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: July 11, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

Please find the agenda and supporting documents enclosed for the upcoming Commission meeting on:

Thursday, May 15, 2025
1:30 pm to 3:30 pm

Where to attend:

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

2) Woodward Park Library
Large Study Room
944 E. Perrin Ave.
Fresno, CA 93720

Meeting materials have been emailed to you.

Currently, there are **10** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
July 17, 2025
1:30pm - 3:30pm

Meeting Locations:

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

2) Woodward Park Library
Large Study Room
944 E Perrin Ave
Fresno, CA 93720

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D Attachment 3.E Attachment 3.F Attachment 3.G Attachment 3.H Attachment 3.I Attachment 3.J	**Consent Agenda:** • Commission Minutes dated 5/15/25 • Finance Committee Minutes dated 3/20/25 • QIUM Committee Minutes dated 3/20/25 • Public Policy Committee Minutes dated 3/5/25 • Finance Committee Charter • Credentialing Committee Charter • Peer Review Committee Charter • Quality Improvement/Utilization Management Charter • Public Policy Committee Charter • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	
	Action	**A. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Executive Officer Annual Review Per Government Code Section 54957(b)(1)	
	Information	**B. Conference with Legal Counsel – Existing Litigation, pursuant to Government Code section 54596.9** a. Fresno County Superior Court Case No. 24CECG020996	

	Information	**C. Conference Report Involving Trade Secret – Discussion of Service, Program, or facility:** Estimated Date of Public Disclosure: July 1, 2025 Government Code section 54954.5	
5. Information	Attachment 5.A	**Public Disclosure: July 1, 2025 – Health Net Community Solutions Contract** • BL 25-008	J. Nkansah, CEO
6 Action	Attachment 6.A Attachment 6.B	**Community Support & Community Reinvestment Policy and Procedure** • BL 25-009 AD-103 Community Support Community Reinvestment Policy • AD-103 Requirements for RHA Funding of Community Support & Community Reinvestment Programs Policy *Action: Review and approve policy AD-103*	J. Nkansah, CEO
7 Information	Attachment 7.A	**Review of Fiscal Year End 2025 Goals** • BL 25-010 Review of Fiscal Year End Goals 2025	J. Nkansah, CEO
8 Action	Attachment 8.A	**Goals and Objectives for Fiscal Year 2026** • BL 25-011 Goals and Objectives FY 2026 *Action: Approve Goals for FY 2026*	J. Nkansah, CEO
9 Action	Attachment 9.A Attachment 9.B	**CYBHI MOU CBH-MCP Interim Model 04032025** • BL 25-012 CYBHI Carelon Behavioral Health MOU • California Children and Youth Behavioral Health Initiative Network Support, Claims, Claims Processing and Payment Remittance MOU. *Action: Approve CYBHI MOU*	Jeff Nkansah
	Handout will be available at meeting	*PowerPoint Presentation will be used for item 10-11*	
10 Information	Attachment 10.A	**Care Management** • 2024 Program Evaluation & Executive Summary	P. Marabella, MD, CMO
11 Action	Attachment 11.A	**Long Term Care** • 2025 Quality Assurance Performance Improvement Plan *Action: Approve 2025 Quality Assurance Performance Improvement Plan*	P. Marabella, MD, CMO

12 Action		**Standing Reports**	
		Finance	D. Maychen, CFO
	Attachment 12.A	• Financials as of May 31, 2025	
		Medical Management	P. Marabella, MD, CMO
	Attachment 12.B	• Appeals and Grievances Report	
	Attachment 12.C	• Key Indicator Report	
	Attachment 12.D	• Quarterly Summary Report	
	Attachment 12.E	• Credentialing Sub-Committee Quarterly Report	
	Attachment 12.F	• Peer Review Sub-Committee Quarterly Report	
		Executive Report	
	Attachment 12.G	• Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	
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 September 18, 2025 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item #3
Attachment 3.A-K

FKM RHA Reappointments

Consent Agenda

3.A	Commission Minutes 5/15/25
3.B	Finance Minutes 3/20/25
3.C	QIUM Minutes 3/20/25
3.D	Public Policy Minutes 3/5/25
3.E	Finance Committee Charter
3.F	Credentialing Charter
3.G	Peer Review Charter
3.H	QIUM Committee Charter
3.I	Public Policy Committee Charter
3.J	Compliance Report

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
May 15, 2025

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

	Commission Members		
	Sara Bosse, Director, Madera Co. Dept. of Public Health	✓	**David Luchini**, Director, Fresno County Dept. of Public Health
✓*	**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	✓	**Lisa Lewis**, Ph.D., Kings County At-large Appointee
	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		
	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 FKM RHA Appointment/ Reappointments Action J. Nkansah, CEO	The Commissioners ratified the Fresno County Board of Supervisors' reappointment of Dr. Hodge and Dr. Cardona for an additional three-year term.		***Motion**: Ratify reappointments of Fresno County BOS appointed Commissioners* *A roll call was taken.* *11 – 0 – 0 – 6* *(Neves / Frye)*
#4 Chair and Co-Chair Nominations for FY 2026 Action J. Nkansah, CEO	The Commissioners nominated and subsequently re-elected David Hodge, MD as chair and Supervisor Joe Neves as Co-Chair to serve during Fiscal Year 2026.		***Motion**:* *Nominate and Approve Chair and Co-Chair:* *11 – 0 – 0 – 6* *(Frye / Soares)* *A roll call was taken*
#5 Consent Agenda • *Commission Minutes dated 3/20/25.* • *Finance Committee Minutes dated 2/20/25.* • *QI/UM Committee Minutes dated 2/20/25.* Action D. Hodge, MD, Chair	All consent items were presented and accepted as read. *Kerry Hydash arrived on Teams at 1:33 pm (included in vote)* *Supervisor Bredefeld arrived at 1:34 pm (not included in vote)*		***Motion**: Consent Agenda was approved.* *12 – 0 – 0 – 5* *(Neves / Naz)* *A roll call was taken*

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#6 Closed Session	Jeff Nkansah reported out of closed session in the absence of general counsel. The Commission met in closed session to discuss the items agendized specifically item #6.A Conference Report Involving Trade Secret, Government code section 54954.5. The Commission discussed those items and direction was given to staff. There were no other reportable actions and closed session recessed at 1:51 pm.		***No Motion***
#7 Legal Services Action J. Nkansah, CEO	The Commission approved the Attorney Services Agreement between Epperson Law Group, PC and Fresno Kings Madera Regional Health Authority for an additional three years.		***Motion:*** *Approve Attorney Services Agreement.* *13 – 0 – 0 – 4* *(Neves / Naz)* *A roll call was taken.*
#8 CEO Annual Review Ad-Hoc Committee Selection Action J. Neves, Co-Chair	Commission members selected for the CEO Annual Review ad-hoc committee are Dr. Hodge, John Frye, and Paulo Soares.		***Motion:*** *Commissioners selected and approved ad-hoc committee for CEO annual review.* *13 – 0 – 0 – 4* *(Neves / Soares)* *A roll call was taken.*
#9 Sub-Committee Members for FY 2026 Information D. Hodge, MD, Chair	No changes in Commission members were made for FY 2026 to the following committees, as described in BL 25-006: • Finance Committee • Quality Improvement/Utilization Management Committee • Credentialing Sub-Committee • Peer Review Sub-Committee • Public Policy Committee		***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#10 Community Support & DHCS Reinvestment Program Action J. Nkansah, CEO	Jeff Nkansah presented the 2025-2026 Community Support & DHCS Reinvestment Program proposed grant recommendations as a result of the Ad-hoc committee. The RHA Commission was presented with the proposed updates in preparation for DHCS All Plan Letter (APL) 25-004 requirements, now formalized as BL 25-007. The current RHA Commission Community Support Program will continue. DHCS Community Reinvestment Program will be added to the RHA Commission Community Support Program. Overall Grants Budget planning and spending will encompass spending in both Community Support and Community Reinvestment programs. On April 29, 2025, the Ad-Hoc Committee met to discuss the Funding Recommendations and categories which exceed $25,000 and the changes which were necessary in preparation for planning and implementing the DHCS Community Reinvestment requirements. There was robust discussion, therefore, as a result more time is being allotted to ensure the full RHA Commission understands the Ad-hoc's recommendation being brought to the full Commission. Approximately $2.378 Million is being allocated towards Community Support Programs which will support Contingency, Recreation Supports, Provider Network and member Support, Education Scholarships and Community Workforce Support, Community Infrastructure and Community Based Organization Support. Approximately $2.0 Million is being allocated towards DHCS Community Reinvestment Program in preparation for planning and funding of identified DHCS Community Reinvestment activities in the DHCS required categories. A total of approximately $4.378 Million is being planned for reinvestment within Fresno, Kings, and Madera Counties during Fiscal Year 2025-2026. Changes to this program include the amounts that were previously allocated under Provider Network Support for Funding for Specialists, Behavioral Health, and Ancillary Providers, and also Provider Incentive quality bonus, and Provider Infrastructure Supplies & Equipment. In addition, there was also a reduction in the Member Support category. The value added service pilot was unsuccessful,	*Supervisor Bredefeld asked for a specific description of a Provider incentive.* *Jeff Nkansah responded with the Plan's current existing program there are certain quality improvement metrics that the State requires they monitor to improve quality such as Well Child Visits, and immunizations as examples. The Plan's program identified the top 5-10 performers who were doing well, whether it was clinics or PCPs. If they were doing well, then those quality based improvement measures the Plan offered an additional supplement payment to recognize them for being a high performer.* *Rose Mary Rahn asked if there is a plan to look at opportunities for other CBOs to ask for funds, is it an application process, or is it based on who asks for funds? And is there ever the thought of*	**Motion**: Approve Community Funding Grant Recommendations 13 – 0 – 0 – 4 (Luchini / Neves) *A roll call was taken.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	and it is scheduled to be discontinued by 12/31/2025. Examples of permissible investments and impermissible use of funds was provided. This does not mean that incentives to the Plan's Providers are going away completely. Providers are the lifeline of the organization and provide care to our members and the Plan wants to ensure that this continues to be recognized. Health Net, our Plan Administrator, has a quality incentive program CalViva Health's program supplemented Health Net's. CalViva Health's Performance Standard requires Health Net to perform as it pertains to Quality. The Incentive Programs Health Net has in place will likely continue so there should be no adverse impact in CalViva Health stopping the current Supplemental Program. Health Net also has a Quality Edge Program which is similar in nature to CalViva Health's Provider Infrastructure Program. Due to this duplication, there should also be no adverse impact in the loss of this Provider Infrastructure Supplies & Equipment line item. Specialists will be added to the funding previously reserved for PCPs and Extenders and at the direction of the Ad-Hoc Committee, Behavioral Health was also added. The line item will be monitored in the future to determine whether the budgetary amount(s) should be increased in the future due to these changes. As a result of the ad-hoc committee meeting, the recommendation for the Plan is to continue the Community Support Funding for Provider Network Support, to continue the existing Community Support around the existing and currently designed Education Scholarships & Community Workforce Support, the ability to continue acting quickly under Community Support to support the Plan's Food Bank partners and community partners who are looking to enhance neighborhoods, and to continue supporting the Plan's trusted partners who are doing great work within the community under RHA Community Support while working with them through a transition to determine if they will qualify in the future for DHCS Community Reinvestment Funding, or if they will need to remain within RHA Community Support or if the RHA Commission needs to reconsider funding in the future.	*sustainability beyond this funding?* *Jeff Nkansah responded, stating that initially the first part is to get the requestor through the first stage and then at that time they would try and apply for community investment funding. Beyond that other individuals have the opportunity to reach out to the Plan for funding opportunities. As those new entities are reaching out to the Plan, the initial path is to see if they fit within the DHCS Community Reinvestment funding. As for sustainability, with reference to the Community Reinvestment the Plan would evaluate if there is a need to keep doing that specific activity. In reference to Community Supports, the Plan and Commission would look at if it's still worthwhile to continue funding the activity.*	

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		Dr. Lisa Lewis asked if there's anything they can do to help with engaging more Community Supports within Kings County. *Courtney Shapiro stated to reach out to her directly with any recommendations for Kings County.* *Jennifer Armendariz asked for enrollment support to be defined in reference to the Grants Budget.* *Jeff Nkansah stated it has to do with focusing on members, not market share, and what the Plan can do in that area to uniquely impact members directly. As an example, possibly a gym membership being a value added service focusing on physical health and wellbeing.* *Jennifer Armendariz added that looking at the governors May revised draft legislation on the quarterly requirements for enrollment for Medi-Cal*	

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		members coming down, does that overlap with this program? Is the Plan going to help support? What may be impacted with the Plan's CBOs? It seems there's a lot of overlap with CalAIM funding which is probably not on the table. With that perspective is the Plan thinking about enrollment and support in the future as this budget comes to fruition from the State. *Jeff Nkansah responded that a great deal of that energy and effort landed with the Plan's administrative partner.* *David Luchini asked for a refresher on the outcome tracking for these programs.* *Courtney Shapiro responded the Plan linked to all of the County Health Department documents as well as Behavioral Health documents and for the outcomes the departments had to tell the Plan what*	

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		type of evaluations are being performed on the item they are asking for and throughout the year that outcome report will be created and will be publicized on the CVH website. Currently the Plan receives reports from each of the funding partners that are over $25,000 before they can apply for funding in the future.	
#11 Health Equity Program Description and Work Plan Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2024 Health Equity Work Plan Annual Evaluation, the 2025 Health Equity Program Description, and the 2025 Health Equity Work Plan. With regard to the 2024 Health Equity Annual Evaluation, there were 50 measurable objectives, and all 2024 work plan activities were completed. The four sections included: 1. Language Assistance Services: • Updated / amended contracts with four vendors to expand services. • Distributed a newsletter article informing members how to access language services. • Two hundred and two (202) staff completed their bilingual assessment / re-assessment. • Updated Non-Discrimination Notice (NDN) to include additional protective groups. • Thirty-six (36) translation reviews were completed in 2024. 2. Compliance Monitoring: • HEQ reviewed 5 interpreter complaints and 37 grievance cases with 3 interventions identified.		***Motion:*** *Approve Health Equity 2024 Annual Evaluation, 2025 Program Description, and 2025 Work Plan* *13 – 0 – 0 – 4* *(Neves / Frye)* *A roll call was taken*

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	• Attended QI/UM Workgroup, weekly and Public Policy Committee (PPC) meetings, quarterly. • Two (2) findhelp trainings were completed with 966 overall new programs added to the platform. • All HEQ Policies & Procedures reviewed and updated. 3. Communication, Training, and Education • One (1) A&G training was completed on coding and resolution of grievances. • Six (6) call center trainings conducted to 85 new staff; training decks updated. • Providers were updated on cultural practices, LAP services, health literacy, and on-line cultural competency/Office of Minority Health (OMH) training. • Language identification poster for provider offices was remediated and posted in provider library. 4. Health Literacy, Cultural Competency, and Health Equity: • English material review completed for a total of 77 materials. • Completed 4 provider trainings for 164 providers. (Special Needs & Cultural Competency, Language Assistance Program & Plain Language for Health Literacy, and Community Connect) • Conducted annual Heritage/CLAS Month with 2,060 staff who attended the event. • Completed 2 cultural competency trainings for staff; (Gender Neutral Language and Bridging Gaps for Equal Access to Health Care). • Supported the completion of quality projects. Projects target measures: W30-6+ and SUD/MH. Changes to the 2025 Health Equity Program Description include: • Added member's preferred pronouns as data we collect. • Executive Summary includes a statement regarding "adding Arabic as a threshold language" this is incorrect. It is being corrected to, "Spanish and Hmong are threshold languages for CalViva and are monitored. As part of quality assurance efforts, we also monitor Armenian, Chinese, and Arabic."		

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	• Added specific training and materials that are available to support staff in providing culturally competent services. • Added additional information regarding CLAS/Heritage Month. • Listed training topics for providers. • Added the Health Literacy Toolkit and what it consists of. • Updated the Health Equity core levels changing local to community, data to provider, and included member as the third core area. The 2025 Health Equity Work Plan is consistent with the 2024 Work Plan while incorporating enhancements in four categories: 1. Support & Oversight: • Expanded on activities regarding language vendors. • Added new responsibility encompassing oversight of Health Education's material field testing. • Added oversight of translation coordination for other departments. • Expanded on activities and support provided to A&G staff on culture and linguistic (C & L) related grievances. • Updated Call Center training oversight. • Added new activities to be completed by CVH Health Equity Officer. 2. Reporting: • Detailed how language and demographic information collected is used to identify emerging languages. • Added a new activity to include an annual review of emerging and threshold languages. • Updated responsibilities for Population Needs Assessment (PNA) to supply data instead of authoring sections. • Added action plans to address PNA and Geo Access report findings. • Expanded to include how the grievance trend analysis is used to evaluate the effectiveness of the LAP program. • Added details regarding the Disparity Projects and annual reporting requirements. 3. Members and Providers:		

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	• Elaborated on member's alternate format standing request report and responsibility for reasonable accommodation requests. • Expanded details on content and purpose of the member newsletter. • Expanded on findhelp/Community Connect activities to include additional marketing efforts (row 40) and trainings of Cozeva integration. • Included participation in CAHPS Action Plan meetings to improve member experience. • Elaborated on the topics that are covered in Provider Updates and made available to providers. • Added new Health Literacy Toolkit that will be made available to staff and providers. • Added list of topics for Provider Training. 4. Accreditation & Regulatory: • Expanded on DHCS/DMHC audit readiness to include details regarding reviews and support. • For external forums (NCQA, DHCS, etc.) added information regarding participation and responsibilities. • Included NCQA Accreditation support and a list of the required reports to provide. • Expanded on Disparity Projects support and deliverables. Conclusions for the Language Assistance Program for 2024: • Spanish and Hmong are CalViva Threshold Languages. Spanish (97%) consistently has highest volume, and Hmong was 3% of calls. • Interpretation was performed via the following: o 80% telephonic interpreters down from 84% in 2023 o 18% face-to-face – down from 20% in 2023 o 2% Sign language – down from 3% in 2023 o 0.1% Video Remote Interpretation - up from 0% in 2023 • Behavioral Health interpretation was performed via the following: o 3.5% telephonic interpreters o 46.9% face-to-face o 23.9% Sign language		

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	○ 25.7% Video Remote Interpretation • Limited English and non-English membership remain high for CVH population and therefore interpreter services are integral to maintaining safe, high-quality care.		
#12 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of March 31, 2025</u> As of March 2025, total current assets were approximately $796.5M; total current liabilities were approximately $628.9M. Current ratio is approximately 1.27. TNE as of March 2025 was approximately $177.3M, which is approximately 670% above the minimum DMHC required TNE amount. For DHCS standard, the minimum required TNE is approximately $185M, which the Plan is short by approximately $7M; however, the DHCS financial performance measure does fluctuate as revenues fluctuate. As of March 2025, interest income actual recorded was approximately $9M, which is approximately $6M more than budgeted due adding more funds to the money market funds and interest rates being higher than projected. Premium capitation income actual recorded was approximately $1.75B which is approximately $380.4M more than projected primarily due to higher MCO taxes which was recently revised in December 2024 by CMS; this increased the Plan's MCO taxes by approximately $237M through March 2025 which was not anticipated. In addition, revenues are higher due to enrollment and rates being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $1.03B which is approximately $139M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $43.1M which is approximately $2.5M more than budgeted due to enrollment being higher as more members have been retained through the redetermination process. License expense, the fees that DMHC assesses on Plans, actual recorded was approximately $1.1M which is approximately $47K more than projected due to fees being higher than anticipated. MCO taxes actual recorded was $660M		***Motion**: Standing Reports Approved* *12 – 0 – 0 – 5* *(Neves / Soares)* *A roll call was taken.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	which is approximately $237.2M more than budgeted due to the increased revised MCO taxes. Total net income through March 31, 2025, was approximately $15.6M, which is approximately $9.2M more than budgeted primarily due to interest income being approximately $6M higher than projected, and rates and enrollment being higher than projected. <u>FY 2026 Proposed Budget</u> On March 20, 2025, the FY 2026 budget was reviewed and approved by the Finance Committee to move to the Commission for recommendation of full review and approval. With regard to budget assumptions, enrollment is projected to gradually decline throughout FY 2026 primarily due to the end of redetermination flexibilities. When the Medicaid redetermination resumed July 1, 2023 from the COVID pause the State of California applied for Federal waivers for redetermination flexibilities, these flexibilities will end June 30, 2025. In addition, the Plan projected for a decline in enrollment as a result of potential changes at the Federal and State levels. The House, Energy and Commerce committee recently released the proposal for cuts to Medicaid at the Federal level; however, several major cuts to Medicaid were not included in that proposal. One major potential cut to Medicaid that was left off the proposal related to reducing the adult expansion federal match from 90% to approximately 50% in California which is more the traditional match for most aid categories. The Medicaid per capita caps were left out as well. Things to note that were in the proposal are Medicaid work requirements effective January 1, 2029. This applies to able bodied adults ages 19-64; they would have to be either working, engaged in community service, or in an educational training program at least 80 hours per month. Their eligibility would be redetermined two times per year as opposed to the annual one time per year. There are exemptions for the work requirement such as pregnant women, disabled persons, and those under the age of nineteen. Effective October 1, 2027, if a State provides Medicaid coverage to undocumented beneficiaries, the federal match would be reduced from 90% to 80%, which would impact California.		

