA measures.
2. **Cultural Training** to Improve behavioral health/substance use Treatment Compliance for the Hispanic population in the Central Valley.
3. **Expand Resources** by engaging with local providers - Resiliency Center. **(Abandoned)**
    - Statistically significant improvement in the percentage of timely SUD/MH ED visit provider notifications in Fresno and Madera Counties for remeasurement period 1 (MY24) and remeasurement period 2 (MY25).
    - Although the MPL has not yet been met for FUM/FUA measures in Fresno or Madera counties, compliance rates have more than doubled for both measures in both counties since the project was initiated.
    - **PIP Closed:** HSAG final scoring 100% High Confidence for methodology. High Confidence (100%) for significant improvement.

2. DHCS Collaboratives

A. **Institute for Healthcare Improvement (IHI) Collaborative Project to Improve Well Child Visit Rates for Hispanic Children zero to fifteen (0 to 15) months in Fresno County.** Successful collaboration with Clinica Sierra Vista to implement all four (4) interventions at three (3) high volume pediatric clinic sites. This project demonstrated our ability to spread interventions within an FQHC and sustain these improvements over time.

- **Phase 2 began Sept 2025 to Sept 2026:**
    1. Expanding Appointment Access – Designated Outreach Staff
    2. Optimizing Scheduling Workflow – Newborn Gateway
    3. Connect Birthing Parents to Resources – Community Baby Showers
    4. New WIC Referral Process

VIII. Findings/Outcomes

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

One area of non-compliance that was identified through routine monitoring remains open during Quarter 3:

1. Blood Lead Screening in Children – provision of anticipatory guidance by providers.

Health Net was notified of the unsatisfactory performance in this area, and a Corrective Action Plan is in progress. See Blood Lead Screening Report above. Oversight and monitoring processes will continue.

Item #12

Attachment 12.G

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: October 29th, 2026

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Q3 2026

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 3rd Quarter 2026 CalViva Health (CVH) Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on July 16th, 2026. At the July meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering Q1 2026 were reviewed for delegated entities and Q2 2026 for HN, including Behavioral Health. Q1 2026 data for all organizations is summarized in Table 1 below. There were no unanticipated credentialing patterns identified in this reporting period.

Table 1. Q1 2026 CalViva Health Credentialing/Recredentialing by Organization

	BH	HN	Adventist	ASH	CVMP	ChildNet	CSV	Envolve	Grow	IMG	LaSalle	Mindpath	Santé	Teladoc	UPN	Totals
Initial Credentialing	10	23	10	0	20	14	4	8	78	6	26	21	0	30	26	276
Recredentialing	19	10	24	0	63	13	11	4	69	19	31	0	3	37	8	311
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	29	33	34	0	83	27	15	12	147	25	57	21	3	67	34	587

III. **The 2026 Adverse Events Report** for Q2 2026 (April through June) 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 Q2 2026.
  - Credentialing submitted three previously presented, remaining open cases to the Credentialing Committee in the second quarter of 2026.
    - All cases involved individual practitioners.
    - All cases stemmed from a state licensing board action.
    - One case was placed on annual monitoring, and two cases were closed with no further action.
    - Zero cases involved behavioral health.
  - There were no reconsiderations or fair hearings during Q2 2026.

- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 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 Q2 2026.
- Reviews completed in April, May, and June identified one (1) practitioner and one (1) provider requiring removal from the Plan's network.
  - The provider appeared on both the CMS Preclusion report and the Suspended and Ineligible Provider Listing.
  - The practitioner appeared on the Suspended and Ineligible Provider Listing.
- The practitioner and provider were notified, as well as impacted Plan departments such as Claims, Network Management, Delegation Oversight, Special Investigations Team, and Provider Data Management.
- April, May, and June 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 Q2 2026.

IV. The **Access & Availability Substantial Harm Report Q2 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 Q2 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).
- The Investigations Team submitted 13 cases to the Peer Review Committee in the second quarter of 2026:
  - Of the 13 cases, zero (0) cases were related to appointment availability issues without significant harm, and four were related to significant harm without appointment availability issues.
- There were zero incidents involving appointment availability issues resulting in substantial harm to a member or members in the second quarter of 2026.

V. The **Credentialing Adverse Actions** report for Q2 2026 for CalViva Credentialing Sub-Committee from HN Credentialing Committee was presented. One (1) case was presented for discussion in April, May, and June 2026. The Credentialing Committee reviewed a case involving a request for administrative termination of the practitioner's participation in Fresno County due to failure to satisfy required Facility Site Review (FSR) and Medical Record Review (MRR) corrective action requirements. Following the review, the practitioner was required to submit a Corrective Action Plan (CAP) with supporting evidence showing that the cited deficiencies had been resolved. Because the deficiencies remained unresolved after the regulatory correction period and extension, the Credentialing Committee administratively terminated the practitioner's participation, effective 06/25/2026, for the impacted practice site only. This action is regulatory and administrative in nature. Network terminations resulting from failed or noncompliant FSR/MRR findings remain in effect for three (3) years, after which the practitioner may reapply for participation. There are no appeal rights for this administrative action, consistent with the termination being based on noncompliance with regulatory participation standards rather than on a determination of professional competence or conduct.

VI. The county-specific **Credentialing Subcommittee Reports** of significant subcommittee activities for April through June 2026 were presented. There was one (1) termination in Fresno County, and three (3) CAPs were issued in Madera County for Q2 2026.

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

Item #12

Attachment 12.H

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:	October 29th, 2026
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Q3 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 July 16th, 2026. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2026 were reviewed for approval. There were no significant cases to report.

II. The **2026 Adverse Events Report for Q2** 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.

- There were eight (8) cases identified in Q2 2026 that met the criteria and were submitted to the Peer Review Committee.
    - Four (4) cases were regarding practitioners, and four (4) cases involved organizational providers (facilities).
    - Of the eight (8) cases, three (3) were tabled, one (1) was closed to track and trend with a letter of concern, one (1) was closed to track and trend with a letter of education, and three (3) were closed to track and trend.
    - Eight (8) cases were quality of care grievances, zero (0) were potential quality issues, and zero (0) were track and trend.
    - One (1) case involved seniors and persons with disabilities.
    - One (1) case involved behavioral health.

- The Investigations Team submitted five (5) previously presented, remaining-open cases to the Peer Review Committee in Q2 2026.
    - Two (2) cases were regarding practitioners, and three (3) cases involved organizational providers (facilities).
    - Of the five (5) cases, one (1) was tabled, one (1) was placed on monitoring, and three (3) were placed on pending closure.
    - Two (2) cases were quality-of-care grievances, three (3) were 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.
- There were zero (0) new or previously reported incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2026.
- Grievance data reviews (NCQA CR 5.A.3-4) completed in March, April, and May did not identify any providers/practitioners who met the Peer Review trended criteria for escalation.
- Two (2) cases were placed on or remain on corrective action in Q2 2026.
- Grievance data reviews for health equity, site review, chaperone, or medical records, completed in April, May, and June, did not identify any providers/practitioners who met the Peer Review trended criteria for escalation.
- There was one (1) new case and one (1) previously reported case identified outside of the ongoing monitoring process in which an adverse injury occurred during a procedure by a contracted practitioner (NCQA CR.5.A.4) in Q2 2026.
- The reviewing Medical Directors determined that further outreach was required for ten (10) 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.
- Zero (0) 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 Q2 2026.

III. The **Access & Availability Substantial Harm Report for Q2 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.

- The Investigations Team submitted thirteen (13) cases to the Peer Review Committee in Q2 2026.
    - Of the thirteen (13) cases, zero (0) cases were related to appointment availability issues without significant harm, and four (4) were related to significant harm without appointment availability issues.

- There were zero incidents involving appointment availability issues resulting in substantial harm to a member or members in Q2 2026.

IV. The **Q2 2026 Peer Count Report** was presented at the meeting with a total of thirteen (13) cases reviewed. Case outcomes included:

- Five (5) cases were closed and cleared. Zero (0) cases were closed/terminated. Zero (0) cases were deferred. Four (4) cases were tabled for further information. There was one (1) case with CAP outstanding/continued monitoring, and three (3) are pending closure for CAP compliance.

V. The **Peer Review Sub-Committee reports** for April through June 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 Q2 2026.