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	California would lose approximately $3.2B annually. At the State level, the May revised was released May 14, 2025, and the State is facing a $12B budget deficit and to address the budget deficit, the State is proposing to freeze undocumented Medicaid enrollment beginning January 1, 2026, for those over 19 and over; undocumented children will still be covered. It also stated if an undocumented beneficiary is currently enrolled in Medi-Cal they would not lose their coverage. In addition, the State is proposing to implement a $100 premium/month for undocumented immigrants aged 19 and over; would not apply to children, effective January 1, 2027. When the Plan created the budget for FY 2026 in March 2025, we believed that the undocumented population would be at risk of facing cuts, therefore we projected a decline in enrollment related to the undocumented population which aligns with the State's FY 2026 budget proposals. Medical revenue is projected to increase primarily due to an increase to MCO taxes which have substantially increased from FY 2025 and due to an increase in capitation rates paid by DHCS, noting that with those increased MCO tax funds, the State is looking to increase rates to Providers for primary care, specialty care, maternity care, and emergency department services. FY 2026 budgeted Medical revenue is projected to be approximately $2B which is approximately $198M more than budgeted in FY 2025 primarily due to an increase in MCO taxes by approximately $190M, and an increase in capitation rates net of a decrease in membership. Interest income is projected to be approximately $5M, which is $1M more than budgeted in FY 2025 due to the fact that it appears the Federal Reserve is going to be slower in decreasing the rates relative to what the Plan budgeted in FY 2025. Medical Cost expense is projected to be approximately $1.2B, which is approximately $9.3M more than budgeted due to an increase in capitation rates paid by DHCS. Admin Services fee expense is projected to be approximately $52.1M which is approximately $1.6M less than budgeted due to a decline in enrollment.		

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	Salary and wage expense is projected to be approximately $5.4M which is approximately $406K more than budgeted due to accounting for up to 5% raise in salaries, 8% increase in insurance premiums, and succession planning efforts for key management positions nearing retirement age. Consulting and accreditation expense is projected to be approximately $545K which is an increase by $145K as the Plan is looking to hire a retention consultant who will be focused on member satisfaction and dissatisfaction, and looking into ways the Plan can increase and/or retain membership. Grants and Community Support is projected to be $4.4M as stated earlier as part of agenda item #10. License expense is projected to be approximately $1.8M which is approximately $356K more than budgeted in FY 2025 due to the projected increased assessment fee by DMHC. MCO taxes projected to be $753.5M which is an approximate increase of $190M more than what was budgeted in FY 2025 due to the MCO tax that was revised in December 2024 by CMS, which substantially increases the MCO taxes through December 2026. Capital Expenditure budget is projected to be $600K, which is a $100K increase due to accounting for potential tenant improvements to current vacant office space. Net Income is projected to be approximately $9M which is approximately a $338K increase in comparison to FY 2025 primarily due to interest income being higher by approximately $1M due to higher interest rates net of a decrease in membership.		
• **Compliance Report** M.L. Leone, CCO	**Compliance** <u>Compliance Report</u>		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Year to date there have been 111 Administrative & Operational regulatory filings for 2025; 15 Member Materials filed for approval; 48 Provider Materials reviewed and distributed, and 37 DMHC filings. There have been sixteen (16) potential Privacy & Security breach cases reported year to date, with one (1) being high risk. Since the 3/20/25 Compliance Regulatory Report to the Commission, there were two (2) new MC609 cases filed. There are 28 cases that remain open and under investigation. The two new cases encompassed: • One case identified a Skilled Nursing Provider (SNF) inappropriately billing SNF services rather than custodial services. • Another case identified a non-participating DME provider who does not have an active California Department of Public Health (CDPH) Home Medical Device Retail (HDMR) license and is ineligible to dispense prescription medical devices. The Annual Oversight Audits currently in progress since last reported include Behavioral Health, Marketing, Call Center, Credentialing, Claims/PDRs, Health Education, and Quality Improvement, none of which were completed. Regarding the DHCS 2023 Focused Audit for Behavioral Health and Transportation, , the Plan received DHCS' Final Report findings and formal CAP request on 9/4/24. There were nine deficiencies (4 for behavioral health and 5 for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 6/15/25. Regarding the DHCS 2024 Medical Audit, on 10/3/2024, DHCS sent out the 2024 Final Audit Report and CAP request. There were two deficiencies. The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA		

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	extension notices specify the information Health Net requested but did not receive., and the Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 6/15/25. Regarding the DMHC 2025 Medical Follow-Up Audit, the DMHC conducted the Follow-Up Audit on May 5, 2025. The Plan is currently in the process of responding to post-onsite audit requests and is awaiting further correspondence from the DMHC. The Audit focused on previously identified deficiencies related to the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. The Plan is currently in the process of responding to post-onsite audit requests and is awaiting further correspondence from the DMHC. Regarding the Department of Healthcare Services (DHCS) 2025 Medical Audit, the 2025 DHCS Audit will be conducted virtually from 6/2/2025-6/13/2025. The Entrance Conference will begin on 6/2/25 @ 10:00am. The Plan submitted all required pre-audit documentation. DHCS has since issued follow-up requests, which the Plan is currently reviewing and addressing. New this year for DHCS will be the inclusion of ECM and post-stabilization. Regarding the Annual Network Certifications, the 2024 Subnetwork Certification (SNC) Landscape Analysis was conducted on 1/3/2025, the Plan submitted the 2024 SNC deliverable. Within the submission, the Plan reported that CalViva issued Corrective Action Plans (CAPs) to certain providers due to network adequacy deficiencies. As a result, DHCS has requested that the Plan submit quarterly updates on the status of these CAPs until they are fully resolved. The first quarterly update was submitted on 3/26/2025. For the 2024 Annual Network Certification (ANC), the Plan submitted the 2024 ANC on 3/17/2025 and is awaiting a response from DHCS. With regard to Transgender, Gender Diverse, or Intersex (TGI) Training, in further support of the Plan's compliance with DHCS APL 24-017 and DMHC APL 24-018,		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	the Plan most recently submitted the TGI training curriculum and revised policies to DHCS and DMHC on 3/14/2025. With regard to reporting year 2025 measurement year 2024 Timely Access and Annual Network Submission (TAR) the Plan submitted its Annual TAR filing to DMHC on 5/1/25. The Central Valley Regional Center (Fresno), and Madera County Department of Behavioral Health Services (Alcohol and SUD) contractual requirements/DHCS initiatives were executed and posted to the CVH website. New DHCS regulations/guidance was provided in the Compliance Report, Appendix A. The next Public Policy Committee meeting will be held on June 4,2025, 11:30am - 1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard for Quarter 1, 2025. Year-Over-Year Comparison – Q1 2025 Appeals & Grievances Volume By County: • There was an increase in the appeals volume for all three counties served compared to Q1 2024. • For grievances, there was a volume increase of 22.2% in Fresno County, 13.8% in Madera County, and 31.7% in Kings County. One Year Look Back of Appeals & Grievances Volume Comparison by County: • When compared to Q4 2024, appeals showed a decrease in volume of 9.1% in Fresno County and 12.5% in Kings County. Madera County showed an increase of 86.6%.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Grievances volume for Fresno and Madera counties showed a decrease of 3.7% and 5.2% respectively. Kings County had an increase of 5.1%. Year-Over-Year Comparison – Q1 2025 Top Appeals & Grievances Trend By Classification Codes: • In Q1 2025, there was an 89.3% increase in appeals for Not Medically Necessary classification code compared to Q1 2024. • For grievances, there was an increase in all top five (5) classifications: 36.9% in Access to Care, 135.2% in Eligibility Issues, 23% in Administrative Issues, 41% Balance Billing, and 3.1% in transportation compared to Q1 2024. One Year Look Back Top Appeals & Grievances Trend by Classification Codes: • In Q1 2025, there was a 3.4% increase in appeals for Not Medically Necessary classification code compared to prior quarter. • For grievances, an increase was noted in two of the top five classifications in volume, 20.6% in Access to Care, and 5.3% in Balance Billing compared to prior quarter. • There was a decrease of 2% in Administrative Issues and 21.4% in Transportation grievances in Q1 2025 compared to prior quarter. Trending Appeals (volume) by Category: • In Q1 2025, in the Not Medically Necessary classification, increases were seen in four out of the five categories. • Diagnostic-MRI was the only category with a decrease of 18.7% compared to Q1 2024. • Looking back at the four prior quarters, Q1 2025 showed decreases in four out of the five categories. Diagnostic-Genetic Testing had an increase compared to Q3 2024. Trending Grievances (volume) by Category: • The trending grievances that had a noted increase are PCP Referral for Services of 1,350%, General Complaint Vendor CSR of 126.6%, and Eligibility Dispute of 1,000% compared to Q1 2024.		

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

	• Availability of Appointment with Specialist and Inappropriate Payment Demand (par) had a slight decrease of 9% and 11.7% respectively in volume compared to Q1 2024.
	• Prior Authorization Delay (5.4%) and Availability of Appointment with Specialist volume show an improvement of 5.4% and 44.4% respectively in Q1 2025 compared to Q4 2024.
	• There was an increase in grievance volume in Transportation Missed Appointment of 257.1%, General Complaint Vendor of 54.5%, and Eligibility Dispute of 1,000% from prior quarter.
	
	Overall, there is a volume increase in appeals year over year. Most of the appeals are for services that were classified as not medically necessary. The top drivers of this increase are Diagnostic MRI, Self-injectable Medications, Diagnostic Genetic Testing, Diagnostic CAT Scan, Outpatient – Procedure, and Medically Tailored meals.
	
	In Q1 2025, a total of 144 appeals were received, 121 of those appeals were classified as Not Medically Necessary. Even though more appeals were received, 43.7% were upheld, and no changes were made.
	
	Opportunities for Improvement for Appeals:
	• Not Medically Necessary:
	  • Educate providers on the criteria for medical procedures coverage and what needs to be submitted to avoid unnecessary denials and procedure delays.
	  • Ensure providers are submitting all needed information prior to medically necessary procedures.
	• Community Supports Related-Medically Tailored Meals:
	  • Educate Providers on the criteria to qualify for medically supportive meals.
	
	Summary for Grievances:
	• Year over year, an increase is noted in the number of grievances received. The top grievance was for services classified under Access to Care.		

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	• The top drivers of this increase are associated with Prior Authorization Delay, PCP Referral for Services, Transportation Missed Appointment, Network Availability, Available appointment with Specialist, and Specialist Referral for Services. • In Q1 2025, a total of 535 grievances were received, 152 of those grievances were classified as access to care. Even though more grievances were received, 26.4% were addressed and substantiated, and no changes were made. Opportunities for Improvement for Grievances: • Prior Authorization Delay: o The provider should keep members informed of prior authorization and the timeline for approval. o Continue providing live and recorded provider training webinars to address prior authorizations on a regular basis. • PCP Referral for Services: o Establish or reassess current audit of referral process and turnaround approval times. • Transportation Missed Appointment: o Request feedback from the vendor on how they will address complaints related to no show transportation and make reliable transportation accessible to members. • Network Availability: o Expand telehealth services, offering diverse payment options, and utilizing data analytics to optimize network design and ensure equitable access to care. • Available Appointment with Specialist: o Expand specialist network in rural areas through the Provider Network team. o Leverage contract language to incentivize provider groups to increase volume as well as meeting member experience expectations. • Specialist Referral for Services: o Enhance relationships with referring physicians, streamlining the referral process, and leveraging technology (i.e., EHR, patient portals, etc.).		

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	<u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through Q1 2025. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through March 31, 2025. • Membership has had a slight decrease. • Readmission rates for all categories have decreased when compared to prior year, most likely related to improved transition of care services and improved post discharge destinations. • Utilization has increased slightly with the exception of SPDs. Care Management (CM) engagement rates are up, and all areas continue to improve. <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q1 2025. Two meetings were held in Quarter 1, one on February 20th, 2025, and one on March 20th, 2025. The following program documents were approved: 1. QI/UM Committee Charter 2025 2. 2024 Quality Improvement/Health Education End of Year Evaluation 3. 2025 Quality Improvement/Health Education Program Description 4. 2025 Quality Improvement/Health Education Work Plan 5. 2024 Utilization Management/Care Management End of Year Evaluation 6. 2025 Utilization Management Program Description 7. 2025 Care Management Program Description 8. 2025 Utilization Management/Care Management Work Plan 9. 2025 Population Health Management Strategy Description 10. Continuity & Coordination of Medical Care Report for 2024 11. Continuity & Coordination Medical & Behavioral Healthcare Report for 2024 12. NCQA Non-Behavioral Health Member Experience Report		

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	13. NCQA Behavioral Health Member Experience Report The following Oversight Audit Results were presented and accepted at the February meeting: 1. 2024 Utilization Management/Care Management Oversight Audit 2. 2024 Continuity of Care Oversight Audit 3. 2024 Emergency Services Oversight Audit 4. 2024 Pharmacy Oversight Audit Other General Documents approved were: 1. Pharmacy Provider Updates 2. Medical Policies 3. Pharmacy Policies & Procedures 4. Utilization Management Policy & Procedure (1) The following Quality Improvement Reports were reviewed: Appeals and Grievance Dashboard & Quarterly Reports; A & G Validation Audit Report; Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Reporting; Behavioral Health Performance Indicator Report; and Initial Health Appointment Report. Additional Quality Improvement reports from Q1 were reviewed as scheduled during Q1. The following Access Reports were reviewed: Access Workgroup Quarterly Report for Q4 2024, and Access Work Group minutes from December 3rd, 2024. Other Access-related reporting included the Standing Referrals Report, Specialty Referrals Report, and Provider Office Wait Time Report. The Utilization Management & Case Management reports reviewed were the Key Indicator Report & Concurrent Review Report, Inter-rater Reliability Results for Physician and Non-physicians, and Enhanced Care Management and Community Supports Report (Q4 2024). Additional UMCM reports were reviewed as scheduled during Q1.		

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• **Equity Report** S. Xiong-Lopez, EqO	Pharmacy quarterly reports reviewed were Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, Inter-rater Reliability Review Report and Quality Assurance Results, which were all reviewed for Quarter 4. The Q1 HEDIS® Activities were focused on data capture for measurement year 2024 (MY24). Managed Care Medi-Cal health plans have eighteen (18) quality measures that they are evaluated on for MY2024 and the Minimum Performance Level (MPL) continues to be the 50th percentile. Quality Improvement Activities included two Performance Improvement Projects, Improve Infant Well-Child Visits (WCV) in the Black/African American(B/AA) Population in Fresno County, and Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue. DHCS Collaboratives include Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative, and Institute for Healthcare Improvement (IHI) Behavioral Health Collaborative. DHCS County Projects include for Fresno County, Transformational Equity Improvement Projects; for Kings County, Comprehensive Equity Improvement Projects; and for Madera County, Lean Equity Improvement Project. No significant compliance issues have been identified. Oversight and monitoring processes will continue. **Health Equity** <u>Equity Report</u> Women, Infant, and Children (WIC) Initiative Update: WIC pilot update from Center for Data Insights and Innovation (CDII)- they reached out to re-initiate the WIC pilot project now being called “Family Benefits” which will not only look at dual eligibility of Medi-Cal and WIC but also include CalFresh eligibility and having a streamline cross-enrollment.		

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	Perimenopause/ Menopause Project- Hanford: The workgroup in Kings County developed a survey and will be ready to distribute to women between the age of 30-60. Women who express their interest in this survey about perimenopause and menopause symptoms will be referred over to a CBO Champion for Women's health education. Kings County public Health currently has a MOU with Valley Voices and identified as the CBO champion with the capacity to delivery women's health education to women between the ages of late 30's to 60. We are currently in discussion about how to fund this initiative in Kings County. Future discussion on the role of CHW and is it billable or other funding/incentive needs for our CBO champion to help us with this perimenopause/menopause project. NCQA Health Equity Accreditation: NCQA returned minimal issues with the Plan's initial submission on 4/2. All outstanding issues were addressed, and final submission was completed 4/11 and sent back to NCQA for Preliminary review. The closing call was completed on 4/28 with the suggestion to revise the Heath Equity Work Plan to include more specific details in SMART goals. 2025 HE Work Plan has been updated to reflect the SMART goals per NCQA's request. Preliminary report by NCQA reviewers was returned 5/2 with one remaining issue specifically asking CVH's HE Program Description to connect back to the Work Plan's SMART Goals. At this time, CVH decided to not rebuttal the 1 outstanding issue remaining in order to move the accreditation process along to the final stage for Health Equity accreditation. CVH will hear back from NCQA about accreditation status, hopefully by the end of May. <u>Current Health Equity Community Activities</u> March 27, 2025, the CMO and CHEO from Public health plans and commercial plans across CA convened in Sacramento to discuss Health Equity and Quality. Specifically, Diversity, Equity and Inclusive and transgender training and activities. Health Equity Officers were able to share some of their concerns as they relate to federal changes and how to continue doing today's work for tomorrow. Other topics of discussion included, how to collaborate and create an Equity Structure across state and how to individualize Health Equity in each county and effectively build partnership with community stakeholders to move the needle in health equity. This convening is planned by DHCS and is expected to be a quarterly		

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• **Executive Report** J. Nkansah, CEO	convening to ensure that effectiveness in their health equity roadmap and continue support from DHCS. Next convening with DHCS will be 6/6/25. On April 4, 2025, CVH participated in the Fresno Community Foundation- Fresno Drive workgroup and organized a mental health conference for the community in West Fresno. There were approximately 120 participants at the conference to address topics such as holistic and cultural healing, racism and public health crisis, building resiliency, financial trauma, and Postpartum wellness. The break-out sessions were in both Spanish and English. On April 23, 2025, CVH was invited and also sponsored the Central Valley Voices in Capital Mall for the Health Equity event in Sacramento. CBOs, community leaders, politicians, law and decision makers throughout the San Joaquin Valley were bussed to the Sacramento Capitol Mall to share their voice and express their gratitude, concerns, and current fear to the state. Individuals like CA State Representative, Arambula, representative from CA Governor's office, and Attorney General Bonta were present to echo the importance of the central valley's voice at the event. On May 8, 2025, CVH sponsored and participated in a Perinatal Wellness Brunch. This event brought in various organizations that focused on Perinatal health, and family services. Other Stakeholders present included Fresno Department of Behavioral Health, Department of Social Services, Black Infant Health, First Five, Cradle to Career, Health Plans, and community leaders to initiate a collective network of services to create a partnership. **Executive Report** <u>Executive Dashboard</u> Enrollment as of March 2025 is 432,619. Enrollment for Anthem is approximately 205,107, and the enrollment for Kaiser is approximately 10,428. Market Share is currently approximately 66.75%.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding Information Technology Communications & Systems, Provider Activities, Claims Process, and Provider Disputes, there are no significant issues or concerns at this time. Quarter 4 2024 numbers are available. Regarding the Call Center and CVH Website, the Members self-service option to gain access to their Member ID Card through the CalViva Health Website which launched on March 18, 2025, currently has approximately 500 registered member accounts without being actively promoted or advertising this service. The Plan continues to monitor Federal and State activities with regard to immigration, Medicaid, DEI and budgetary concerns.		
#13 Final Comments from Commission Members & Staff	Supervisor Bredefeld asked if it was required by State law for the undocumented to register for Medicaid. Daniel Maychen, CFO, stated the Plan is not required to enroll the undocumented population, it's voluntary on their part to enroll if they want to. CVH currently has approximately 56,000 undocumented members; and the total for the State is approximately 1.6M.		
#14 Announcements	None.		
#15 Public Comment	None.		
#16 Adjourn	The meeting adjourned at 3:27 pm. The next Commission meeting is scheduled for July 17, 2025, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