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

Item #12
Attachment 12.I

Executive Dashboard

	2025	2025	2025	2025	2025	2026	2026	2026	2026	2026	2026	2026	2026
Month	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**
CVH Members													
Fresno	342,450	340,709	339,554	339,029	338,291	334,955	332,883	331,574	329,434	326,859	323,305	322,802	321,186
Kings	38,789	38,783	38,729	38,689	38,719	38,543	38,391	38,329	37,893	37,698	37,395	37,276	37,112
Madera	50,958	50,850	50,648	50,627	50,523	50,017	49,650	49,306	48,811	48,347	48,023	47,850	47,685
Total	432,197	430,342	428,931	428,345	427,533	423,515	420,924	419,209	416,138	412,904	408,723	407,928	405,983
SPD	48,274	48,274	48,382	48,315	48,254	47,340	47,218	46,990	46,357	46,347	46,263	46,068	46,008
CVH Mrkt Share	66.81%	66.79%	66.83%	66.84%	66.89%	66.83%	66.85%	66.89%	66.93%	66.96%	66.96%	67.00%	66.93%
ABC Members													
Fresno	149,921	148,987	147,973	147,293	146,465	144,988	143,482	142,360	141,087	139,469	137,744	136,983	136,638
Kings	25,190	25,146	25,108	25,166	25,184	25,211	25,126	25,016	24,783	24,665	24,571	24,500	24,373
Madera	27,375	27,240	27,076	26,930	26,742	26,472	26,186	25,888	25,405	25,112	24,731	24,561	24,393
Total	202,486	201,373	200,157	199,389	198,391	196,671	194,794	193,264	191,275	189,246	187,046	186,044	185,404
Kaiser													
Fresno	10,252	10,551	10,714	10,976	11,117	11,321	11,662	11,971	12,085	12,210	12,333	12,536	12,721
Kings	231	239	246	259	259	269	270	265	263	265	272	268	286
Madera	1,741	1,775	1,811	1,843	1,864	1,923	1,986	2,013	2,019	2,042	2,054	2,113	2,141
Total	12,224	12,565	12,771	13,078	13,240	13,513	13,918	14,249	14,367	14,517	14,659	14,917	15,148
Default													
Fresno	58.94%	61.52%	59.59%	60.44%	63.29%	64.73%	65.80%	63.89%	65.20%	64.79%	65.84%	65.61%	
Kings	56.57%	46.17%											
Madera	45.13%	50.43%					58.10%						
County Share of Choice as %													
Fresno	59.30%	61.73%	60.40%	60.85%	61.54%	59.09%	59.53%	59.04%	60.04%	60.68%	59.55%	53.65%	
Kings	55.81%	56.51%		55.43%	56.30%	53.62%	N/A	50.16%	57.80%	53.61%	52.90%		
Madera	65.07%	61.08%	63.92%	65.14%	57.46%	55.67%	67.31%	66.46%	60.44%	67.34%	62.50%		

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	**22**	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	**1.9 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**	**2025**	**2025**	**2025**	**2025**	**2026**	**2026**
		Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	(Main) Member Call Center	**# of Calls Received**	**41,923**	**40,133**	**42,619**	**37,637**	**43,343**	**39,739**
		# of Calls Answered	**41,609**	**39,766**	**42,295**	**37,365**	**42,983**	**39,175**
		Abandonment Level (Goal < 5%)	**0.70%**	**0.90%**	**0.80%**	**0.70%**	**0.80%**	**1.40%**
		Service Level (Goal 80%)	**92%**	**94%**	**96%**	**95%**	**89%**	**88%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,008**	**917**	**963**	**847**	**938**	**918**
		# of Calls Answered	**1,004**	**909**	**959**	**843**	**933**	**916**
		Abandonment Level (Goal < 5%)	**0.40%**	**0.90%**	**0.40%**	**0.50%**	**0.50%**	**0.20%**
		Service Level (Goal 80%)	**95%**	**96%**	**98%**	**98%**	**98%**	**99%**
	Transportation Call Center	**# of Calls Received**	**14,958**	**15,899**	**18,401**	**21,331**	**22,357**	**24,968**
		# of Calls Answered	**14,868**	**15,819**	**18,327**	**21,246**	**22,267**	**24,893**
		Abandonment Level (Goal < 5%)	**0.40%**	**0.20%**	**0.20%**	**0.30%**	**0.20%**	**0.10%**
		Service Level (Goal 80%)	**86%**	**85%**	**84%**	**91%**	**91%**	**91%**
	CalViva Health Website	**# of Users**	**79,000**	**34,000**	**54,000**	**52,000**	**53,000**	**42,200**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Do You Qualify**	**Do You Qualify**
		Top Device	**Mobile (70%)**	**Mobile (63%)**	**Mobile (62%)**	**Mobile (63%)**	**Mobile (70%)**	**Mobile (68%)**
		Session Duration	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	Q2 2026 numbers are available. At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website activities. The Plan's Member Portal currently has approximately 7,041 active web accounts.							