March 20, 2025

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

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
✓	Paulo Soares		Hector Torres, Sr. Accountant & MIS Analyst
✓	Joe Neves		
✓*	Supervisor Rogers		
✓	John Frye		
✓	Rose Mary Rahn		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am, a quorum was present.		
#2 Finance Committee Minutes dated February 20, 2025 Attachment 2.A Action, D. Maychen, Chair	The minutes from February 20, 2025, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Neves / Rahn)*
#3 Financials – as of January 31, 2025 Action D. Maychen, Chair	As of January 2025, total current assets were approximately $436.2M; total current liabilities were approximately $272.6M. Current ratio is approximately 1.6. TNE as of January 2025 was approximately $173.4M, which is approximately 620% above the minimum DMHC required TNE amount.		Motion*: Financials as January 31, 2025, were approved* *7 – 0 – 0 – 0* *(Frye / Neves)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	As of January 2025, interest income actual recorded was approximately $6.8M, which is approximately $4.3M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $1.18B which is approximately $108.2M more than budgeted primarily due to MCO taxes being higher than projected. In December 2024, CMS approved a revised MCO tax which substantially increased the MCO tax from the first revision. In addition, enrollment and rates were higher than projected. Total Cost of Medical Care expense actual recorded was approximately $787.1M which is approximately $89.3M more than budgeted due to enrollment and rates being higher than projected. Admin Service Agreement fees expense actual recorded was approximately $33.5M which is approximately $1.8M more than budgeted due to enrollment being higher as more members have been retained through the redetermination process. MCO taxes actual recorded was approximately $344.7M which is approximately $15.8M more than budgeted due to the revised MCO taxes. Telephone expense actual recorded was approximately $32K, which is approximately $7K more than budgeted due to the Plan's previous phone service provider increasing the rates stating the Plan was on a legacy platform. In response to that increase, the Plan obtained bids from other phone service providers and has now transitioned to a different phone service provider at a much lower cost. Total net income through January 2025 was approximately $11.7M, which is approximately $6.8M more than budgeted primarily due to interest income being approximately $4.3M higher than projected, and rates and enrollment being higher than projected.		
#4 Fiscal Year 2026 – Proposed Budget • Budget Assumptions • Proposed Budget Action D. Maychen, Chair	Basic assumptions were revised from information presented at the February Finance meeting. The Plan is accounting for impacts to the budget due to changes at the Federal and State levels for Medicaid, particularly accounting for an additional decrease in enrollment. Medical revenue is projected to be approximately $2B which is approximately $198M more than budgeted in FY 2025 primarily due to an increase in MCO taxes by approximately $190M, an increase in capitation rates net of a decrease in membership. Interest income is projected to be approximately $5M, which is $1M more than	*John Fry asked if the Medicaid change takes place October 1, 2025?* *Daniel Maychen stated details are unknown at this time.* *Rose Mary Rahn asked if the Plan is aware of how much of the UIS*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	budgeted in FY 2025 due to the fact that it appears the Federal Reserve is going to be slower in decreasing the rates relative to what the Plan budgeted in FY 2025 and allocating additional funds to the money market funds account. Medical Cost expense is projected to be approximately $1.2B, which is approximately $9.3M more than budgeted due to an increase in rates net of decrease in membership. Admin Services fee expense is projected to be approximately $52.1M which is approximately $1.6M less than budgeted due to enrollment declining as a result of the end of the COVID eligibility flexibilities ending June 30, 2025, and potential changes to Medicaid at the Federal and State levels. Salary and wage expense is projected to be approximately $5.4M which is approximately $406K more than budgeted due to accounting for up to 5% raise in salaries, 8% increase in insurance premiums, and succession planning efforts for key management positions nearing retirement age. Consulting and accreditation expense is projected to be approximately $545K which is an increase by $145K as the Plan is looking to hire a retention consultant who will be focused on member satisfaction and dissatisfaction, and looking into ways the Plan can increase and/or retain membership. License expense is projected to be approximately $1.8M which is approximately $356K more than budgeted in FY 2025 due to the projected increased assessment fee by DMHC. MCO taxes projected to be $753.5M which is an approximate increase of $190M more than what was budgeted in FY 2025 due to the MCO tax that was revised in December 2024 by CMS, which substantially increases the MCO taxes through December 2026. Other income, generated through rental income for the building, is projected to be approximately $355K which is approximately an $80K decrease primarily due to the uncertainty of a current tenant renewing their lease. Capital Expenditure budget is projected to be $600K, which is a $100K increase due to accounting for potential tenant improvements to current vacant office	*population is related to the additional funds the State is requesting for Medi-Cal expenditures?* *Daniel Maychen stated approximately $2.7B was related to the UIS population. Daniel also cited higher pharmaceutical costs and higher enrollment specifically related to seniors in comparison to what the State initially budgeted and in comparison to prior years as reasons for the overage.* *Paulo Soares asked, from an enrollment standpoint, what is the Plan projecting as far as a decrease?* *Daniel Maychen's response the Plan's projection is approximately 50,000 which closely reflects the undocumented population.* *Paulo Soares asked*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	space. Net Income is projected to be approximately $9M which is approximately a $338K increase in comparison to FY 2025 primarily due to interest income being higher by approximately $1M due to higher interest rates net of a decrease in membership.	*about the MCE population as well?* *Daniel Maychen responded the MCE population is about 25% of the Plan's membership, which would have an impact to CalViva. To be conservative, the Plan did account for potential program and enrollment changes by reducing enrollment projections and capitation rates, but the Plan is unsure if the federal government will definitely make program changes to the MCE population at this time.*	
#5 Announcements	The official DMHC financial examination audit report was received and there were no findings noted. The tentative April 2025 meeting will be moved to June as a result of any potential material changes to Medicaid by the State in May 2025.		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#6 Adjourn	Meeting was adjourned at 11:46 am		

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

Dated: 5-15-25

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 5/15/25

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
March 20th, 2025

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	✓	**Maria Sanchez,** Senior Compliance Manager
	Carolina Quezada, M.D., Internal Medicine/Pediatrics, Family Health Care Network	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**Joel Ramirez, M.D.,** Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Nicole Foss, RN,** Medical Management Services Manager
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Zaman Jennaty, RN,** Medical Management Senior Nurse Analyst
	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 10:05 am. A quorum was present.	
#2 Approve Consent Agenda Committee Minutes: February 20, 2025	February 20th, 2025, QI/UM minutes were reviewed, and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member.	**Motion:** *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Specialty Referrals Report (Q4 2024) - Standing Referrals Report (Q4) - Lead Screening Quarterly Report (Q3) - SPD HRA Outreach (Q4) - Evolent (NIA) (Q4) - MedZed Integrated Care Management Report (Q4) - Behavioral Health Performance Indicator Report (Q4) - Pharmacy Provider Updates (Q4 2024, Q1 2025) - Performance Improvement Project Updates – Non-Clinical - Performance Improvement Project Updates – Clinical - PA Member Letter Monitoring Report (Q4) -CVH QIUM Committee Charter 2025 (Attachments A-M) **Action** Patrick Marabella, M.D Chair	A link for the Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Pascual) 5-0-0-3
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (January 2025) - A&G Validation Audit Summary (Q3 2024)	The **Appeals & Grievances Dashboard and Turnaround Time Report** through January 2025 were presented. 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. A total of 184 grievances were received during Q1 2025. During this quarter, 130 grievances were categorized as Quality of Service (QOS), most commonly for prior authorizations and network access.	**Motion:** *Approve* - A&G Dashboard and Turnaround Time Report (January 2025) - A&G Validation Audit Summary (Q3 2024)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments N, O) **Action** Patrick Marabella, M.D Chair	• Administrative issues increased, largely due to changes in PPG contracting and network access issues. • Balanced Billing/no ID cards remains an issue, and we will continue to monitor for improvement. • A new category we are tracking is CalAim: three (3) were related to medically tailored meals, and one (1) was for housing assistance. • Transportation Access, particularly no-shows, remains an issue (only two this month). There were 15 YTD 2025 Quality of Care (QOC) grievances. Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes for this category decreased to 183 in Q1 2025. • The Attitude/Service Provider remains a category to monitor. • ID cards and balance billing issues continue to cause grievances, though improvements are being made in addressing these. The total number of Appeals has increased (68) in Q1 2025. • The CalAim category has been added to Appeals. Similarly to QOS Grievances, most appeals in this category were related to medically tailored meals. The Upholds (60%) and Overturn (40.9%) rates have improved. One (1) letter was out of compliance for turnaround time. ModivCare provided staff with additional training and adjusted the frequency at which they run reports, which will subsequently increase the range of case lookback from 24 hours to 24-48 hours in order to reduce the risk of future late acknowledgement letters. The **Appeals & Grievances Validation Audit Report Q3 2024** was presented. CVH conducts weekly A&G case validations to ensure each Grievance or Appeal case contains the appropriate documentation and evidence necessary for standard and expedited Quality of Service (QOS), Quality of Care (QOC), and Appeal cases. • Ninety-three percent (93%) of cases (665/714) met compliance standards upon receipt. Documents were missing primarily in the Standard QOS and QOC categories. o Of the variety of document types identified as missing, most commonly: Translated Resolution Letters (24) and Case Review forms (10). Q3 2024 counts were consistent with Q2 2024. o Four (4) cases were found to be missing evidence of the DMHC script being read to the	(Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	members, an increase from zero (0) in Q2 2024. o Five (5) cases were created/transferred in error in Q3 2024. Moving forward, continued collaboration with A & G leadership to refine processes, enhance document tracking systems, and provide additional staff training on these critical areas will be essential to sustaining the positive trends and resolving any emerging challenges. All documents identified to be missing from the cases were obtained and inserted to complete the files before closing out the quarter.	
#3 **QI Business** - Initial Health Appointment (IHA) Quarterly Report (Q3 2024) (Attachment P) **Action** Patrick Marabella, M.D Chair	The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an **Initial Health Appointment** (IHA) completed within the first 120 days of enrollment. The Q3 2024 IHA Quarterly Report demonstrates CalViva Health's performance on IHA compliance monitoring from Q4 2023 through Q3 2024. The current approach to monitoring has three components: • Primary Care Physician Facility Site (FSR) and Medical Record Review (MRR) via onsite (or virtual) provider audits. o Facility Site Review/Medical Records Review results show that 97% of pediatric patients and 100% of adult patients completed their IHAs for the providers audited during Q3 2024. For providers who were found non-compliant during the review period, follow-up occurs via provider notification of IHA requirements and corrective action when indicated. • Monitoring of claims and encounters data. o IHA visit rates within 120 days of enrollment in Q3 2024 (30.87%) demonstrate a downward trend of 5.20% from Q2 2024 (36.07%). • Member outreach utilizes a three-step methodology. Outreach Compliant [three (3) attempts completed, two (2) + phone and one (1)+ mail]. o Member outreach completed by the Plan in Q3 2024 demonstrates a slight decline of 0.75% from Q2 2024. The denominator for Q3 2024 is 17,259, with a 74% rate for welcome packets mailed during Q3 2024. ***Discussion:*** *Dr. Ramirez asked if the decline in mailing outreach was due to having incomplete addresses for members.* *Dr. Marabella indicated it was an administrative issue, the timeliness of mailings.* *Amy Schneider indicated that the "Staying Healthy Assessment (SHA)" is no longer technically*	**Motion:** *Approve* - A&G Classification Audit Report (Q3 2024) (Cardona/Ramirez) 5-0-0-3

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	required but asked members of the Committee if it was clear what the IHA requirements are. *Dr. Cardona stated that he still performs a modified SHA with his new members.* *Dr. Pascual indicated that OBGYNs use different assessments.*	
#4 **Key Presentations** - QI/HE Program Description and Change Summary 2025 (Attachment Q) **Action** Patrick Marabella, M.D Chair	The **2025 Quality Improvement/Health Education Program Description** was presented to the committee for approval. Updates include: • **Updated and removed reference to the Annual Scaled-back Access Survey.** It has been replaced with the annual CAHPS survey (throughout). • **Updated ECHO Survey to Behavioral Health Member Experience Survey.** The survey tool is changing (throughout). • **Clinical Practice Guidelines** (pg. 10): Updated provider communication fax to include provider updates. • **Health Education Programs** (pgs. 11-13): Updated Health Promotion Programs to Health Education Programs, revised contact information, adjusted Weight Management and Diabetes Prevention resources, removed outdated programs, added Teladoc Mental Health, and updated Health Program Incentives to include both QI/Health Education. • **MemberConnections® Program** (pg. 14): Added Post Partum Assessment /Edinburgh Postnatal Depression Scale, Notification of Pregnancy as part of the assessments the MemberConnections representatives conduct. • **Transition of Care Services** (pgs. 16-17): Expanded Transitional Care Services to detail post-discharge activities, including risk assessments, health evaluations, care coordination, and follow-ups, while removing the Member Impact section. • **Health Plan Performance** (pg. 19): Added Health Plan accreditation information for CalViva (NCQA). • **Health Equity and Cultural and Linguistic Needs** (pgs. 24-26): Added information on the Diversity, Equity, and Inclusion Training Program. Updated non-discrimination statement to include "language". • **Satisfaction** (pg. 26): Added HSAG CAHPS survey details, renamed Population Needs Assessment to Population Analysis Report, and updated Provider Relations to Provider Engagement for CAHPS improvement. • **Telehealth Services** (pg. 28): Added how the Plan supports Member access to a Provider	**Motion:** *Approve* - QI/HE Program Description and Change Summary 2025 (Ramirez/Pascual) 5-0-0-3

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	through telehealth. CalViva now provides telehealth services to members. • **Health Education** (pg. 39): Revised description to include Health Education resources and framework. • **Provider Network Management** (pg. 41): Clarified that contractual issues that PNM resolves with providers are related to terms and conditions and payment rates for services. • **Program Accreditation** (pg. 42): Added additional scope of the Program Accreditation team's role in Quality Evaluating Data to Generate Excellence (EDGE) program efforts. • **Provider Communication** (pg. 42): Updated description to include specifics on Provider Communication resources and channels. • **Other minor edits.** *Dr. Cardona left the meeting at 10:29 a.m. and returned at 10:32 a.m.*	
#4 Key Presentations - QI/HE & W Work Plan 2025 (Attachment R) **Action** Patrick Marabella, M.D Chair	The **2025 Quality Improvement/Health Education and Wellness Work Plan** was presented for approval. The Work Plan is divided into Three Sections: *I.* ***Work Plan Initiatives:*** *Implement activities to improve performance measures. Includes program objectives, monitoring, and evaluation for the year. Each section has specific initiatives for a total of 13.* 1. *Behavioral Health:* Improving Behavioral Health (Mental Health and Substance Use) Outcomes Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile. (FUA-30) Follow up w/in 30 days after ED Visit for substance use (target 36.18). (FUM-30) Follow up w/in 30 days after ED Visit for mental health (target 53.82). MY2023: FUA-30: (0%, 0/3 objectives met) FUM-30: (0%, 0/3 objectives met) 2. *Chronic Conditions:* Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile for Blood Pressure & Diabetes. Diabetes: CDC >9 – HbA1c to below 9 (MY 2023: 3/3 objectives met, 100%) Heart Health: Control Blood Pressure (MY 2023: 3/3 objectives met, 100%) 3. *Hospital Quality/ Patient Safety:* monitoring of hospital-acquired conditions (infections & c-section rates). Objective: Improve reporting and Directional Improvement based upon scores (5 Hospitals Report). <u>MY2023 Results</u> • Catheter-Associated Urinary Tract Infections (CAUTI): SIR*; 75% of reporting	**Motion:** *Approve* - QI/HE Work Plan 2025 (Ramirez/Pascual) 5-0-0-3

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	hospitals met the measure. • Central Line Associated Blood-stream Infection (CLABSI): SIR; 0% of reporting hospitals met the measure. • C. Diff Infection: SIR; 100% of reporting hospitals met the measure • Methicillin-Resistant Staphylococcus Aureus Infection (MRSA): SIR; 75% of reporting hospitals met the measure. • Colon Surgical Site Infection (SSI-Colon): SIR; 25% of reporting hospitals met the measure. • Nulliparous Term Singleton Vertex (NTSV) C-section Rate; 60% of reporting hospitals met the measure. *SIR = Standardized Infection Ratio 4. *Member Engagement and Experience:* Objective: Improve New Member Completion Initial Health Appointment (IHA) in under 120 days by 1-5% over the prior year. MY2023: IHA: 57.26% 5. *Pediatric and Maternal Health Programs:* Objective: 1-5% improvement over prior year or the MCAS 50th percentile for all measures except Prenatal & Postpartum is 75th percentile*. • Topical Fluoride (TFL-CH) (MY2023: 33%, 1/3 Objectives met) • Well-Child Visits (WCV, W30) (MY2023: 67%, 2/3 Objectives met) • Childhood Immunization (CIS-10, IMA-2) (MY2023: 33%, 1/3 Objectives met) • Prenatal and Postpartum Care*(PPC-Pre, PPC-post) (MY2023 pre: 33% 1/3 Objectives met, post 66% 2/3 Objectives met) • Lead Screenings (LSC) (MY2023: 33%, 1/3 Objectives met) • Developmental Screening (CDEV) (MY2023: 33%, 1/3 Objectives met) Providers are supported to engage with immunization registries and the Vaccines for Children Program. 6. *Pharmacy:* Asthma Medication Ratio (AMR) Objective: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile. (MY 2023: 33%, 1/3 Objectives met) (target 66.24%) 7. *Preventive Health*: Cancer Screening & STI (MCAS) Objective: 1-5% improvement over the prior year or maintain above the 50th percentile.	

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	• BCS – Breast Cancer Screening (MY2023: 100%, 3/3 Objectives met) • CCS - Cervical Cancer Screening (MY2023, 100%, 3/3 Objectives met) • CHL – Chlamydia Screening women (MY2023, 100%, 3/3 Objectives met) • Flu Campaign (MY2023, 100%, 3/3 Objectives met) *8. Provider Engagement:* 1. Improve the Member Experience (CAHPS) – Provider and Plan Focus 2. Improve Provider Access & Availability Survey Results (PAAS & PAHAS) *II.* ***Ongoing Work Plan Activities:*** *Includes ongoing monitoring of cross-functional activities – work performed by or with other Departments. Ensures activities are timely and documented often to meet regulatory or accreditation requirements. Previously called the "Crosswalk".* Multiple activities under each category: Each category has specific activities (46 total). *1. Access, Availability, & Satisfaction* *2. Behavioral Health* *3. Continuity & Coordination of Care* *4. Credentialing/Recredentialing* *5. Disease Management/Chronic Conditions* *6. Quality & Safety of Care and Service* *7. Compliance* *8. QI Infrastructure* *9. Wellness/Preventive Health* *III.* ***Quality Improvement Tracking System Activities Log.*** *Lists the Quality Improvement Tracking System activities that support meeting program objectives for the year identified in Section 1. Some of these activities include, but are not limited to, the following:* 1. Behavioral Health: Conduct live outreach using ADT reports to identify members who had an ED visit for MH, SUD, or Drug Overdose to close care gaps for follow-up care. Improve Teledoc Mental Health Digital Program oversight and management (replaces myStrength). 2. Member Engagement: Identify dual-eligible members and verify they qualify to utilize Community Health Worker (CHW) benefits to support Health Risk Assessment (HRA) completion. Annual member newsletter. 3. Chronic Conditions: Through a vendor partnership, we mail HbA1c home test kits to	

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	members due for a test. 4. Health Education: Create a PowerPoint presentation for Providers that uses QR Codes to link to credible health education resources (Krames & others) to share with their patients. Topics will be focused on MCAS measures. 5. Hospital Quality/Patient Safety: Identify new ways to engage hospital leadership to improve quality metrics related to hospital-acquired infections and equitable maternal health metrics. Produce Hospital Quality Scorecards. 6. Pediatric/Adolescents: Support blood lead screening with in-office analyzer initiative (27 distributed in 2024). Utilize the Transitional Care Team to enroll members in the First Year of Life Program before hospital discharge. Promote the CDC Milestone Tracker app. 7. Pharmacy: Evaluate expanding "Kick It California" (KIC) Smoking Cessation outreach to include the distribution of nicotine replacement therapy kits. Increase awareness of Asthma Remediation Services. 8. Preventative Care: Launch in-home Chlamydia screening. Expand cancer screening, testing, and partnerships with local Community-Based Organizations (CBOs). *Discussion: Dr. Ramirez asked if the in-home Chlamydia screening was a urine test or self-swab. Dr. Marabella indicated it was most likely a urine test, but he will confirm.* *The Committee had no further questions or recommendations.*	
#4 **Key Presentations** - PHM Strategy Description 2025 & Change Summary (Attachment S) **Action** Patrick Marabella, M.D Chair	The **PHM Strategy Description & Change Summary 2025** 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 **2025 Strategy Description** include: • Basic Population Health Management (BPHM) (pg. 10) Updated information regarding the establishment of collaborative partnerships within Fresno, Kings, and Madera counties' LHJs/LHDs to reflect the present state. • Transitional Care Services (pgs. 12-13) Removed "single point of contact" language, removed care section on "Care Manager Responsibilities". Updated the TCS interventions and removed the minimum TCS requirement of 30 days. • PHM Programs and Services (pgs. 14-22) o Changed "Transitional Care Management" to "Transitional Care Services," (TCS).	**Motion:** *Approve* - PHM Strategy Description 2025 & Change Summary (Cardona/Waugh) 5-0-0-3

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	○ Updated age eligibility, program goals, outreach methods, and minor grammatical errors (flu). ○ Removed heart failure and added Sickle Cell Disease (Chronic). ○ Additional eligibility criteria included, updated program services, and stats (Diabetes). ○ Removed SHAPE program. ○ Removed Fit Families for Life program. ○ Updated language for Initial Health Appointment. ○ Updated name to Teladoc, updated oncology list, and eligibility criteria (Oncology). ○ Updated program services for Tobacco Cessation, updated stats. ○ Updated eligibility criteria for BCS Screening to 40-74 years and updated outreach methods (BCS). ○ Updated program goals. • External Partnerships (pg. 25): Removed several entities: local Continuum of Care (COC), Caregiver Resource Centers (CRCs), and Home and Community-Based Services (HCBS) waiver agencies. • Delivery Systems sharing with Practitioners (pgs. 27-28): Fixed grammatical and spelling errors and added information on Closed-Loop Referrals. • Delivery Systems sharing with Members (pg. 29): Removed TCM, updated services names, updated IHA language. • Other minor edits and grammatical corrections. *Discussion: Dr. Cardona asked how the Closed-Loop Referrals system worked. Amy Schneider indicated that the ECM and CS programs will be the first to implement a process to electronically track services provided based upon referrals, and this information will be communicated back to the referring providers (close the loop). Behavioral Health services currently follow a similar process, but without some of the technology and software to simplify tracking. Mary Lourdes Leone indicated that the Plans and counties will have a joint policy on how this Closed-Loop system will be administered, and include system liaisons to monitor and provide oversight.* *There were no additional questions or recommendations from the Committee.*	
#4 Key Presentations - Continuity & Coordination Medical Care Report - Continuity & Coordination	The purpose of the **Continuity & Coordination Medical Care Report 2024** is to promote collaboration among medical health providers and CVH leaders and managers. CVH monitors certain aspects of continuity and coordination of medical care, and by initiating actions to reduce miscommunication and improve care coordination, we will improve patient safety and decrease	**Motion:** *Approve* - Continuity & Coordination Medical Care Report

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Medical & Behavioral Healthcare Report (Attachments T, U) **Action** Patrick Marabella, M.D Chair	the risk of errors in the healthcare system. • Measure #1 Timeliness of Postpartum Care (HEDIS® measure) was met in all three (3) Counties and will continue current strategies. • Measure #2 Eye Exam for Patients with Diabetes (HEDIS® measure) was met in two (2) of three (3) Counties, and actions for improvement to include: o Not all patients have a primary care physician, so information if reported by eye specialists can go without being placed in the member's medical record. Therefore, CVH will utilize COZEVA® reports - a reporting and analytics platform that displays performance in clinical quality and risk measures – for providers and participating provider groups (PPGs) to identify members who need an eye exam. This platform is important as it offers CalViva, as well as medical groups, real-time data on members who have care gaps and missing specialist visits. o Members do not fully understand the need for a retinal eye exam. CVH will provide education to members about what a diabetic retinal eye exam is and its importance. • Measure #3 Pharmacotherapy for Opioid Use Disorder (HEDIS® measure) was not met in two (2) Counties; one (1) County sample was too small (data issue). Barriers and actions for improvement include: o The first barrier is: Lack of coordinated communication about opioid prescriptions among prescribers. CVH will proactively identify high-use members and send provider/provider groups opioid high utilization reports and educate providers on the risks of overuse. o Secondly, members don't fully understand the risks of overusing opioids. CVH will develop educational materials for members and distribute educational materials to providers to share with members. • Measure #4 Plan All-Cause Readmissions (within 30 days) (HEDIS® measure) was met in all three (3) Counties and will continue with current strategies. *There were no questions or recommendations from the Committee.* The **Continuity & Coordination Medical & Behavioral Healthcare Report** promotes collaboration among medical and behavioral health providers and CalViva leaders and managers. The purpose of this presentation is to review and discuss performance results from the activities selected for 2024, and review and confirm activities selected for 2025. The committee will also discuss specific barriers to improvement and share information/brainstorm applicable initiatives or potential	- Continuity & Coordination Medical & Behavioral Healthcare Report (Pascual/Ramirez) 5-0-0-3

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	actions that should be executed. • In 2023, the QI/UM Committee reviewed BH data from provider and member satisfaction surveys and HEDIS® Compliance results from BH measures. • Recommendations were made to select measures to focus on for improvement. • We reviewed initial results and made further recommendations in May 2024. • We have results from RY2024 (MY2023) now to reassess and make additional recommendations for the future. **2023 Review: Antidepressant Medication Management** Acute Phase of Treatment – 60.79% RY24/MY23 (Numerator: Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). Denominator: Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication.) Opportunity #1: Appropriate diagnosis, treatment, and referral of BH disorders commonly seen in primary care. • Effectiveness: Observing year-over-year directional improvement for CVH for both metric components, but not meeting the goal. Due to ongoing reporting issues, MY2023 interventions were stopped mid-year. • Actions: Continued live member outreach only for a portion of the year due to reporting and technical issues. • Opportunities/Next Steps: Identify a new metric/measure for MCL quantifying improvement in this Opportunity Area that aligns with changes in priority and retirement of metric. Continuation Phase of Treatment—38.45% RY24/MY23 (Numerator: Percentage of members who remained on an antidepressant medication for at least 180 days (6 months). Denominator: Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication.) **2023 Review: Depression Screening and Follow-up for Adolescents and Adults (DSF-E)** 14.90% RY24/MY23 (Numerator: Percentage of members who were screened for clinical depression using a standardized instrument. Denominator: Members 12 years of age and older.) Opportunity #2: Preventive BH Program Implementation. • Effectiveness: Large improvement seen in initial depression screenings in MY23 over MY21/22. No National Benchmarks for MY23; goal was directional improvement. Leveraging mobile	

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	digital tools for initial depression screenings likely contributed to the rate increase. • Actions: Improve utilization of myStrength for CVH membership through Call Center, social media, and email. • Opportunities/Next Steps: Maintain current improvement actions. Continue provider education about including LOINC information for gap closure. **2023 Review: Follow-up after Depression Screening for Adolescents and Adults (DSF-E)** 73.27% RY24/MY23 (Numerator: Percentage of members who received follow-up care within 30 days of a positive depression screen finding. Denominator: Members 12 years of age and older from the Initial Population who screened positively.) Given that there are no national benchmarks, the internal goal is achieving directional improvement. CalViva Health did show directional improvement from RY2022 to RY2023, but a decrease was seen in RY2024. We are improving initial screening rates but have not seen the same increase in follow-up screenings after a positive score. Due to relatively small initial screening rates, the eligible populations for this metric remained small in RY2024. *The following quality metrics and goals were met with an improved directional change:* • Timeliness of Information Received from Behavioral Health Practitioners on the Provider Survey • HEDIS® Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) • Depression Screening –ages 12 and older (DSF-E) ^ • HEDIS® Diabetes Screening for Members diagnosed with Bipolar Disorder or Schizophrenia prescribed Antipsychotic Medications (SSD) *The following quality metrics did not meet the goal with an improved directional change:* • HEDIS® Antidepressant Medication Management: Acute (AMM) • HEDIS® Antidepressant Medication Management: Continuation (AMM) *The following quality metrics did not meet the goal with a downward directional change:* • Timeliness of information received from Primary Care Physicians on the MHN Provider Survey • HEDIS® Follow-Up Care for Children Prescribed ADHD Medication: INT (ADD) • HEDIS® Follow-Up Care for Children Prescribed ADHD Medication: C&M (ADD) Depression Screening Follow-Up – ages 12 and older (DSF-E) **^Two opportunities recommended for 2025 with potential actions:** #1 Appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in	

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	primary care. 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). #2 Primary or secondary preventive behavioral healthcare program implementation. Quantifiable Metric: • HEDIS® Depression Screening & Follow-Up (DSF-E) Barriers: • The primary barrier is the inability to obtain LOINC coding information to appropriately close gaps. • Ambiguities around sharing information with privacy regulations. • The provider believes that patients may be sharing the necessary information with the other provider. • Lack of time to exchange information timely.	

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	Potential Actions: • Leverage alternate data sources to obtain LOINC code information (Cozeva, EHRs, etc.) • Distribute revised provider tip sheets that include LOINC coding info and scoring. • Leverage supplemental data streams/digital applications to close gaps internally (Teladoc Mental Health (Digital Program) and ShareCare. • Leverage internal HN CM outreach calls for follow-up screening gap closures. Metrics to Evaluate Effectiveness: • Meeting goal (50th Percentile) for HEDIS® (Depression Screening & Follow Up for Adolescents & Adults (DSF). *Discussion:* *Dr. Marabella asked the Committee for suggestions on how to measure member participation in follow-up referrals.* *Dr. Waugh indicated that the no-show rate for follow-up referrals is about 50%, and in general, the CVH population has a negative association with seeing a mental health provider. Communication regarding a referral is better between the PCP and the BH provider if they are in the same clinic/building and have a relationship. This is not the case with outside provider referrals.* *Dr. Cardona agreed that his patients would rather see their PCP and receive a prescription from them than a BH provider.* *Dr. Marabella pointed out that another barrier to follow-up care is the ability to see members within 30 days of an ED visit or depression screening.* *Dr. Ramirez asked if the Plan was not meeting the measure because of not performing the screening or not doing a follow-up within 30 days? Dr. Marabella will follow up with a data request and will share this discussion with the HN Internal Collaboration Team, as NCQA Standard Q13 was modified in 2025 and is currently under review. This is a good time to make a request.* *Dr. Ramirez confirmed that seeing members within 30 days is challenging as they don't have enough BH providers, which reduces access and availability within the 30-day timeframe.* *There were no further questions, and the Committee agreed to proceed with the two (2) recommended actions.*	
#4 **Key Presentations** - NCQA Behavioral Health Member Experience Report	**NCQA Behavioral Health Member Experience Report 2024 (MY2023)** monitors member experience data for Behavioral Health populations. Member Survey data is evaluated along with appeal and grievance data to identify member pain points and opportunities for improvement	**Motion:** *Approve* - NCQA Behavioral Health Member

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2024 (MY 2023) (Attachment V) **Action** Patrick Marabella, M.D Chair	(NCQA ME.7) The Experience of Care and Health Outcomes (ECHO®) annual survey is used to assess member satisfaction with the Behavioral Health population. • The survey was conducted in 2024 to assess MY2023. • All member grievances and appeals are also evaluated. • Significance testing was conducted to test the significance between MY2023 and MY2022 ECHO survey results because of the history of ECHO surveys and barrier analysis. • No significance testing is performed for appeals and grievances. • The BH grievances, appeals, and ECHO survey data point to similar opportunities. • The volume of data is small, and while patterns may not be identified for CalViva Health, the general trend is that the most impactful member pain points are around Access and Billing/Financial (authorization of care & balanced billing) issues. • There is a strong focus on member outcomes (clinical improvement), as demonstrated by the high response rates to the questions related to "perceived improvement." • The ECHO results specifically indicate that the areas of greatest opportunity are related to Getting Treatment Quickly and Perceived Improvement. Through a barrier analysis of the ECHO results, several opportunities were identified with the following actions taken (or being implemented): Actions to grow the BH Network include: • Increase rates for newly contracted providers and providers willing to accept new patients. • Focus growth in areas of need – the highest numbers of OON requests. • Focus on telehealth options to eliminate geo-access challenges. • Improve Provider Satisfaction through improved speed and accuracy of claims processing and immediate feedback on member complaints/concerns. • Give more feedback to CalViva Health BH providers about member experience and provide resources to make improvements. Barriers being addressed include: • Reduction in stigma leading to greater demand, and the BH network options are not growing at the same rate. • Delays in routine access to care/appointments are rooted in member preference, compatibility, and scheduling needs, and insufficient options.	Experience Report 2024 (MY 2023) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Network availability issues limit provider choice and provider-member compatibility. • Providers might need more frequent reminders or feedback about member perception/experience. Actions to increase resources for PCPs treating BH: • Greater promotion of Collaborative Care Model options and resources. • Improve provider directory accuracy. Barriers being addressed include: • Reduction in stigma leading to greater demand, and the BH network options are not growing at the same rate. • No BH provider "assignment" and limited value-based payment and/or incentives for BH Providers. • Inaccuracies in the provider directory information can lead to delays in finding a provider accepting new patients. Actions for system migration and integration: • Leverage the staggered roll-out of the BH system migration to test/learn and improve process documentation, learn/apply best practices, and minimize negative impacts. • Eliminate/reduce silos between medical and BH. • Greater collaboration and BH data exchange with Medi-Cal counties without violating privacy Rules. Administrative barriers being addressed include: • Members cannot find information about the BH care they need or the BH care they obtained without calling the Plan or provider. • Systemic silos between medical and BH do not help members obtain information and options in an easy, seamless manner. • Privacy regulation concerns limiting collaboration and BH data exchange between Medi-Cal service delivery entities. *There were no questions or recommendations from the Committee.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (January 2025)	The **Key Indicator Report & Turnaround Time Report** through January 2025 were presented. • Utilization for Acute Admits (adjusted PTMPY), for expansion, and adults have increased in Q1 2025. • Utilization for Acute Length of Stay and Readmissions (all adjusted PTMPY) for TANF, MCE, and	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (January

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments W) **Action** Patrick Marabella, M.D Chair	SPDs shows a decline in Q1 2025. • Behavioral Health, Perinatal, Physical Health, Transitional Care Services (TCS), and First Year of Life Care Management referrals and member engagement rates have all increased in Q1 2025 compared to Q4 2024. • Timely Pre-service Routine Deferral letters requiring language translation were delayed. In response, team members received additional training. Leadership is actively involved in achieving the goal of full operational compliance.	2025) (Pascual/Ramirez) 5-0-0-3
#5 **UM/CM Business** - Care Management & CCM Report (Q4 2024) (Attachment X) **Action** Patrick Marabella, M.D Chair	The **Care Management and CCM Report Q4 2024** 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 activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness. • From Q3 to Q4 2024, the referral volume for Physical Health Care Management (PH CM) decreased by 3.8%, while TCS referrals increased by 19%, and Behavioral Health Care Management (BH CM) referral volume declined by 12.5%. Managed cases declined in PH CM and Perinatal CM but rose in BH CM and TCS in Q4. Although referrals decreased, cases managed for the First Year of Life increased in Q4. • Care Management has had success in preventing re-hospitalizations. Referrals to the appropriate case management personnel and the use of ECM and Community Supports have been effective. • PH CM numbers are stable, showing similar performance compared to the previous year. No significant changes were noted. • TCS has shown an increase in the volume of members served this year due to changes in operations. All members discharged from acute care go to TCS first. • While there hasn't been a major shift in the percentage of PCP visits within 7/14/30 days post-discharge, the performance is considered acceptable at 51% in Q3 2024. • BH CM performance is positive with no major concerns. • PCM's total numbers are up compared to last year, with a notable increase in engagement (from 1,000 to 1,300). Key metrics show improved post-enrollment outcomes, such as reduced readmissions, fewer emergency department visits, better prenatal visits, fewer preterm births, and an increase in postpartum care.	Motion: *Approve* - Care Management & CCM Report (Q4 2024) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Seventy-two (72) members completed a Member Satisfaction Survey, with 90% being satisfied with the Care Management program. Going forward, the team will work to obtain accurate contact information and increase participation in the satisfaction survey.	
#5 **UM/CM Business** - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2024 (Attachment Y) **Action** Patrick Marabella, M.D Chair	**InterQual Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2024** were presented. UM staff apply InterQual® Clinical Decision Support Criteria along with other evidence-based medical policies, clinical support guidelines, and technical assessment tools approved by the Medical Advisory Council to ensure consistent and standardized medical criteria review across all cases. Following InterQual (IQ) IRR preparatory training in Q3 2024, InterQual IRR modules were administered to the physician reviewers and the non-physician clinical staff, requiring a minimum score of 90% to pass. Below are the results of testing completed in Q4 2024. • The initial overall pass rate was 90%. Following remediation and retesting, the majority of staff and physicians scored at or above 90%. • Lead & Senior Clinical Review Clinicians (Appeals and Concurrent Review) achieved near-perfect scores. • Utilization Management Managers and Medical Directors showed high competency in their respective domains, with most scoring 95-100%. • External Consultants and Prior Authorization Reviewers scored 100%. • Sub-Acute Skilled Nursing Facility: Several Senior Clinical Review Nurses and Concurrent Reviewers scored below 80%, with one dropping from 85% to 60% on a retest. • Behavioral Health: Some Medical Directors and Psychologists initially scored 75-90%, requiring additional training.	Motion: *Approve* - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2024 (Pascual/Ramirez) 5-0-0-3
#5 **UM/CM Business** - Enhanced Care Management (ECM) & Community Supports (CS) Performance Report (Q4 2024) (Attachment Z) **Action**	**Enhanced Care Management & Community Supports Performance Report (Q4 2024)** summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system with program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) are responsible for administering both ECM and CS services. • For ECM, of 14,934 members who were assigned in the three (3) CVH counties, 1,437 were successfully enrolled, accounting for a 9.6% enrollment rate.	Motion: *Approve* - Enhanced Care Management (ECM) & Community Supports (CS) Performance Report (Q4 2024) (Pascual/Ramirez)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	• The average assignment to enrollment percentage for each county is: Fresno (10%), Madera (5.8%), and Kings County (10.9%). • For CS, a total of 35,229 authorizations were submitted between January to Dec 2024. • The total paid CS claims were for services related to Medically Tailored Meals/Medically Supported Foods (71%), followed by Housing Transition/Housing Sustaining/Housing Deposits Services (21%), Short-Term Post-Hospitalization Housing (3%), and Asthma Remediation, Day Habilitation Services, and Personal Care and Homemaker Services (1%). • Fresno (82.8%) accounted for the most referrals, followed by Madera (8.6%) and Kings (8.55%). Barriers to ECM and CS uptake continue to be focused on a lack of accurate or available member contact information, difficulty finding members to refer into the program, and a lack of awareness by members and other providers of the program. CS referrals can be made through two routes, either directly to the contracted CS provider or through the Findhelp website. (Findhelp is a closed-loop community resources and referrals online platform used to identify local resources and support staff and community partners when searching for local social services, including plan-contracted CS providers.) • A total of 1,154 CS referrals were made through Findhelp between January through December 2024 to a total of 20 CS providers. Fresno (90%) accounted for the most referrals, followed by Kings (7%) and Madera (3%).	5-0-0-3
#5 **UM/CM Business** - Medical Policies (January 2025) (Attachment AA) **Action** Patrick Marabella, M.D Chair	The **Medical Policies (January)** were presented to the committee. Dr. Marabella recommended that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback. Medical Policies are compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. Updated policies for January 2025 include, but are not limited to: • CP.MP.62 – Hyperhidrosis Treatments • CP.MP.70 – Proton and Neutron Beam Therapies • CP.MP.107 – DME • CP.MP.142 – Urinary Incontinence Devices and Treatments • CP.MP.168 -- Biofeedback • CP.MP.173 -- Implantable Intrathecal or Epidural Pain Pump • CP.MP.180 -- Implantable Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	Motion: *Approve* - Medical Policies (January 2025) (Pascual/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CP.MP.190 -- Outpatient Oxygen Use	

#6 **Pharmacy Business**
- Pharmacy Executive Summary (Q4 2024)
- Pharmacy Operations Metrics (Q4 2024)
- Pharmacy Top 25 Prior Authorizations (Q4 2024)
- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2024)
- Pharmacy Quality Assurance Results 2024
 	
(Attachments BB-FF)
 	
Action
Patrick Marabella, M.D Chair
	The **Pharmacy Executive Summary Q4 2024** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements.
	• Pharmacy Operations Metrics
	  o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q4 2024.
	  o Overall, TAT for Q4 2024 was 97.8%.
	  o PA volume was lower in Q4 2024 compared to Q3 2024 and there were some drug-specific differences. October had a higher volume compared to all other months in Q4 2024.
	
	The **Pharmacy Operations Metrics Q4 2024** provides key indicators measuring the performance of the PA Department in service to CalViva Health members. The turnaround time (TAT) expectation is 100%, with a threshold for action of 95%.
	• The average turnaround time met the standard with 97.8%.
	
	The **Pharmacy Top 25 Prior Authorizations Q4 2024** identifies the most requested medications to the Medical Benefit PA team for CalViva Health members and assesses potential barriers to accessing medications through the PA process. The top 25 PA requests in Q4 2024 were mostly consistent with the top 25 drugs reviewed in Q3 2024, with a few placement variations. Pegfilgrastim and IV Iron continue to drive PA volume due to the existence of preferred products in the PA polices versus the branded products.
	
	The **Quality Assurance Reliability Results (IRR) for Pharmacy Q4 2024** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten (10) prior authorizations [four (4) approvals and six (6) denials] from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas, with a threshold for action of 90%.
	• The 90% threshold was met. The 95% goal was not met. The overall score was 92.50%.
		Motion: *Approve*
		- Pharmacy Executive Summary (Q4 2024)
		- Pharmacy Operations Metrics (Q4 2024)
		- Pharmacy Top 25 Prior Authorizations (Q4 2024)
		- Quality Assurance Reliability Results (IRR) for Pharmacy (Q4 2024)
		- Pharmacy Quality Assurance Results 2024
		