Provider Network & Engagement Activities	**Year**	**2026**	**2026**	**2026**	**2026**	**2026**	**2026**	**2026**
	Month	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
	Hospitals	**11**	**11**	**11**	**11**	**11**	**11**	**11**
	Clinics	**169**	**170**	**171**	**171**	**176**	**175**	**176**
	PCP	**440**	**438**	**435**	**434**	**427**	**437**	**438**
	PCP Extender	**506**	**514**	**522**	**530**	**529**	**564**	**565**
	Specialist	**1528**	**1549**	**1539**	**1564**	**1594**	**1605**	**1610**
	Ancillary	**344**	**343**	**344**	**346**	**347**	**355**	**355**
	Year	**2024**	**2025**	**2025**	**2025**	**2025**	**2026**	**2026**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Behavioral Health	**558**	**545**	**562**	**486**	**295**	**460**	**438**
	Vision	**114**	**112**	**104**	**106**	**35**	**41**	**41**
	Urgent Care	**17**	**17**	**16**	**16**	**12**	**15**	**15**
	Acupuncture	**2**	**3**	**3**	**3**	**7**	**8**	**9**
	Year	**2024**	**2025**	**2025**	**2025**	**2025**	**2026**	**2026**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	% of PCPs Accepting New Patients - Goal (85%)	**91%**	**89%**	**89%**	**92%**	**92%**	**93%**	**93%**
	% Of Specialists Accepting New Patients - Goal (85%)	**96%**	**96%**	**96%**	**97%**	**92%**	**97%**	**97%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**99%**	**99%**	**99%**	**95%**	**94%**	**94%**	**94%**
	Year	**2026**	**2026**	**2026**	**2026**	**2026**	**2026**	**2026**
	Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
	Providers Interactions by Provider Relations	**375**	**623**	**564**	**606**	**716**	**657**	**673**
	Reported Issues Handled by Provider Relations	**55**	**69**	**46**	**44**	**35**	**35**	**20**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**3**	**23**	**22**	**33**	**17**	**75**	**26**
	Interventions Deployed for PCP Quality Performance Improvement	**3**	**23**	**22**	**33**	**17**	**75**	**26**
Message From the CEO	At this time there are no significant issues or concerns as it pertains to the Plan's Provider Network and Provider Engagement Activities.							

Claims Processing	**Year**	**2024**	**2025**	**2025**	**2025**	**2025**	**2026**	**2026**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	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	94% / 98% N/A	96% / 98% N/A	99% / 99% N/A	99% / 99% 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	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	99% / NA NO	98% / NA 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% / NA NO	100% / NA 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% / NA NO	100% / NA NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	79% / 95% YES	91% / 100% YES	84% / 99% YES	83% / 99% YES	84% / 100% YES	92% / 100% YES	96% / 100% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 100% YES	93% / 100% YES	92% / 100% NO	92% / 100% YES	83% / 100% NO	68% / 100% NO	97% / 100% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	98% / 100% NO	95% / 100% NO	97% / 100% YES	99% / 100% NO	99% / 100% NO	98% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% NO	100% / 100% NO	95% / 100% NO	100% / 100% NO	100% / 100% NO	100% / NA NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	98% / 100% NO	98% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	99% / NA NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	97% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	98% / NA NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 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% / NA NO
Message from the CEO	Q1 and Q2 2026 numbers are available. Management is working with PPG 2 and 3 on performance. PPG 7 and 8 are providing run out data. PPG 8 has completed their run out data as of Q2 2026.							

Provider Disputes	**Year**	**2024**	**2025**	**2025**	**2025**	**2025**	**2026**	**2026**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	100%	99%	99%	99%	99%	86%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	99%	99%	100%	99%	99%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	100%
	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%	78%	91%	60%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	96%	99%	95%	99%	99%	98%	100%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	99%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	100%	100%	99%	100%	100%	99%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	99%	100%	100%	99%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	100%	100%	99%	100%	100%	99%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	100%	100%	100%	100%	100%	100%
Message from the CEO	Q1 & Q2 2026 numbers are available. Management is working with PPG 2 and the Medical Provider Disputes team on improving performance.							