		(Ramirez/Cardona)
		5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **Quality Assurance Reliability Results for Pharmacy 2024** reviews the prior authorizations performed on the medical benefit drugs to evaluate the consistency and accuracy with which the MedPharm Pharmacy staff involved in utilization management (UM) review and apply prior authorization criteria in decision-making and communicate the decisions made to providers and patients. • The Quality Assurance (QA) results for all quarters in 2024 show that the Overall (cumulative) threshold was met for the random request reviews in each quarter of 2024 with an average score of 93%. However, the 95% goal was not met. Criteria Application and Clarity of Response seemed to be the largest contributing factors to the overall score meeting the threshold, but not meeting the goal. After each quarterly review, QA results are provided to the Pharmacy Services Management for review to discuss opportunities for improvement based on deficiencies in the individual categories and specific cases. The Health Plan provides ongoing feedback and guidance on all cases reviewed.	
#7 Policy & Procedure Business - Pharmacy Annual Policy & Procedure Review (Attachment GG) Action Patrick Marabella, M.D Chair	The **Pharmacy Annual Policy & Procedure Review** was presented to the committee. The following policies were presented for annual review with **no changes made:** RX-001 Medication Prior Authorization RX-002 Program Metrics Review RX-005 Pharmacy Prior Authorization and Medical Necessity Criteria RX-006 Specialty Pharmacy Program RX-007 Injectable Medication Review RX-008 Mental Health Parity RX-120 Drug Utilization Review **The following policies were presented for annual review and were approved with the following changes:** RX-003 Pharmacy Program: Added section on HN Pharmacy Advisory Committee. *Dr. Marabella stated that HN's Pharmacy oversight committee structure has changed since Centene acquired HN. HN has formed a Pharmacy Advisory Committee specifically for Medicare and MediCal for California, of which Dr. Marabella is a member.*	Motion: *Approve* - Pharmacy Annual Policy & Procedure Review (Cardona/Ramirez) 5-0-0-3
#8 Credentialing & Peer Review Subcommittee Business - Credentialing Subcommittee Report (Q1 2025)	The **Credentialing Sub-Committee Quarterly Report Q1 2025** was presented. The Credentialing Sub-Committee met on February 20, 2025. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q3 2024 were reviewed for delegated entities, and Q4 2024 for Health Net (HN) and HN Behavioral Health (BH). A	Motion: *Approve* - Credentialing Subcommittee Report (Q1 2025)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment HH) Action Patrick Marabella, M.D Chair	summary of Q3 2024 data was presented. • The **Adverse Events Q4 2024** report was presented. o There were no (0) cases identified in Q4 2024 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no (0) reconsiderations or fair hearings during Q4 2024. o There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of appointment availability. o There were no (0) cases identified outside of the ongoing monitoring process this quarter. (NCQA CR.5.A.4) • The **Access & Availability Substantial Harm Report Q4 2024** was presented and reviewed. This report identifies incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked by severity level. o After a thorough review of all Q4 2024 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1). • The **Credentialing Adverse Actions** report for Q4 2024 for CalViva from the HealthNet Credentialing Committee was presented. o There was one (1) case presented for discussion for Q4 2024 for CalViva Health. The Medical Board of California issued the practitioner a public letter of reprimand, with terms and conditions to include, but not limited to, 1) The practitioner shall complete an education course. 2) The practitioner shall complete a medical recordkeeping course. The case will be monitored to ensure compliance with the Medical Board's terms and conditions.	(Pascual/Waugh) 5-0-0-3
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q1 2025 (Attachment II)	**Peer Review Sub-Committee Quarterly Report Q1 2025** was presented. The Peer Review Sub-Committee met on February 20, 2025. • The county-specific **Peer Review Sub-Committee Summary Reports for Q4 2024** were reviewed for approval. No (0) significant cases to report. • The **Q4 2024 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) and Credentialing Adverse Action (AA) cases identified during the reporting period.	Motion: Approve - Peer Review Subcommittee Report Q1 2025 (Ramirez/Waugh) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	○ There were 11 cases identified in Q4 that met the criteria for reporting and were submitted to the Peer Review Committee. Four (4) of these cases involved a practitioner, and seven (7) cases involved organizational providers (facilities). ○ Of the 11 cases, six (6) were tabled, zero (0) were deferred, zero (0) were closed to track and trend with a letter of concern, two (2) were closed to track and trend with a letter of education, and three (3) were closed to track and trend. ○ Six (6) cases were quality of care grievances, three (3) were potential quality issues, zero were lower level, and zero (0) were track and trend. ○ Three (3) cases involved Seniors and Persons with Disabilities (SPDs), and none (0) involved Behavioral Health. ○ There were no (0) incidents involving appointment availability resulting in substantial harm to a member or members in Q4. ○ There were no (0) cases that met the Peer Review trended criteria for escalation. ○ There was one (1) case 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) ○ There were 23 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. • The **Access & Availability Substantial Harm Report for Q4 2024** was also presented. This report aims to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances, Quality of Care (QOC), and Potential Quality Issues (PQIs) related to identified appointment availability issues, and they are ranked by severity level. ○ Fifteen* (15) cases were submitted to the Peer Review Committee in Q4 2024. There were four (4) incidents found involving appointment availability issues *without significant harm* to a member. Two (2) cases were determined to be related to significant harm to a member but *without appointment availability issues*. No cases (0) were related to behavioral health issues. *One (1) case appeared twice in the quarter. ○ There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2024.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The **Q3 2024 Peer Count Report** was presented and discussed with the committee. There was a total of 15 cases reviewed. There were nine (9) cases closed and cleared. There were six (6) cases tabled for further information.	
#9 **Compliance Update** -Compliance Regulatory Report (Attachment JJ)	Mary Lourdes Leone presented the **Compliance Report**. **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 and availability, specialty referrals, utilization management data, grievances, and appeals etc. **Oversight Audits:** The following annual audits are in progress: Credentialing, Call Center, Claims/PDR, and Quality Improvement. The following annual audits have been completed since the last Commission report: Pharmacy (No CAP). **Fraud, Waste, and Abuse:** Since the 2/20/25 Compliance Report, there have been no new MC609 filings with the DHCS. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation:** As a reminder, on 9/6/24, the Plan received DHCS's final report findings and formal CAP request. There were nine (9) deficiencies in total [four (4) for behavioral health and five (5) for transportation]. The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. The Plan is on track to complete its stated corrective actions and will provide its next monthly update on 4/10/25. **Department of Health Care Services ("DHCS") 2024 Medical Audit:** As a reminder, on 10/3/2024, DHCS sent out the Final Audit Report and CAP request. There were two findings: • The Plan did not ensure that the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten (10) working days. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 4/1/25. **Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit:** On 1/6/25, the Plan	-Compliance Regulatory Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. All requested documents were submitted on 2/5/25. Awaiting a response from DMHC. **Department of Health Care Services ("DHCS") 2025 Medical Audit:** The 2025 DHCS Audit will be conducted virtually from 6/2/2025-6/13/2025. The Entrance Conference will begin on 6/2/25 @ 10:00 a.m. All Pre-Audit document requests are due to DHCS by 3/17/2025. **Memorandum of Understanding (MOU):** Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOUs, which have been posted to CalViva's website: • Madera County MHP MOU • Amendment No. 1 to Fresno County MHP-DMC-ODS MOU **Annual Network Certifications:** • 2024 Subnetwork Certification (SNC) Landscape Analysis – On 1/3/2025, the Plan submitted the 2024 SNC deliverable. DHCS has followed up requesting additional information. The Plan has submitted all additional documents and is awaiting approval. • 2024 Annual Network Certification (ANC) - The Plan is on track to submit all required documents by the 3/17/2025 due date **Transgender, Gender Diverse, or Intersex (TGI) Training:** DHCS APL 24-017 and DMHC APL 24-018 require Plans to conduct TGI training to staff who are in direct contact with Members. Plans are required to submit evidence of training along with the curriculum. The Plan has been working on deliverables associated with these APLs, such as updating its provider directory to show which providers are offering gender affirming care, monitoring and tracking grievances as they relate to gender affirming care, and updating the Plan's policies and procedures. On 2/28/2025, the Plan submitted P&Ps to DHCS, along with the required attestation regarding the provider directory. The TGI curriculum and various other documents are due to DHCS and DMHC by 3/14/2025. **(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR):** On March 11, 2025, the Plan convened its "Kick-Off" meeting for the MY2024/RY2025 Timely Access Report ("TAR") filing, which must be filed with DMHC by 5/1/2025. **New DHCS Regulations/Guidance:** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2025.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Public Policy Committee (PPC): The Public Policy Committee met on March 5, 2025. The following reports were presented: • Q4 2024 Appeal and Grievance Report • A&G Dashboard review by Dr. Marabella • CalViva Health Annual Report • Semi-Annual Member Incentives • 2024 Annual Compliance Report The next PPC meeting will be held on June 4, 2025, from 11:30 a.m. - 1:30 p.m., CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. *Dr. Cardona left the meeting at 12:03 p.m.*	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is on May 15th, 2025. The Committee agreed that the PowerPoint presentations are helpful and liked the adjusted meeting format. Dr. Marabella announced that Dr. Quezada and Dr. Waugh have agreed to continue serving on the QIUM Committee for another two (2) year term. *Dr. Cardona returned to the meeting at 12:05 p.m.*	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 12:06 p.m.	

NEXT MEETING: May 15th, 2025

Submitted this Day: May 15, 2025

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

Acknowledgment of Committee Approval:

X
Patrick Marabella, MD, Committee Chair

Public Policy Committee
Meeting Minutes
March 5, 2025

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

Committee Members			Community Base Organizations (Alternates)
✓	Joe Neves, Chairman	✓	Jeff Garner, KCAO
✓	David Phillips, Provider Representative		Roberto Garcia, Self Help
	Vacant, Kings County Representative		**Staff Members**
	Vacant, 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	✓	Mary Lourdes Leone, Chief Compliance Officer
✓	Norma Mendoza, Madera County Representative	✓	Steven Si, Compliance Manager
		✓	Maria Sanchez, Senior Compliance Manager
		✓	Patrick Marabella, MD, CMO
			Amy Schneider, RN, Senior Director, Medical Management
		✓	Sia Xiong-Lopez, Equity Officer
		*	= late arrival
		•	= 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 11:34 am. Roll call was taken to establish a quorum.		
#2 Meeting Minutes from December 4, 2024 **Action** Joe Neves, Chair	The December 4, 2024, meeting minutes were reviewed and approved.		**Motion:** Approve December 4, 2024, Minutes 4-0-0-3 (Mendoza / Phillips)
#3 Enrollment Dashboard	Maria Sanchez presented the enrollment dashboard through December 2024. Membership as of December 31, 2024, was 432,709. CalViva Health maintains a 66.86% market share.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
Information Maria Sanchez			
#4 Annual Report **Information** Courtney Shapiro	This is a mandated report by DHCS and is for the benefit of stakeholders, community partners, and elected officials, and is posted on the CVH website for public viewing. Courtney Shapiro gave a brief summary of the report and each PPC member was provided with a hard copy of the annual report.		**No Motion**
#5 Committee Membership Update **Information** Courtney Shapiro	Public Policy Committee membership has been updated as follows: Renewals: Martha Miranda, Kings County, pending renewal due to Medicare being switched to another Plan. Martha has done everything needed to be switched back to CalViva and will be back on the PPC as soon as we have confirmation. Vacancy: Fresno County seat is currently vacant.		**No Motion**
#6 Appeals, Grievances and Complaints **Information** Maria Sanchez Dr. Marabella, CMO	For Q4 2024 there were nine (29) Coverage Disputes (Appeals), 112 Disputes Involving Medical Necessity (Appeals), 60 Quality of Care, 123 Access to Care, and 314 Quality of Service, for a total of 638 appeals and grievances for Q4. The majority of which are from Fresno County. There were 397 appeal cases for Fresno County, 21 for Kings County, and 67 for Madera County, for a total of 485 for the 2024 calendar year. There were 398 grievances cases for Fresno County, 44 for Kings County, and 54 for Madera County for a total of 496 for Q4 2024. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for all categories. There was a total of 498 Exempt Grievances received in Q4 2024. Of the total grievances and appeals received in Q4, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 178 • Appeals: 41		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Exempt: 41 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 were categorized as PCP Delay, PCP Care, and Specialist Care. The top categories of appeal cases resolved were related to Advanced Imaging, Other, and DME. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received. Dr. Marabella presented the Appeals & Grievances Dashboard for Q4 2024. The total of grievances for Q4, as stated, was 497, which is a decrease from the previous two quarters. The majority of grievances are Quality of Service, having to do with Access-Other, Administrative, Balance Billing, Other, and Transportation. Quality of Care grievances has decreased from prior year. Exempt grievances have increased when compared to previous year. Areas to note are Attitude/Service-Provider, Transportation-Access-Provider No Show, and Claims Complaint-Balance Billing from Provider. Appeals for 2024 increased when compared to prior year. The majority of appeals were pre-service with Consultation, DME, Advanced Imaging and Other being the highest categories, and consistent with previous year.		
#7 Marketing Campaign Creative Discussion **Information** Courtney Shapiro Melissa w/JSA	Courtney introduced Melissa, with JSA, who presented JSA's marketing campaign for the next fiscal year. Melissa gave a presentation to the PPC which included the 2024 creative ads that are currently out in the community, and two new concepts for next fiscal year. Melissa asked the committee for their opinion on what they feel would stand out to the general public and which ads they liked and/or preferred the best. The committee and staff provided Melissa with questions and recommendations on wording, color, layout, photography, etc. Melissa stated she would take all recommendations into consideration for the upcoming creatives. Courtney added that before any creatives are published, they must be approved by the State.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#8 DHCS Community Reinvestment **Information** Courtney Shapiro	Courtney Shapiro shared the Plan's funding will be changing. During the March Commission meeting a new policy was presented to the Board members regarding the DHCS Community Reinvestment. The State is setting new language and policies for all managed health plans to fund specific to their requirements to go into effect 2026. CVH is gearing up for these changes by reviewing the net income of the Plan and DHCS gives the Plan a percentage of what CVH has to spend on community reinvestment specific to the buckets that DHCS assigns; that in turn is how CVH has to fund. CVH will continue to come back to the PPC for feedback/input with funding in this new bucket/requirement by DHCS. The budget for fiscal year 2026 will be brought to the Commission in May for approval. Once that is approved, CVH hopes to implement this new funding policy prior to the 2026 State requirement. Programs funded will also be added to the CVH website for public information. PPC members are encouraged to reach out either during a PPC meeting, or at any time, to share funding ideas/recommendations.		**No Motion**
#9 Regulatory Audit Status 2023 DHCS Focused Audit CAP 2024 DHCS Audit CAP 2025 DMHC Follow-up Audit 2025 Annual Audit-Virtual **Information** Mary Lourdes Leone, CCO	Updates will be provided in #11 – 2024 Annual Compliance Report. The Plan provides the State with status reports for each Corrective Action Plan (CAP) on a monthly basis. The Plan received notice from DHCS regarding the virtual 2025 Annual Audit. The plan is currently preparing the preaudit filing information.		**No Motion**
#10 Health Education Member Incentive Programs Semi-Annual Report Q3 & Q4 **Information** Steven Si	A total of 2,263 CalViva Health members participated in six-member incentive programs during Q3-Q4 2024. In total, $56,575 worth of gift cards were distributed to members as awards. Out of the recipients, 85% were from Fresno County, 10% were from Madera, and 5% were from Kings. There was a 40% decrease in the total member incentive awards given during Q3-Q4 2024. For the following measures of Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Childhood Immunization Status (CIS-10), and Well Care Visits (WCV), there were no barriers for		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Quarters 3-4, 2024. The decrease in the number of gift cards compared to Quarters 1-2, 2024 is part of the Quality/Provider Engagement strategy to develop and deploy most action plans in collaboration with providers in the first half of the year, in an effort to avoid a rush cycle of care gap closure during quarters three and four. Nets steps for Q1-Q2 2025: Diabetes Prevention Program (DPP): • The DPP contract and program materials are currently under review with the Department of Health Care Services (DHCS) for Cal Vivia Health. • Upon DHCS approval of the contract and program materials, next steps include: o Launching member outreach campaigns o Conducting Provider Webinar to promote the new DPP service to CalViva Health members Child and Adolescent Well Care Visits (WCV), Childhood Immunization Status (CIS-10), Cervical Cancer Screening (CCS), and Breast Cancer Screening (BCS) update: • Continue to distribute member incentives at point-of-care in collaboration with selected providers. Quality EDGE Program: • The Quality EDGE member incentive request form was submitted to the CVH Compliance Team on August 20, 2024 and submitted to DHCS. Per the response received from DHCS regarding their updated data documentation for new member incentive requests, further strategy needs to be developed before resubmitting the request to meet DHCS data collection requirements. W30-6+ PIP: • Continue to monitor the distribution of member incentive gift cards to members who enroll in Black Infant Health and attend a prenatal group class or postpartum group class or attend an infant well-child visit at the 2-month visit and report findings.		
#11 2024 Annual Compliance Report **Information** Mary Lourdes Leone, CCO	In 2024, the Compliance Program was focused on the following key activities: • Achieving National Committee for Quality Assurance (NCQA) Accreditation. • Developing a Diversity, Equity, and Inclusion (DEI) training curriculum. • Implementing DHCS' requirement to execute new Memoranda of Understanding (MOUs) with third-party entities.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Responding to the 2023 Department of Health Care Services ("DHCS") Focused Audit Corrective Action Plan (CAP), and the 2024 DHCS Audit CAP. • Responding to the 2022 DMHC Audit Final Report and CAP. • Successfully completing the 2024 Health Services Advisory Group (HSAG) Network Validation Audit. • Implementing the Plan's California Advancing and Innovating Medi-Cal (CalAim) Models of Care for the Children and Youth and Justice Involved populations of focus ("POF"). • Completing the carve-in of the Subacute Care Facilities and Intermediate Care Facilities (ICF) for individuals with developmental disabilities (ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes). The Member Service Call Center received 149,941 calls, of which 148,798 were answered. Overall service level was 93%. The Member Service Call Center for Mental Health received 3,588 calls, of which 3,561 were answered. Overall service level was 93%. The Provider Network remains stable. In 2024, contracted Providers were sent approximately 305 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 22 informational letter templates for contracted providers and 22 forms intended for provider use. In 2024, 47 communications were reviewed by the Plan. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2025 Member Handbook/Evidence of Coverage (EOC) was made available to members by posting to the CalViva Health website for downloading. In 2024 the Plan completed Delegation Oversight Audits for Health Net in the areas of Appeals and Grievances, Call Center, Claims, Credentialing, Fraud Waste & Abuse, Health Education, Pharmacy, Privacy and Security, Provider Disputes, and Utilization Management. Corrective action plans (CAPs) were required for nine of the functional areas, Appeals and Grievances,		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Claims, Credentialing, Provider Disputes, Privacy and Security, Emergency Room, Utilization Management, Provider Network, and Quality Improvement. For calendar year 2024, the Plan had a total of 2,599 Grievances and Appeals, of which 2,589 were resolved with 99.96% turn-around-time. The number of cases resolved for Seniors & Persons with Disabilities (SPDs) was 754 with a 98.6% turn-around-time. The number of cases resolved for Exempt Grievances was 2,201 with a 100% turn-around time. For calendar year 2024, there were a total of 93 Independent Medical Reviews and State Hearings. A total of 51 DMHC cases, and 42 DHCS State Hearings. Turn-around time was 100%. The Regulatory audits and Corrective Action Plans (CAPs) included: • 2023 DHCS Focused Audit - There were nine deficiencies in total (4 for behavioral health and 5 for transportation). • 2024 DHCS Audit - There were two findings: The Plan did not ensure written PA extension notices specified the information requested and did not receive from the provider; and the Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. • DHCS 2022-2023 EQR Performance Evaluation – There were two recommendations that focused on the following: working to resolve the findings from the DHCS 2022 annual DHCS audit and improving MY2022 HEDIS measures. • DHCS 2024 Encounter Data Validation (EDV) Study –Overall, the Plan did not meet Encounter Data Completeness standard (i.e.,<10%) in two categories, and did not meet the Encounter Data Accuracy standard (>90%) in the three categories. The Plan is working with Health Net on strategies to improve standards in 2025. • DHCS RY 2023 Subnetwork Certification (SNC) – For RY 2023 SNC, the Plan issued five PPGs CAPs for not meeting time and distance standards. The Plan submitted quarterly updates to DHCS and on 12/10/24 DHCS approved the Plan's SNC. • 2023 DHCS Annual Network Certification (ANC) - The Plan submitted Phase 1 of the ANC in February 2024 and Phase 2 in March 2024. The Plan received DHCS approval on December 4, 2024. • 2024 Network Adequacy Validation (NAV) Audit - DHCS' external auditor, Health Systems Advisory Group (HSAG), conducted a new annual Network Adequacy Validation (NAV) audit	*Jeff Garners asked if these audits are generated through State and/or Federal mandates?* *Mary Lourdes Leone responded they are mandated through the State.*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	of MCPs per CMS requirements. The audit was conducted on June 18, 2024, and the audit was closed on September 30, 2024, noting all items had been accepted. • Compliance with Timely Access and Network Reporting Statutes - The Plan successfully submitted and received approval for compliance with the new Timely Access Regulations. • Measurement Year (MY) 2022 Timely Access Report (TAR) – On May 6, 2024, DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan submitted a response on August 1, 2024. • Measurement Year (MY) 2023 Timely Access Report (TAR) - Results of the 2023 DMHC Timely Access Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Survey (PAHAS) indicated that the Plan met the compliance rate standards for all with the exception of the following: Urgent Care Appointment with a specialist (that requires prior authorization) within 96 hours; and Non-Urgent Care Appointment with a specialist within 15 business days. Health Net issued CAPs to five PPG and 6 Direct Network providers. All CAPs have been closed. New or expanded benefits or programs consist of: • Enhanced Care Management (ECM): On January 1, 2024, the Plan launched the JI POF ECM benefit. The Plan continues to work on improving its JI ECM provider network by and is expected to complete contracts with all remaining providers by July 2025 • Community Supports (CS): The following CS services went live 7/1/24: Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties); and Recuperative Care (Madera County]. Additionally, the Plan updated its CS Final Elections to indicate that the following CS would be going live 1/1/25: Recuperative Care (Kings County); Recuperative Care (Madera County); Short-Term Post-Hospitalization Housing (Madera County); and Sobering Centers (Madera County). • Long-Term Care Phase II Carve-In: The Plan completed the network readiness and policy deliverables on July 7, 2024 for ensuring coverage for ICF/DD and Subacute Care Facilities (Adult and Pediatric). • Adult Expansion: Effective January 1, 2024, DHCS expanded Medi-Cal eligibility to individuals who are 26 through 49 years of age. The Plan worked with providers to maintain member's PCP assignment. Implementation Activities for 2024 DHCS Contract Requirements:		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Hired a Health Equity Officer • Submitted the annual Population Health Management Strategy • Developed a Diversity, Equity, and Inclusion (DEI) training program • Achieved full NCQA Health Plan Accreditation • Carved-in coverage for ICF/DD and Subacute Care facilities • Submitted updated fully-executed MOUs with third-party entities The Key Focus Areas for 2025 consist of: • Senate Bill 923 regarding transgender, gender diverse or intersex cultural competency training program and provider directory requirements. • Senate Bill 225 regarding network adequacy standards and methodology for RY2025. • Assembly Bill 186 regarding Skilled Nursing Facility Workforce Quality Incentive Program. • Applying for NCQA Health Equity. • Development and maintenance of a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. • Submitting Emergency Preparedness and Response Plan (EPRP) deliverables to DHCS. • In 2025, CalViva will once again be audited by DHCS, and will also submit to a DMHC's 18-month follow-up audit on 5/5/2025.		
#12 2025 CalViva Health Member Handbook / Evidence of Coverage **Information** Mary Lourdes Leone, CCO	Mary Lourdes Leone confirmed every year, effective January 1st, CalViva is required to post the new Member Handbook / Evidence of Coverage (EOC) online on the CVH website. The 2025 Member Handbook is up and available on the CVH website. The DHCS is currently in the process of developing the 2026 version which will be effective for next January.		**No Motion**
#13 Announcements / Final Comments from Committee Members and Staff	Maria Arreola shared there were nine promotores in the CHW training. The first health fair of the year was held with three attendees. Norma was nominated for a state award for promotores. Norma shared they are working in the community with the CalAIM program through FindHelp. In January there was a Parkinsons conference via Zoom with 700 in attendance. It was also shared that there is a concern in the community regarding Medi-Cal and non-legal people; they were told nothing has changed or is changing. Mary Lourdes shared that currently there is no		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	need to be concerned. Jeff Nkansah suggested that members with questions or concerns should reach out to their local elected officials. Jeff Garner shared they just opened a new transitional housing program in Hanford. They will also be opening a new apartment complex for affordable housing. KCAO is celebrating their 60th year of service in Kings County. Jeff Nkansah shared the member portal for access to Member ID Cards is very close to go-live on the CVH website. *Chairman Joe Neves left at 1:12 pm* *David Phillips left at 1:12 PM*		
#14 Public Comment	None.		
#15 Adjourn	Meeting adjourned at 1:23 pm.		

NEXT MEETING June 4, 2025, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: June 4, 2025

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

Approval Date: June 4, 2025

Approved By: _____
Joe Neves, Chairman

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
FINANCE COMMITTEE

I. Purpose

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

II. Authority

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

III. Definitions

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

IV. Committee Responsibilities

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

V. Committee Membership:

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

B. Term of Committee Membership

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

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

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

VI. Meetings

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

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

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

VII. Committee Support

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

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** July 17, 2025

David Hodge, MD
Commission Chairperson

Fresno-Kings-Madera Regional Health Authority
Credentialing Subcommittee Charter

I. Purpose:

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

II. Authority:

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

III. Definitions:

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

IV. Committee Focus:

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

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

V. Committee Membership:

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

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

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

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

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

VI. Meetings:

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

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

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

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

VII. Committee Support:

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

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

VIII. Authority

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

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~July 18, 2024~~

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

I. Purpose:

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

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

II. Authority:

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

III. Definitions:

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

IV. Committee Focus:

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

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

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

V. Committee Membership:

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

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

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

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

VI. Meetings:

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

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

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

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

VII. Committee Support:

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

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

VIII. Authority

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

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

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~July 18, 2024~~

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

I. Purpose:

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

II. Authority:

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

III. Definitions:

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

IV. Committee Responsibilities:

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

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

Deleted: <#>Annual Health Education Program Evaluation ¶

13. Population Health Management Assessment Report
14. Population Health Management Segmentation Report
15. Population Health Management Effectiveness Analysis Report
16. Quality Improvement Health Equity Transformation Plan

B. Reviews quarterly reports of Work Plan progress for the programs listed above;
C. Monitors key clinical and service performance indicators for QI, UM, HE and Credentialing/Recredentialing activities (e.g., access & availability, over and under utilization, key UM and case management indicators, behavioral health, population health, appeals and grievances, HEDIS® and CAHPS® measure results, provider satisfaction surveys, disease management and public health programs activities, timeliness standards etc.);
D. Analyze and evaluate the results of QI and Health Equity activities;
E. Monitor effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social drivers of health (SDoH), and community needs and makes ongoing recommendations;
F. Provide oversight and review reports of delegated UM and Credentialing/ Recredentialing functions and collaborative QI functions;
G. Reviews summarized grievance reports for medically related issues and administrative quality concerns;
H. Reviews analysis of potential quality incident reports (developed from grievances/complaints, utilization management, utilization reports suggesting over or under utilization);
I. Oversees and monitors CalViva's participation in the Department of Health Care Services ("DHCS") required Performance Improvement Projects ("PIPs");
J. Approve and oversee conduct of special QI studies as warranted;
I. Brings general medically-related concerns to the attention of the Plan's Operating Administrator (Health Net);
J. Analyze and evaluate the results of the QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Public Policy Committee and Community Advisory Groups.
K. Advises on the conduct of provider and member satisfaction surveys and submits its review to the Commission;
L. Reviews the results of clinical outcome studies, identifies gaps and reports findings to the Commission;
M. Forwards to the Credentialing Sub-Committee and Peer Review Sub-Committee potential quality incidents that might involve the conduct of specific providers and should be further investigated;
N. Receives reports from the Credentialing Sub-Committee and Peer Review Sub-Committee;
O. Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission.
P. Ensure that the Plan follows state, federal, contractual and NCQA requirements for QI, UM, HE and Credentialing.
Q. Ensures member confidentiality is maintained during Committee discussions.

V. Committee Membership:

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

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

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

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

VI. Meetings:

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

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

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

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

VII. Committee Support:

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

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

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

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

IX. Authority

A. Health & Safety Code Sections 1370, 1370.1

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

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:**

Deleted: 3/21/2024

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

I. Purpose:

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

II. Authority:

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

III. Definitions:

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

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

IV. Committee Focus:

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

B. Principal Responsibilities:
   1. Review a quarterly summary report regarding the specific nature and volume of complaints received through the grievance process and how those complaints were resolved.
   2. Make recommendations concerning the structure and operation of the Plan's grievance process including suggestions to assist the Plan in ensuring its' grievance process addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities.

3. Review and evaluate member satisfaction data.
4. Advise on health education and cultural and linguistic service needs through review of a population needs assessment, demographic, linguistic, and cultural information related to the Plan's population to make recommendations regarding:
   4.1. Linguistic needs of populations served and identify any enhancements or alternate formats that Plan materials may need.
   4.2. Policies needed for increasing member access to services where there may be barriers resulting from cultural or linguistic factors.
   4.3. Changes needed to the provider network to accommodate cultural, linguistic, or other ethnic preferences.
   4.4. Improvement opportunities addressing member health status and behaviors, member health education, health equity, social determinants of health ("SDoH"), and gaps in services.

5. Advise on problems related to the availability and accessibility of services.
   5.1. Review data/other Plan information and make recommendations for policy or Plan/provider network changes needed related to Americans with Disabilities Act (ADA) requirements or to minimize barriers and increase access for members with disabilities (e.g., identifying potential outreach activities, etc.).
6. Review member literature and other plan materials sent to members and advise on the effectiveness of the presentation.
7. Make recommendations or suggestions for member outreach activities, topics or articles/information for publication on the member website, in member education materials or newsletters, etc.
8. Recommend review/revision and/or development of policies and procedures to the RHA Commission or other Plan committees as appropriate based on the Committee's review of grievance, member satisfaction, and other Plan data.
9. Review financial information pertinent to developing the public policy of the Plan.
10. Review and provide input in annual reviews and updates to relevant policies and procedures affecting quality and Health Equity. CalViva health will provide a feedback loop to inform PPC members how their input has been incorporated.
11. Other matters pertinent to developing the public policy of the Plan.

V. Committee Membership:

A. Composition

1. The RHA Commission Chairperson shall appoint the members of the PPC selection committee. CalViva Health will make a good faith effort to ensure that the PPC selection committee is comprised of a representative sample of each of the persons mentioned below to bring different perspectives, ideas, and views to the PPC:

    1.1. Persons who sit on the PPC selection committee are a representative sample of RHA Commission members from the following stakeholder areas: Safety Net Providers including FQHCs, behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community based service Providers; and
    1.2. Persons and community based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

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

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

    3.4. Two (2) Community Based Organizations (CBO) representatives shall be appointed as alternate PPC members to attend and participate in meetings of the Committee in the event of a vacancy or absence of any of the members appointed as provided in subsection 3.1 above.
        3.4.1. The alternates shall represent different Community Based Organizations (CBO) that serve Fresno, Kings, and/or Madera Counties and provide

community service or support services to members entitled to health care services from the Plan.

3.4.2 Two (2) alternates from the same CBO shall not be appointed to serve concurrent terms.

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

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

B. Term of Committee Membership

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

C. Vacancies

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

D. Voting

1. All members of the PPC shall have one vote each.

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

VI. Meetings:

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

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

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

C. Notice
   1. At the end of each PPC meeting, the next meeting date will be determined by consensus unless a pre-arranged schedule has been established.

2. Committee members will be notified in writing in advance of the next scheduled meeting.

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

VII. Committee Support:

A. PPC Coordinator

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

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

7.2. To arrange for interpreter services for PPC members the PPC Coordinator is responsible for partnering with Health Equity to contact and request interpreter services.

VIII. Other Requirements:

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

IX. Authority:

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

APPROVAL:

RHA Commission Chairperson	David S. Hodge	**Date**: 9/19/24
	David Hodge, MD	

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of DHCS Filings													
Administrative/ Operational	35	23	25	26	21	15	2						147
Member Materials Filed for Approval;	5	2	5	1	5	7	0						25
Provider Materials Reviewed & Distributed	11	13	12	12	8	16	17						89
# of DMHC Filings	6	9	12	8	13	4	3						55

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	5	4	2	4	4	5							24
High-Risk	0	1	0	0	0	0							1

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of New MC609 Cases Submitted to DHCS	1	0	1	1	1	2							6
# of Cases Open for Investigation (Active Number)	29	28	28	28	30	31							

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 5/8/2025 Compliance Regulatory Report to the Commission, there were three new MC609 filings. One case was a non-participating laboratory with allegations of false representation and billing for services not rendered; One case is regarding a provider who is billing rare CPT codes and does not seem to be using the treatment appropriately and members conditions are not improving; One case is a pain medicine specialist that frequently sends requests for trigger point injections with lack of documentation to prove medical necessity. .

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: Health Education, Marketing, Call Center, Claims/PDR, A&G, Health Equity, Member Rights, Privacy and Security and Provider Network. The following annual audits have been completed since the last Commission report: Behavioral Health (CAP), Credentialing (CAP), Quality Improvement (No CAP)
Regulatory Reviews/Audits and CAPS:	**Status**
Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	The Plan is on track to complete its stated corrective actions and will provide its next and final monthly update by 7/21/25.
Department of Health Care Services ("DHCS") 2024 Medical Audit	The Plan responded to all outstanding inquiries, and on May 14, 2025, the Department of Health Care Services (DHCS) formally closed the Corrective Action Plan (CAP).
Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit	The DMHC conducted the Follow-Up Audit on May 5, 2025. As it has been two months since the DMHC requested any additional information, we are awaiting the DMHC's Final Audit Report. The previous finding related to "Inappropriately denying post-stabilization care" is the primary concern for which the DMHC must determine if the Plan had corrected it by the time of the 5/5/25 Follow-Up Audit .
Department of Health Care Services ("DHCS") 2025 Medical Audit	The 2025 DHCS Audit was conducted virtually from 6/2/2025-6/13/2025. The Plan submitted all required pre-audit documentation and follow-up requests. The DHCS indicated it would provide a Preliminary Final Report in September 2025 with a Final Report by 10/1/25.

2025 Network Adequacy Validation (NAV) Audit	On May 28, 2025, the Plan received the 2025 NAV Audit request from the Department of Health Care Services (DHCS). The virtual audit review is scheduled for August 21, 2025. In preparation, the Plan will be submitting the required pre-audit documentation by 7/17/25.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOUs which have also been posted to CalViva's website: • Amendment to DMC State Plan MOU Kings County
Annual Network Certifications	➢ 2024 Subnetwork Certification (SNC) Landscape Analysis – On 1/3/2025, the Plan submitted the 2024 SNC deliverable. Within the submission, the Plan reported that CalViva issued Corrective Action Plans (CAPs) to certain providers due to network adequacy deficiencies. As a result, DHCS has requested that the Plan submit quarterly updates on the status of these CAPs until they are fully resolved.. The most recent quarterly update was submitted on 7/1/2025. ➢ 2024 Annual Network Certification (ANC) - The Plan submitted the 2024 ANC on 3/17/2025. DHCS sent a follow up request, and the Plan responded on 5/29/2025.
(RY)2024 (MY)2023 Timely Access and Annual Network Submission (TAR)	➢ On April 18, 2025, the Department of Managed Health Care (DMHC) issued a Network Findings Report. The findings related to Geographic Access to PCPs and Hospitals, and Provider Data Accuracy. The Plan is preparing a formal response which will be submitted by the July 17, 2025 deadline.
(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR)	➢ On 5/1/2025 the Plan submitted its Annual TAR filing to DMHC. The Plan is awaiting a response.
Plan Administration:	**Status**
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2025.
Committee Report:	**Status**
Public Policy Committee (PPC)	The Public Policy Committee met on June 4, 2025. The following reports were presented: • 2024 Health Education EOY Summary Work Plan Evaluation • 2025 Health Education Work Plan • 2024 Health Equity EOY Summary and Work Plan Evaluation • 2024 Language Assistance Program EOY Work Plan Evaluation • 2025 Health Equity Program Description • 2025 Health Equity Work Plan

	The next PPC meeting will be held on September 3, 2025, 11:30am -1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave #109, Fresno 93711.

APPENDIX A

2025 DHCS All Plan Letters:

- APL 25-002 SNF WQIP
- APL 25-004 Community Reinvestment Requirements
- APL 25-005 Threshold Languages
- APL 25-006 Timely Access Rquirements
- APL 25-007 Enforcement Actions
- APL 25-008 Hospice Services
- APL 25-009 CACs
- APL 25-010 Adult & Youth Screening & Transition of Care Tools
- APL 25-011 HOUSE RESOLUTION (H.R.) 1 – FEDERAL PAYMENTS TO PROHIBITED ENTITIES

2025 DMHC All Plan Letters:

- APL 25-008 Annual Provider Directory Filing
- APL 25-001 Southern California Fires and Enrollees' Continued Access to Health Care Services (1.9.2025).pdf
- APL 25-007 - Assembly Bill 3275 Guidance (Claim Reimbursement) (4.1.2025).pdf
- APL 25-009 – 2025 Health Plan Annual Assessments (4.15.2025).pdf
- APL 25-011 - Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP).pdf
- APL 25-012 - Closure of Rite Aid Pharmacies (6.9.2025).pdf

Item #4

CLOSED SESSION

Item #5
Attachment 5.A

Public Disclosure
Health Net Community
Solutions Contract

BL 25-008

Jeffrey Nkansah
Chief Executive Officer

7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: July 17, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Public Disclosure: July 1, 2025 Health Net Community Solutions Contract

BL #: **25-008**
Agenda Item **5**
Attachment **5.A**

BACKGROUND:

The RHA Commission met in closed session with regards to the following agenda item Conference Report Involving Trade Secret—Discussion of service, program or facility, Estimated Date of Public Disclosure: July 1, 2025 on the following days:

- September 19, 2024
- January 16, 2025
- May 15, 2025
- July 17, 2025

INFORMATION:

This letter is a public disclosure of a Fresno-Kings-Madera Regional Health Authority ("RHA") dba CalViva Health and Health Net Community Solutions, Inc. ("Health Net") contract(s) with an effective date of July 1, 2025.

In accordance with RHA policy and procedure *AD-102 Contract Authority* in part**,** the RHA CEO, or designee is authorized to negotiate, amend, execute and terminate contracts on behalf of the Commission as follows:

- Administrative Services Agreements and Amendments with Health Net Community Solutions, Inc. with financial terms approved by the RHA Finance Committee

- Capitated Provider Services Agreements and Amendments with Health Net Community Solutions, Inc. with financial terms approved by the RHA Finance Committee

A ***modernized*** Administrative Services Agreement and Capitated Provider Services Agreement has been agreed to by RHA and Health Net with the intent to execute with an effective date of July 1, 2025 upon gaining regulatory approval of the new ***modernized*** agreement(s).

The new ***modernized*** Administrative Services Agreement and Capitated Provider Services Agreement agreed to by RHA and Health Net encompass the following guiding principles:

- The financial terms have not changed. The terms remains the same in the new ***modernized*** agreement(s) as previously approved by the RHA Finance Committee.

- There is no "first right of refusal" language in the new ***modernized*** agreement(s) as per the current agreement(s) and as previously preferred by the RHA Commission.

- The new ***modernized*** agreement(s) still continue to adhere to an initial term, automatic renewal terms, and either party still has a right to exercise the terminate without cause language in the contract(s).

- Legal references have been reviewed and if applicable updated in the new ***modernized*** agreement(s).

- Definitions have been reviewed and if applicable updated, removed, or added in the new ***modernized*** agreement(s).

- References to operational business processes have been reviewed and if applicable updated to align with current business operational practices in the new ***modernized*** agreement(s).

- Performance Standards remain in the new ***modernized*** agreement(s).

- Medi-Cal Benefit Program terminology were reviewed as a result of the new California Department of Health Care Services ("DHCS") contract. Where applicable, updates were made in the new ***modernized*** agreement(s).

NEXT STEPS:

Obtain regulatory approval of the new ***modernized*** Administrative Services Agreement and Capitated Provider Services Agreement from the DHCS and the California Department of Managed Health Care ("DMHC") and execute the new ***modernized*** Administrative Service and Capitated Provider Services Agreement(s) with Health Net with an effective date of July 1, 2025.

Item #6.A-B

Community Support &
Community Reinvestment
Policy and Procedure

6.A BL 25-009 AD-103 Community Support Community Reinvestment Policy

6.B AD-103 Requirements for RHA Funding of Community Support & Community Reinvestment Programs Policy

Jeffrey Nkansah
Chief Executive Officer

7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: July 17, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Revised AD-103 Requirements for RHA Funding of Community Support and Community Reinvestment Programs

BL #: **25-009**
Agenda Item **6**
Attachment **6.A**

In February 2025, the Commission discussed the new DHCS Community Reinvestment contractual requirements and DHCS All Plan Letter 25-004 and how the changes would impact the Plan's Community Support Policy and Procedure. A redline of the policy and procedure AD-103 was presented to Commission on February 20, 2025.

The Commission was advised on February 20, 2025 that the revised RHA Commission Policy and Procedure AD-103 would be submitted to DHCS for review and approval. If DHCS requested additional changes the policy will be brought back to the RHA Commission for approval.

The DHCS did not request any changes to the RHA Policy and Procedure which impact how the Plan intends to operationalize the RHA Community Support Program and/or the DHCS Community Reinvestment Program. The DHCS requested technical changes to insert certain aspect of the requirements of the All Plan Letter into the policy and procedure as opposed to Plan's preference to refer to the All Plan Letter. Those changes can be found in redline on the following pages:

- Page(s): 1, 2, 3, 5, 6, and 7

RECOMMENDED ACTION:

2. Approve the revised policy and procedure

POLICIES AND PROCEDURES	**Title**: Requirements for RHA Funding of Community Support & Community Reinvestment Programs
	Procedure #: AD-103
	Page: 1 of 10
Department: Administration	**Effective Date**: 6/1/2017
Region: Fresno, Kings, Madera	**Last Review and/or Revision Dates**: ~~2/20/2025~~July 17, 2025
	LOB: Medi-Cal Managed Care

I. Purpose

A. The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (the "Plan" or "CalViva") Commission has established a process to review and consider funding for project initiative/program requests per CalViva fiscal year (July 1 through June 30) in a consistent, organized and fair manner.

B. This policy also includes the processes and guidelines to fulfill the Plan's contractual requirement to reinvest a minimum level of its net income ("base community reinvestment") into its local communities and an additional investment if it does not meet quality outcome metrics ("quality achievement community reinvestment") for the applicable DHCS identified calendar year, starting with DHCS identified calendar year 2024 contract revenues.

II. Policy

A. CalViva Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability. Review and consideration of funding requests will be performed in compliance with federal and state laws.

B. Community support project initiative(s)/program(s), DHCS community reinvestments, and/or provider network expansion funding will be within the annual budget limits approved by the Commission.

C. All requests for funding must be submitted in writing a minimum of 90 days prior to the anticipated initial funding date.

D. DHCS contractual community reinvestment activities will be conducted in accordance with this Plan policy and procedure and any applicable contractual and/or DHCS All Plan Letter ("APL") community reinvestment requirements (i.e. DHCS APL 25-004).

Any required implementation plan, reporting, etc. will adhere to those aforementioned requirements. Community Reinvestment planning will start in calendar year (CY) 2025, with Community Reinvestment activities starting in CY 2026. The Plan and qualifying subcontractors will ensure all DHCS community reinvestment plans align with overall health equity needs and priorities and coordinate with other Medi-Cal Managed Care Plans operating in the same county to engage local health jurisdictions during the community reinvestment planning process. Investments in community reinvestment activities will occur by no later than the close of the calendar year in which DHCS approves the community reinvestment plan for the applicable investment period and all community reinvestment obligations will be completed by the end of the three-year period.

1. If applicable (i.e. the Plan has a positive net income), the Plan will be required to invest into initiatives that serve the communities in which the Plan operates, starting with net income based on CY 2024 contract revenues for Community Reinvestment activities initiated in CY 2026, unless the Plan and its qualifying subcontractor do not have a positive net income for the applicable CY. The required investment amount would be provided by DHCS to the Plan and confirmed as mutually accurate by the Plan and DHCS.

    1.1. The Plan will allocate a base community reinvestment amount equal to 5% of the Plan's annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues for the year; and 7.5% of the Plan's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues for the year.

    1.2. A quality achievement community reinvestment will be required of the Plan if the Plan serves a county which has been assigned to an enforcement tier 2 or tier 3 as it pertains to its quality performance. If this occurs 100% of the reinvestment must go towards investments in the "cultivating improved health category". If applicable, the Plan will allocate additional funds equal to 7.5% of its annual net income. The required investment amount would be provided by DHCS to the Plan and confirmed as mutually accurate by the Plan and DHCS.

2. If applicable, the Plan will also notify and ensure any qualifying subcontractors as defined in DHCS APL 25-004 also fulfill their obligation to make a base community reinvestment in accordance with the applicable contractual and/or DHCS All Plan Letter community reinvestment requirements (i.e. DHCS APL 25-004). The quality achievement community reinvestment requirement does not apply to qualifying subcontractors and the qualifying subcontractor is permitted, but not required, to transfer their obligation amount to the Plan to administer their reinvestments on their behalf in accordance with requirements.

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2.1. Qualifying subcontractors will allocate base community reinvestment funds equal to 5% of the qualifying subcontractors annual net income that is less than or equal to 7.5% of revenues under its subcontractor agreement with the Plan for the year; and 7.5% of the qualifying subcontractors annual net income that is greater than 7.5% of revenues under its subcontractor agreement with the Plan for the year. The required investment amount would be provided by DHCS to the Plan and confirmed as mutually accurate by the Plan, DHCS, and qualifying subcontractor within 7 calendar days of notice from DHCS.

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III. Definitions

A. **Commission** - the 17-member Commission appointed according to the provisions of the Joint Exercise of Powers Agreement under which the Fresno-Kings-Madera Regional Health Authority "(RHA") dba CalViva Health is governed.

B. **Fresno-Kings-Madera Regional Health Authority (RHA)** – the multi-county health authority established through a Joint Exercise of Powers Agreement between the counties of Fresno, Kings, and Madera to provide services to eligible Medi-Cal beneficiaries within the jurisdiction of the counties.

C. **Ad-Hoc Funding Review Committee** – An Ad-Hoc committee appointed by the Commission to review budgeted recommendations and / or funding requests in excess of $25,000. The Ad-Hoc Committee will include a minimum of three (3) Commissioners, the Chief Executive Officer, Chief Financial Officer, and Equity Officer.

IV. Procedure

A. **Requirements for Community Supports Project Initiatives/Programs**

1. Requesting organization(s) must submit a completed application for Provider Infrastructure Grants, or a formal written request for Community Support Funding and any applicable supporting documentation for review.

2. The requesting organization if requested by CalViva Health, must indemnify CalViva Health for any claims or legal action related to the funded project initiative/program. The indemnification document will be provided by the Plan's legal counsel and executed prior to the initial funding date.

3. The Ad-Hoc Funding Review Committee will review budgeted recommendations and evaluate any funding requests in excess of $25,000 and make a recommendation to the Commission. The review and evaluation will include but not be limited to consideration of the following criteria:
   - 3.1. CalViva Health Mission and Principles
   - 3.2. Provider access impact
   - 3.3. Benefit to Plan members
   - 3.4. Improve Quality of Care
   - 3.5. Impact on current CalViva Health budgeted funds available
   - 3.6 Information from Plan staff research and input

4. Upon completion of the review, the Ad-Hoc Funding Review Committee will prepare a recommendation for the Commission. The recommendation will include at a minimum:
   - 4.1. The recommended total amount to be funded
   - 4.2. The length of time for funding and any incremental time periods for the funding payments
   - 4.3. Any conditions or other qualifications imposed on the funding

5. The Commission will review the funding requests and approve/deny/modify the recommendation and identify any specific conditions or other qualifications that must be met by the requesting organization.
   - 5.1. Subsequent to the Commission decision, the requesting organization will be notified of the decision in writing and, if approved, informed of any specific conditions/requirements and other instructions.

6. Funded project initiatives/programs and organizations must submit paid invoices, if required, and provide periodic (e.g. semi-annual, annual, etc.) reports to the Commission that include use of funds and progress toward stated goals. The frequency of reporting will be determined by the Plan based on the type of project initiative/program funded.
   - 6.1. Failure to submit required invoices and/or quarterly reports may result in the Commission making a decision to cease funding.
   - 6.2. Unsatisfactory periodic reports may also result in the Commission making a decision to cease funding.

B. **Additional Requirements for DHCS Community Reinvestment Activities**

1. Any funded DHCS community reinvestment activities shall include the requirements mentioned in Procedure, Section IV, A, 1-6 above and the following guiding principles:

   - 1.1. Health Outcomes and Equity – The Plan's Equity Officer will help inform community reinvestment activities. Investments will be targeted toward reducing existing health disparities and/or promoting improved health

outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers in access to health and social services and environments that negatively impact health.

1.2. Engage with the Community – The Plan's community advisory committee (i.e., Public Policy Committee) will be consulted. This consultation shall include but is not limited to soliciting recommendations and validating community reinvestment plans are adequately targeted towards the needs of the community. ~~and f~~Funded activities will be directly informed by Community Health Assessment(s), Local Health Jurisdiction(s), and County Behavioral Health.

1.3. Target Non-Contract Activities – Funding will be directed toward activities that are not otherwise included in the Plan's Medi-Cal contract or services carved out of the Plan's Medi-Cal contract but covered under Medi-Cal.

2. Any funded DHCS community reinvestment activities will fit within the following five DHCS community reinvestment categories:

2.1. Cultivating neighborhoods and built environment – investments that create neighborhoods and environments that promote health, well-being and safety.

2.2. Cultivating a health care workforce – investments that build the next generation of health care workers including, for example, addressing workforce shortages and establishing a health career pipeline for youth and young adults.

2.3. Cultivating well-being for priority populations – investments that address community-specific needs through tailored supports and services not covered under the Plan's Medi-Cal contract to priority populations such as those identified through the CHA / CHIP process or an ECM population of focus (e.g. children and youth receiving foster care, justice involved populations, children and families.)

2.4. Cultivating local communities – investments that bolster the lives of individuals and contribute to the advancement and well-being of a community such as through education initiatives, employment and training programs, programs to eradicate poverty, and initiatives that address social isolation.

2.5. Cultivating improved health – investments targeted toward upstream root causes of poor health that address immediate and long term health-related needs as defined by the community.

3. Any funded DHCS community reinvestment activities will be identified within the Plan's community reinvestment plan (initial, starting in early Q3 calendar year 2026 and/or subsequent, annually thereafter from the initial):

    3.1. The community reinvestment plan(s) and report(s) will be submitted to DHCS in accordance with any applicable templates for review and approval and include all of the details required in accordance with applicable contractual and/or DHCS All Plan Letter Community Reinvestment requirements (i.e. DHCS APL 25-004). The proposed community reinvestment activities will be identified separately for the Plan and if applicable, its qualifying subcontractors, by county served, based on net income for the applicable CY and will also include but is not limited to~~.~~:

        3.1.1. Description of activities and their use category or categories
        3.1.2. Description of how activity is informed by LHJ/CHA process
        3.1.3. Identification of LHJ/CHIP activity that activity matches
        3.1.4. Description of activity identified through the BHT planning
        3.1.5. Description of anticipated benefits
        3.1.6. Description of approach to engage the Plan's PPC
        3.1.7. Description of approach to engage other stakeholders
        3.1.8. Description of any investments recommended by Plan's PPC but not included in the Plan
        3.1.9. Summary input by the Plan's Equity Officer and the Plan's QI/UM committee if applicable
        3.1.10. The expected dollar amount allocated
        3.1.11. The expected populations that will benefit from or participate
        3.1.12. Description of how activities will be measured and evaluated
        3.1.13. Signed attestation from local Public Health and County Behavioral Health Directors.
        3.1.14. Signed letters from the Plan's community advisory committee (i.e., PPC) which includes the degree to which the Plan engaged these stakeholders in the community reinvestment planning efforts and the feedback obtained regarding the reinvestment activities
        3.1.15. Listing separately the Plan's and qualifying subcontractors activities.
        3.1.16. The actual dollar amount spent on each activity and by county
        3.1.17. Description of activity by category and county
        3.1.18. Description of how activity aligns with guiding principles and designated categories
        3.1.19. Description of outcomes including any data and qualitative description of benefits to Members and the communities in which they reside

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3.2. The DHCS-approved community reinvestment plan(s) and community investment report(s) will be posted on the Plan's website. The community reinvestment report(s) will appear on the Plan's website in Q2 CY 2030 and every three years thereafter.

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3.3. Each community reinvestment plan(s) within the investment period will either indicate the allocation of additional investments for each activity documented in the initial plan for funding obligations and/or propose funding allocations for any new/revised activities for the applicable calendar year that meet all applicable contractual and/or DHCS All Plan Letter Community Reinvestment requirements.

3.4. Each community reinvestment plan(s) within the three-year investment period at a minimum will include the expected dollar amount for each community reinvestment activity in the initial community reinvestment plan approved by DHCS based on funding obligations for the applicable calendar year.

4. Any Community Reinvestment obligations will not be met through expenditures for:

4.1. Provision of health care services to eligible members within the scope of Medi-Cal benefits or state-funded services as defined in the Plan's primary or secondary operations contracts, inclusive of all exhibits and attachments.

4.2. Provision of health care services to eligible Members within the scope of Medi-Cal benefits or state funded services that are carved out of the primary or secondary operations contracts.

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4.3. Health care services inclusive of activities that improve health care quality, as defined at Title 42 Code of Federal Regulations ("CFR") section 438.8(e)(3).

4.4. Administrative activities of the Plan including member incentives and/or grants or any procedural or administrative activities related to Community Reinvestment planning or implementation, or member incentives and/or grants.

C. **Additional Requirements for Provider Network Expansion Funding**

1. The Plan will work with contracted network participating provider groups ("PPGs") or other contracted organizations to promote increased provider capacity

and access by providing funds for initial costs related to recruitment of new providers to the Plan's network.

2. Funding available for recruitment of primary care physicians ("PCP"), mid-level and specialist subsidies will be determined on an annual basis as part of the annual budget planning for the Plan's upcoming fiscal year. The Commission reviews and approves the annual budget.
   2.1. Depending on the budget, provider network needs and Plan goals, the subsidies may only be available for PCP recruitment and/or mid-level recruitment and/or specialist recruitment in any given year.
   2.2. Subsidies will identify the specific cost elements to be covered and a defined percentage and maximum of the total costs of the recruited individual.

3. Interested PPGs/organizations currently contracted in the Plan's provider network must submit an application and any applicable supporting documentation for review by the designated Ad-Hoc Committee.

4. The Ad-Hoc Funding Review Committee will review and evaluate the provider network expansion funding requests and make a recommendation to the Commission. The review and evaluation will include but not be limited to consideration of the following criteria:
   4.1. CalViva Health Mission and Principles
   4.2. Provider access impact
   4.3. Benefit to Plan members
   4.4. Quality of Care
   4.5. Impact on current CalViva Health budgeted funds available
   4.6 Information from Plan staff research and input
   4.7. The contracted entity's relationship with the Plan, track record and stability
   4.8 Geographic region (need for PCPs, mid-levels, specialists)
   4.9. Type of PCP (Family Practice, Internal Medicine, Pediatrics) or specialist
   4.10. Practice Setting - organized clinic, small group, etc.
   4.11. Number of provider positions subsidies are being requested for

5. Once approved for the subsidy funding, the requesting PPG/organization must meet the following requirements:
   5.1. Physicians must have an unrestricted California license and be actively Board Certified in the appropriate medical specialty. Mid-levels must have unrestricted California licensure or certification as applicable.
   5.2. Physicians must have an EMR/EHR or be in the process of implementing an EMR/EHR and cooperate with the Plan in providing access to transmission of data to and from the Plan for CalViva Health members.
   5.3. Physician must be open to the Plan's Medi-Cal business, with no member limit for a minimum of eighteen months.

5.4. Physician must be new to the Plan and preference is to be new to the Fresno, Kings and Madera counties medical community.

5.5. The contracting or employment entity will have to pay a pro-rated amount back to the Plan if the provider leaves the practice before two full years of participation.

6. Exceptions can be made to selection criteria and/or requirements if clinical needs outweigh either the criteria or requirements.

7. If the contracted PPG/organization is unable to hire the provider within 6 months from the signing of the agreement with the Plan; then the funding opportunity may be withdrawn and an alternate site, entity and physician type may be selected.

8. The Plan reserves the right to unilaterally withdraw the funding opportunity at any point in the process

V. Authority

A. RHA Joint Powers of Authority and Bylaws
B. DHCS Community Reinvestment Contractual and APL Requirements (25-004)

VI. References

A. None

APPROVAL:

Officer/Committee Chair Person David S. Hodge **Date:** ~~February 20, 2025~~July 17, 2025

Name: David S. Hodge, MD
Title: Commission Chair

Date	Department	Comment(s)
6/1/2017	Finance	New Policy
5/19/2022	Administration	This policy replaces in its entirety the previous policy approved by the Commission. Policy was updated to change departments from Finance to Administration. Edits were made to reflect current operational practices for the Community Support Programs.

2/20/2025	Administration	Policy was updated to address the new 2024 DHCS Contractual Requirements surrounding Community Reinvestments and DHCS All Plan Letter 25-004
7/17/2025	Administration	Policy was updated again to address the requirements requested by DHCS due to a Review Tool which was released by DHCS on March 4, 2025 related to APL 25-004.

Item #7

Attachment 7.A

Review of Fiscal Year End 2025 Goals

BL 25-010 Review of Fiscal Year End Goals 2025

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

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

DATE: July 17, 2025
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Review of Goals and Objectives for Fiscal Year End 2025
BL #: 25-010
Agenda Item 7
Attachment 7.A

DISCUSSION:

Category:	Goal:	Results/Review
Market Share	Maintain market share	Market Share is approximately 66% and has remained the same from the prior Fiscal Year.
Medical Management / Quality Improvement	Continue the work on both PIPS: (1) Clinical-- African America/Black Well Child Visits in Fresno County and (2) Nonclinical-- Follow up after ED visit for substance use disorder (SUD)/mental health (MH) issue in Fresno and Madera Counties. Also begin work on three other QI Health Equity projects using the LEAN Methodology: (1) Madera County initiate a LEAN project to improve follow up after ED visit for SUD or MH issue, Behavioral Health Domain with an emphasis on the Hispanic population. (2) Kings County initiate a LEAN project to improve provider reconciliation /gap closures for Children's Well Care Domain measures with emphasis on the Hispanic population. (3) Fresno County initiate a Comprehensive project to improve compliance with Children's Health Domain measures (Well Child Visits, Immunizations and Lead Screening). In addition, a special Health Equity based QI project has been initiated in collaboration with the Institute for Healthcare Improvement (IHI) and sponsored by DHCS to improve Children's Well Care Visit compliance. An FQHC in Fresno County has been selected for this effort which continues through the end of March 2025.	Both PIPs have completed the planning phase and data gathering is underway: 1) Black Infant Health supported infant well child visits and use of the CDC Milestone Tracker App are monitored as evidence of outcomes. 2)Follow up after ED visit for Substance Use Disorder or Mental Health tracked by use of EMR "Smart Phrases" as evidence of provider assessment and referral after ED visits. The Madera County LEAN project was continued for Follow Up after ED visit for Substance Use Disorder or Mental Health using Community Health Workers as provider to link to services. The Kings County LEAN project has been updated to Comprehensive project by including the Chronic domain HEDIS® measure AMR (Asthma Medication Ratio). Work continues on the Childhood Domain. Fresno County Comprehensive project has now expanded to a Transformational framework which includes not only Childhood and Behavioral Health domains but also Chronic Domain with AMR. Additionally DHCS has required a collaborative effort by both CalViva and Anthem to address improvement in at least one of the domains – Childhood. The planning phase and data gathering for that project has been initiated. For the Health Equity IHI Collaborative we have successfully completed the initial 5 Interventions to improve Well Child Visits for Hispanic children 0-15 months with a selected FQHC. The second phase will begin in late August to include collaboration with Community Based Organizations –WIC and Centro La Familia.
Funding of Community Support Program	Administer the Community Investment Funding Program	10 Provider recruitment grants awarded.

Continued on page 2

Category:	Goal:	Results/Review
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirement and meet the DHCS TNE requirement of at least 1 month's contract revenues based on CalViva's average monthly contract revenues for the previous twelve months.	CalViva has met the DMHC TNE requirement. CalViva did not meet the DHCS reserve standard as we were approximately $7.7M short. However, we are continuing to make progress towards meeting the DHCS reserve standard.
Direct Contracting	Maintain current direct contracts to align with TNE requirements.	Maintained current direct contracts. TNE requirements have been met and presently there is no longer a need for this to be an ongoing Fiscal Year goal, therefore, this is being removed as a Category and Goal for Fiscal Year 2026.
Community Outreach	Continue to participate in local community initiatives.	Participated in Cradle to Career, See 2 Succeed Vision Program, The Children's Movement of Fresno (TCM Fresno), Back 2 School Backpack event, Reading Heart Advisory Group, Coalition for Digital Health, and 150+ CBO Sponsorships.
State and Federal Advocacy	Continue to advocate Local Initiative Plan interest.	Continued as a Local Health Plan Association and Mid State MGMA Board Member.
Health Plan Accreditation	Maintain activities to have NCQA Health Plan Accreditation by 2025 and NCQA Health Equity Accreditation by 2026.	CalViva Health is NCQA Health Plan and NCQA Health Equity Accredited as of June 30, 2025.
Diversity, Equity, and Inclusion	Promote diversity in recruiting and hiring. Implement activities to identify opportunities to improve around Diversity, Equity and Inclusion. Offer mandatory annual Diversity, Equity, and Inclusion training to employees which will include cultural competency, bias and/or inclusion.	Diversity, Equity, Inclusion training was completed 11/1/2024 for all staff. DEI training was also approved by DHCS. DEI survey was distributed to Staff, leadership, Board and Committee members to identify potential Equity opportunities. The identified CVH internal opportunities include room setting changes during staff meetings and implementation of Cultural potluck. Equity projects include Perimenopause/ menopause study/workgroup in Kings County Network Improvement Committee with Fresno County Superintendent schools WIC Pilot, Mobile health clinics, Live Well Madera Diabetes and heart disease work group.

Item #8

Attachment 8.A

Fiscal Year 2026 Goals & Objectives

BL 25-011 Goals and Objectives FY 2026

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

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

DATE: July 17, 2025
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Goals and Objectives for Fiscal Year 2026
BL #: BL 25-010
Agenda Item: 8
Attachment: 8.A

DISCUSSION:

Category:	**Goal:**
Market Share	Maintain market share
Medical Management / Quality Improvement	Continue the work on both Performance Improvement Project (PIPS): (1) Clinical-- African America/Black Well Child Visits in Fresno County and (2) Nonclinical-- Follow up after ED visit for substance use disorder (SUD)/mental health (MH) issue in Fresno and Madera Counties. Successfully complete the Madera LEAN project and DHCS submissions for Follow Up after ED Visits for Substance Use Disorder or Mental Health issue in Madera County. Successfully complete the Kings County Comprehensive project and DHCS submissions for the Chronic Domain-Asthma Medication Ratio (AMR) and the Childhood Domain- All eight (8) MCAS Childhood & Adolescent measures. Successfully complete the Fresno County Transformational Project and DHCS submissions in Collaboration with Anthem Blue Cross for the Childhood Domain (Six (6) of eight (8) Childhood & Adolescent measures) working with a large FQHC. Also complete the Asthma Medication Ratio (AMR) Project from the Chronic Domain. Complete the IHI Health Equity project in Fresno County working with an FQHC and CBOs for Childhood Domain (Well Child visits). Complete the IHI Behavioral Health project in Fresno County working with Fresno County Behavioral Health and Anthem Blue Cross on the Behavioral Health Domain to improve follow up after an ED Visit for SUD/MH issues
Funding of Community Support Program	Administer the Community Investment Funding Program
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirement and meet the DHCS reserve standard of at least one month's contract revenues based on CalViva's average monthly contract revenues for the previous twelve months.
Community Outreach	Continue to participate in local community initiatives.
State and Federal Advocacy	Continue to advocate Local Initiative Plan Interest
Health Plan Accreditation	Maintain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation Certifications
Diversity, Equity, and Inclusion	Continue to monitor various ongoing Equity projects and identify any new opportunities to improve around Diversity, Equity, and Inclusion. Continue to monitor changes in member population health gaps and disparities to keep DEI annual training up to date with trends. Offer DEI training as per DHCS and NCQA requirement. Take part in QIUM meetings and assist/ add input with quality as it relates to Health Equity and ensure that Health Equity reports meet DHCS and NCQA standards. Complete HN internal annual Audit.

Item #9
Attachment 9.A-B

CYBHI MOU CBH-MCP Interim Model 04032025

9.A BL 25-012 CYBHI Carelon Behavioral Health MOU

9.B California Children and Youth Behavioral Health Initiative Network Support, Claims, Claims Processing and Payment Remittance MOU.

Jeffrey Nkansah
Chief Executive Officer

7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: July 17, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

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

BL #: **25-012**
Agenda Item **9**
Attachment **9.A**

BACKGROUND:

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

The California Department of Health Care Services ("DHCS") has contracted ("DHCS Agreement #23-30348") with Carelon Behavioral Health ("CBH") to manage certain implementation components of the statewide, multi-payer, school-linked fee schedule ("CYBHI Fee Schedule") and support DHCS and participating entities with the management of the school-linked statewide provider network of behavioral health practitioners, which is comprised of local education agencies (LEAs), county offices of education (COEs), public institutions of higher education (IHEs), and community-based individual, group and organizational providers designated in-network by LEAs, COEs, or IHEs (collectively, "Providers").

As a "Participating Entity", DHCS requires Fresno-Kings-Madera Regional Health Authority dba CalViva Health a Medi-Cal Managed Care Plan, to coordinate components of the program under the terms specified in this MOU. Additionally, CalViva Health will fund CYBHI Fee Schedule program claims for eligible services furnished by Providers to enrolled members of CalViva Health. The MOU must be signed "as is" as the Regulators, which include DHCS and the California Department of Managed Health Care ("DMHC"), are not accepting any redlines.

RECOMMENDED ACTION:

1. The CEO and RHA Outside Counsel agree the CEO's ability to execute MOUs are limited to local and state agencies that provide services as described in the DHCS Medi-Cal Agreement. CBH is not a local and/or state agency, therefore approval of the RHA Commission is needed to execute the California Children and Youth Behavioral Health Initiative Network Support, Claims Processing and Payment Remittance Memorandum of Understanding as presented to the RHA Commission on July 17, 2025.

CALIFORNIA CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

NETWORK SUPPORT, CLAIMS PROCESSING AND PAYMENT REMITTANCE

MEMORANDUM OF UNDERSTANDING

This Children and Youth Behavioral Health Initiative (CYBHI) Network Support, Claims Processing and Payment Remittance Memorandum of Understanding ("***MOU***") is made and entered into by and between **CalViva Health**, a **Knox-Keene licensed Managed Health Care Plan** pursuant to the laws of the State of California, as amended ("***Participating Entity***"), and Carelon Behavioral Health, Inc., a Virginia Corporation ("***CBH***") to be effective as of **May 1, 2025** (the Effective Date) and services shall commence on the Commencement Date in section 7.1 of this MOU. Participating Entity and CBH may be referred to herein individually as a "***party***" or collectively as the "***parties***".

RECITALS

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

WHEREAS, the parties will implement the CYBHI Fee Schedule program in two phases 1) Interim Clean Claims Payment Model and 2) ASO Payment Model;

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

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

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

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

ARTICLE 1: DEFINITIONS

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

1.1 AAA is the American Arbitration Association.

1.2 ASO Payment Model means the model that includes the eligibility and encounter file exchanges, as well as some components of the Interim Clean Claim Payment Model as directed by DHCS.

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

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

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

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

1.7 Confidential Proprietary Information is any non-public proprietary information of the parties respectively, including without limitation, the terms of this MOU, business plans and processes, customer/Member lists and information, financial records, methodologies, intellectual

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

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

1.9 FERPA means The Family Educational Rights and Privacy Act (FERPA) codified at 20 U.S.C. § 1232g, and the FERPA regulations codified at 34 CFR Part 99.

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

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

1.12 Interim Clean Claim Payment Model means the payment of claims for the CYBHI Fee Schedule Services as described in section 5.2.

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

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

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

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

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

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

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

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

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

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

Article 2: Relationship

2.1 Relationship of Parties. In the performance of their respective roles and responsibilities in the CYBHI Fee Schedule program and the provisions hereunder, the relationship between the parties and their respective employees and agents is that of independent parties entering the

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

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

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

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

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

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

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

2.4 CBH Facilitates Claims Administration and Payment Remittance. The parties acknowledge and agree that per DHCS guidance and requirements, Providers will submit claims to CBH. CBH will review the claims to ensure proper coding. Claims found to contain errors will be returned to the respective Provider for correction. CBH will prepare and send an invoice listing Clean Claims for eligible members to the Participating Entity. Participating Entity will review Clean Claims and send claims payment to CBH. CBH will remit payment for Clean Claims to Providers in a timely manner.

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

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

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

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

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

2.10 Cooperation. During the term of this MOU and subject to any legal or contractual restrictions, the parties agree to reasonably cooperate to address issues associated with claims dates of service.

Article 3: Data Sharing & Ownership

3.1 Data Sharing & Ownership. All information and materials, including computer software, provided by a party to the other party in connection with performance of services, including modifications, changes and derivatives thereto are and shall remain the property of providing party or the providing party's licensors, who shall retain all intellectual property rights therein. The receiving party obtains no right, title, or interest therein, except that receiving party may use the information and materials made available by the providing party for the sole, exclusive

and limited purpose of performing services under this MOU. Each party, respectively, shall comply with the terms of any license or other agreement applicable to the disclosing party. A receiving party shall not encumber a disclosing party's information and materials in any way, and promptly shall return to the materials in the receiving party's possession or control upon the disclosing party's request and in any event upon termination or expiration of this MOU.

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

3.3 Access. Each party: (a) will provide the other with a copy of their respective terms of use and/or security guidelines applicable to any use or access to the party's system or any software/hardware, respectively; and (b) agrees that any of its employees or independent contractors that access the other's systems shall access only information, reports and data applicable to performance under this MOU; and (c) shall follow procedures and guidelines established by the other regarding access to their systems and/or software/hardware. In addition, each party agrees to implement necessary security controls and adhere to and comply with, in all material respects, the other's Security Standards. Each party shall comply with any amended Security Standards of the other party as soon as possible but in no event later than the time period required for compliance indicated in any law, rule, regulation, order, judgment or decree.

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

parties agree to comply with any state or federal laws regarding notice the appropriate state or federal authorities.

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

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

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

Article 4: [reserved]

ARTICLE 5: RESPONSIBILITIES OF EACH PARTY

5.1 Screening Providers. In accordance with the DHCS-approved procedures, CBH shall screen CYBHI Providers ("CYBHI Screening Process") and rescreen CYBHI Providers. CBH will screen and enroll Providers required within sixty (60) calendar days of receipt of the Standard Provider Import ("SPI"). The CYBHI Screening Process for licensed and Pupil Personnel Services ("PPS") providers shall include verification of identity such as name, date of birth, NPI, licenses or PPS credentials issued by the state, as applicable, suspended, excluded and ineligible provider databases, and various sanctions checks. Participating Entity shall accept claims from Providers screened by CBH for the CYBHI program. The CYBHI Screening Process shall include verification of Medi-Cal enrollment, as applicable. Where a CYBHI Provider is not yet Medi-Cal enrolled, such Provider shall have a one hundred and twenty (120) calendar day period to complete the Provider Application and Validation for Enrollment ("PAVE") Medi-Cal enrollment process ("Enrollment Grace Period"). During the Enrollment Grace Period, Participating Entities shall accept and pay claims from Providers. After the Enrollment Grace Period if the Provider is not Medi-Cal enrolled, then Provider shall be disenrolled and CBH shall recoup applicable claims payment from Provider for refund to Participation Entity as appropriate.

5.2 Claims Administration and Payment Remittance. CBH shall process all claims information from Providers for CYBHI Services as directed by DHCS guidance CBH shall submit invoices on a CBH provided layout to Participating Entity for review and applicable fulfillment via sFTP exchange. Such invoices shall include pertinent member, provider and service detail in accordance with Section 5.4. CBH shall reject and return claims which do not qualify as Clean Claims to claims submitter. Such claims shall not be delivered to the Participating Entity. Within

21 calendar days of receipt of invoice, Participating Entity shall send CBH an electronic post-review response file utilizing the provided layout in accordance with Section 5.4 and shall send the financial fulfillment of the invoice to CBH in accordance with Section 5.4, or may reject or deny the invoice if permitted by state and federal law. In accordance with DHCS requirements, CBH shall send remittance of claims to Providers.

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

5.2.1 Interim Clean Claims Payment Model. Until such time as CBH and the Participating Entity jointly complete critical technical onboarding for the Administrative Services Organization (ASO) Payment Model, Participating Entity agrees to the following procedures:

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

5.2.1.2. Participating Entity must verify member eligibility, identify Clean Claims on the invoice sent by CBH that are deemed "payable" and remit payment to CBH within state-specified timelines.

5.2.1.3. Alternately, CBH may verify member eligibility using enrollment data from the Participating Entity once the eligibility file exchange is setup between CBH and the Participating Entity. Upon completion of this exchange, section 5.2.1.2 will become inoperable. Participating Entity may reconcile claims report during audit processes.

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

5.3 ASO Payment Model. CBH and Participating Entity agree to work collaboratively to implement the ASO Payment Model infrastructure during the Interim Clean Claims Payment Model period, as directed by DHCS. Upon full implementation of ASO Payment Model, which includes the execution of an ASO Payment Model MOU, the Interim Clean Claims Payment Model MOU shall no longer be necessary to effectuate payment of Clean Claims.

5.3.1 Within sixty (60) business days of completing ASO implementation, as mutually defined by CBH and Participating Entity, CBH will send Participating Entity a complete encounter data record for all Clean Claims paid during the Interim Clean Claims Payment Model period.

5.4 CBH Reporting to Participating Entity: CBH shall send a weekly claim report file in accordance with Exhibit B and shall include:

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

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

5.5 Claims Validation**.** CBH shall review claims received from Providers and determine that the claim is eligible for payment under the CYBHI Fee Schedule based on DHCS business rules.

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

5.7 Provider Dispute Resolution. CBH will review Provider claims disputes, including but not limited to claims disputes regarding claims that are a) paid at the incorrect rate; b) include an incorrect interest payment; and c) incorrectly denied for no coverage or not a Covered Service.

In accordance with California law, CBH will timely acknowledge receipt of the dispute notice, document the determination and timely share the determination letter with the Provider. CBH will send provide dispute resolution reports to DHCS in accordance with CBH's contract with DHCS.

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

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

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

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

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

5.12 Network Support. CBH shall assist DHCS with Provider network support, Provider inquiry support, Provider relations, and Provider education and communication for the CYBHI program. CBH will work directly with DHCS to support Providers and Participating Entity with Technical Assistance.

5.13 ASO Implementation. Participating Entity and CBH shall timely coordinate activities to implement the ASO infrastructure based on DHCS-approved prioritization and sequencing of Participating Entities. CBH and Participating Entity shall dedicate sufficient and appropriate staffing and resources to ensure all ASO implementation timelines are met.

ARTICLE 6: COMPENSATION

6.1 Payments. The parties acknowledge that DHCS shall compensate CBH for its CYBHI administrative services in accordance with the contract between CBH and DHCS.

6.2 Taxes, Assessments & Surcharges. Each party shall be solely responsible for its respective state and/or federal tax obligations arising from or relating to this MOU. Notwithstanding the above and/or anything to the contrary in this MOU, where there is a tax, assessment, fee, or surcharge: (a) on medical, behavioral health and/or chemical dependency services, and/or claims costs, whether inpatient or outpatient; (b) surcharge imposed upon plans operating

and/or claims for services rendered by providers in the state; and/or (c) for covered lives within a state, Participating Entity is and shall remain responsible for registration, calculation, payment and any associated reporting for these taxes, assessments, fees, and/or surcharges.

ARTICLE 7: TERM AND TERMINATION

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

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

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

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

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

7.6 Notice to Members. Following notice of termination of this MOU by DHCS or either party, DHCS will determine which party will notify Members and Providers, and other persons and

entities that DHCS deems to have an interest herein of such termination. Each party agrees to provide the other party with an advance copy of such Member notice(s).

Article 8: Governing Law & Compliance

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

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

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

8.4 Participating Entity Compliance.

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

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

8.5 Non-Discrimination. Non-Discrimination. The parties will perform their respective obligations under this MOU in manner so as not to discriminate against Members on the basis of color, race, creed, age, sex, (which includes discrimination on the basis of sex characteristics, including intersex traits, pregnancy or related conditions, gender, gender identity, sex

stereotypes, and sexual orientation), disability, place of origin, source of payment, or type of illness or condition.

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

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

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

Article 9: Dispute Resolution

9.1 Dispute Resolution. The parties agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this MOU promptly by negotiation between the parties. The exclusive remedy for unresolved disputes between the parties under this MOU, including without limitation a dispute involving interpretation of any provision of this MOU, questions regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this MOU, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration.

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

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

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

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

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

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

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

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

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

ARTICLE 10: GENERAL PROVISIONS

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

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

10.3 Confidentiality of Clinical Records & HIPAA. The parties agree to comply with all applicable confidentiality and privacy laws, and to maintain processes designed to protect the confidentiality of Member medical information, personally identifiable information and PHI as required by applicable state and/or federal laws, rules and/or regulations, including, without limitation, HIPAA

(including its privacy, security and administrative simplification rules and acts) (45 CFR Part 160 and Subparts A and E of Part 164) , the Confidentiality of Medical Information Act (California Civil Code Section 56 *et seq.),* the Insurance Information Privacy Practices Act (California Insurance Code Section 791, *et seq.*), and the California Consumer Privacy Rights Act (California Civil Code Section 1798.100, *et seq.*). The parties acknowledge and agree that CBH is a business associate of DHCS subject to a Business Associate Agreement ("BAA") (as that term is defined in HIPAA). With respect to the treatment of PHI, the terms of the BAA between DHCS and CBH shall control.

10.4 Confidential Proprietary Information. Each party shall hold Confidential Proprietary Information of the other in the strictest confidence and shall not disclose it to anyone other than those employees and agents performing services for or in support if this MOU and who have a need to know, and then only to the extent necessary, in order to carry out the terms of this MOU, or to accreditation authorities, to the extent necessary. Confidential Proprietary Information may not be used in any way not specifically allowed under this MOU, including in each party's own business, whether or not competitive with the other party. The party in possession of or otherwise with access to the other party's Confidential Proprietary Information shall employ such processes and take such care as to safeguard the confidentiality of such Confidential Proprietary Information. Each party will promptly notify the other of any loss or accidental or unauthorized disclosure of the other's Confidential Proprietary Information. Upon termination of this MOU, the recipient of Confidential Proprietary Information shall promptly deliver to the other party any and all such Confidential Proprietary Information of the other party in its possession or under its control, and any copies made thereof, except as otherwise provided for by the express prior written permission of the party to whom the Confidential Proprietary Information belongs. The parties recognize that no remedy of law may be adequate to compensate a party for a breach of the provisions of this Section 10.4; therefore, the parties agree that a party may seek temporary or permanent injunctive relief against the party breaching this provision, in addition to all other remedies to which either is otherwise entitled, and this provision in no way limits such other remedies of the parties. Such temporary or permanent injunctive relief may be granted without bond, which each party waives.

10.5 Member Communications. DHCS determines how the parties may communicate with Members. The parties acknowledge and agree that nothing contained in this MOU is intended to interfere with or hinder communications between Providers and Members regarding a Member's medical condition or mental health or substance use disorder or available treatment options. The parties agree that all patient care and related decisions are the responsibility of the treating Provider and that, regardless of any coverage or payment determination(s) made or to be made by Participating Entity or CBH, neither Participating Entity nor CBH dictates nor controls clinical decisions with respect to the medical and/or behavioral health care or treatment of Members. All communications with a member shall comply with confidentiality requirements set forth under state and federal law as applicable, including requirements

related to sensitive services as set forth under California Insurance Code section 791.29 and California Civil Code section 56.107

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

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

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

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

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

10.11 Force Majeure. Neither party nor their subcontractor(s) or affiliate(s) hereto shall be held responsible for delay or failure to perform hereunder when such delay or failure is due to fire, flood, epidemic, strikes, acts of God or the public enemy, acts of terrorism, acts of war, unusually severe weather, legal acts of public authorities, or delays or defaults caused by

public carriers, or other circumstances which cannot reasonably be forecast or provided against.

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

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

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

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

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

- Exhibit A Claim Invoice File Layout
- Exhibit B CYBHI Fee Schedule Program Participating Entity Interim Model Companion Guide

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

and provisions herein.

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

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

Fresno-Kings-Madera Regional Health Authority DBA CalViva Health

By: _____

Print Name: Jeffrey Nkansah

Title: CEO

Date: _____

By: _____

Carelon Behavioral Health, Inc.

By: _____

Print Name: _____

Title: _____

Date: _____

By:_____

Address for Notice:

7625 N. Palm Ave.
Suite 109
Fresno, CA 93711
Attn: Jeffrey Nkansah

Address for Notice:

General Counsel
Carelon Behavioral Health, Inc.
200 State Street, 3rd floor
Boston, Massachusetts 02109

Copy to:

Jason Epperson
Epperson Law Group, PC
114 E. Shaw Ave.
Fresno, CA 93710

Item #10
Attachment 10.A

Care Management

2024 Program Evaluation
& Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Carrie-Lee Patnaude, Director Care Management

COMMITTEE DATE: July 17, 2025

SUBJECT: CalViva Care Management Program Evaluation 2024 Executive Summary

Summary:

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

Purpose of Activity:

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

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

The 2024 CM Program Evaluation encompasses a review of care management programs through the documentation of current and future strategic initiatives and goals. The evaluation tracks key performance metrics and provides for an assessment of our progress and identifies critical barriers.

Analysis/Findings/Outcomes:

I. Cases Managed

The goal to increase cases managed in 2024 over 2023 was met (5,954 in 2023 and 7,520 in 2024). Overall, 1.74% of the total population was managed in 2024 amongst physical health CM, behavioral health CM, perinatal CM, First Year of Life (FYOL), and the Transitional Care Services (TCS) program. The average population of members in 2024 was 433,417. The overall percentage of population managed in Physical Health CM was 0.34%. Behavioral Health demonstrated 0.18%. The population managed in Perinatal CM was 0.41%. First Year of Life managed 0.11%, and Transitional Care Services demonstrated 0.69%.

II. Monitoring audits for compliance with regulatory standards

The Plan completed file reviews and audits as planned in 2024. As a result, it was identified that each program met the goal of 90% or greater audit scores in 2024. Additional training and individual coaching were completed in 2024 for staff with below goal scores.

III. Care Management Outcomes

a. Physical Health and Behavioral Health Outcomes

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

Claims data demonstrated a reduction in readmissions for the care managed members, 2.3% decrease (pre 28.2% vs post 25.9%) in readmission rate based on claims. This was short of the 3% goal, however an improvement over 2023 which only achieved a reduction of 1.5%. There was also a 23% reduction in ED utilization for this population by 261 ED visits and a reduction of 599 ED visits per 1,000 members per year. Comparing health care costs demonstrated a reduction in inpatient claims of 452, a decrease of 1,917 for outpatient services, and a decrease of 246 in pharmacy claims.

b. Perinatal Outcomes

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

Members in the Perinatal CM program demonstrated a 6.3% percentage increase in compliance with completing the first prenatal visit in their first trimester and a 8% percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program. There were 1% fewer pre-term deliveries for high-risk members managed than high-risk members not managed, which was short of the goal of 2%.

IV. Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. The goal for member satisfaction is > than 90%. 3/13 survey questions had responses scoring over 90%. 3/13 survey questions scored 89%. 90% (65/72) of respondents were satisfied with the Care Management Program. 97% (64/66) of respondents were satisfied with the help they received from CM.

There were two grievances related to care management in 2024. The goal for member complaints/grievances < 1/10,000 members was met.

V. Summary and Priorities

In 2024, the key accomplishments for the CM were:

- Successful coordination for CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Filled open CM positions.
- Managed more members compared to 2023 in BH, Perinatal, TCS, and FYOL programs
- Enhanced the Transitional Care Services program to meet PHM requirements:
    - Outreach all Acute Inpatient Admissions
    - Onsite staff at Community Regional Medical Center
    - Increased engagement in program
    - Enhanced coordination with Telehealthdocs for post discharge follow up referrals.

The primary goals for 2025 are to complete activities related to:

- Increase member enrollment in Transitional Care Services program.
    - Increase number of hospitals we have on site staff presence at.
- Manage more members across CM programs.
- Launch texting program with members
- Increase the reduction in readmissions and ED visits for members in CM
- Increase Prenatal and Postpartum visit goals for Perinatal program.
- Support CalAIM Community Supports programs and referral for members through FindHelp.

Care Management Program Evaluation 2024

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Care Management Program Evaluation - 2024

I. Overview

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

Health Net provides Care Management to CalViva members. Care Management services were available for 431,003 assigned CalViva members in Fresno, Kings, and Madera counties in 2024.

In 2024, our focus was on strategic initiatives and Population Health Management activities, while continuing to further relationships across departments and with community partners. Activities included increased outreach of acute inpatient admits, increasing enrollment in Transitional Care Services program, increasing member outreach, and managing more members across all Care Management Programs. CalViva continued to support our members, providers, community partners, and staff.

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

Beliefs

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

Purpose of Self-Assessment

The purpose of this self-assessment is to provide information about our Care Management (CM) Program and evaluate the effectiveness of the program. Performance is measured against internal and established external standards of care. This self-assessment is reflective of 2024 and findings are used to establish goals for 2025.

II. Program Infrastructure and Evaluation

Medical Management Committees

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

Care Management Program

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

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

Behavioral Health (BH) Program

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

facilitate a referral. The Care Manager works together with these internal and external teams to ensure continuity of care for the shared member.

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

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

Care Management Referrals

Members for CM were identified through a variety of sources including the concurrent review process, reports such as the Notification of Pregnancy, Health Risk Screening, Sickle Cell, Concurrent Review, Pharmacy, Impact Pro, and Population Health Management, as well as providers and preferred provider groups (PPGs), county entities, and member self-referrals. Overall, the volume of referrals for 2024 was 11,977 for CM programs. The volume of referrals for physical health demonstrated an average of 241 per month for the entire year. The volume of referrals to behavioral health averaged 94 per month for the year and 187 per month for the Perinatal Care Management program. The volume of referrals for Transitional Care Services demonstrated an average of 444 per month for the entire year and 32 per month for the First Year of Life Program. Care management cases requiring clinical expertise were managed by licensed care managers and cases only requiring assistance with social needs such as housing, finance, and other resources were managed by support staff with social work experience.

The data for the Care Management program is divided into three main categories: Physical Health, Behavioral Health, and Perinatal Care Management.

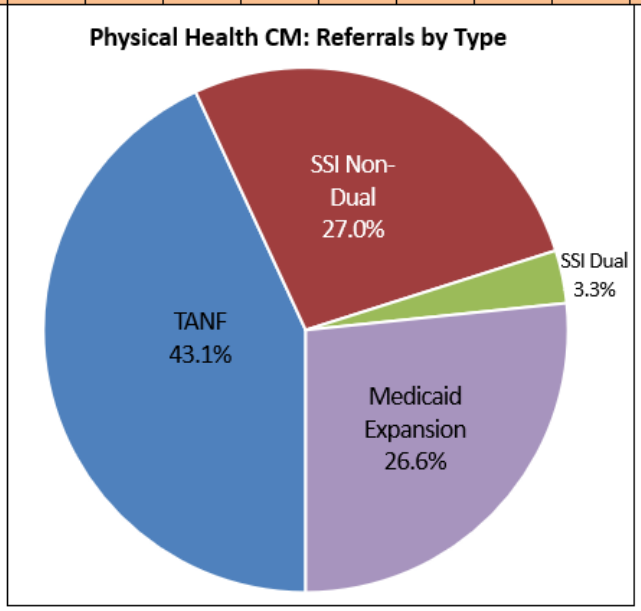
Physical Health

- Referrals by Type:
  - Total number of referrals for 2024 was 3,649
  - 30.0% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 26.6 % of the members referred were Medi-Cal Expansion.
  - 43.1 % of the members referred were TANF.

Table A. Physical Health CM Referrals by Population Type

CalViva Physical Health Care Management Referrals By Type: 1/1/2024 - 12/31/2024

TYPE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	189	142	169	118	162	70	119	149	99	181	87	88	**1,573**
SSI Non-Dual	61	116	133	94	121	64	71	95	71	61	50	48	**985**
SSI Dual	5	17	18	8	9	12	11	12	9	8	4	6	**119**
Medicaid Expansion	77	117	144	86	85	71	85	91	40	68	66	42	**972**
TOTAL REFERRALS	**332**	**392**	**464**	**306**	**377**	**217**	**286**	**347**	**219**	**318**	**207**	**184**	**3,649**

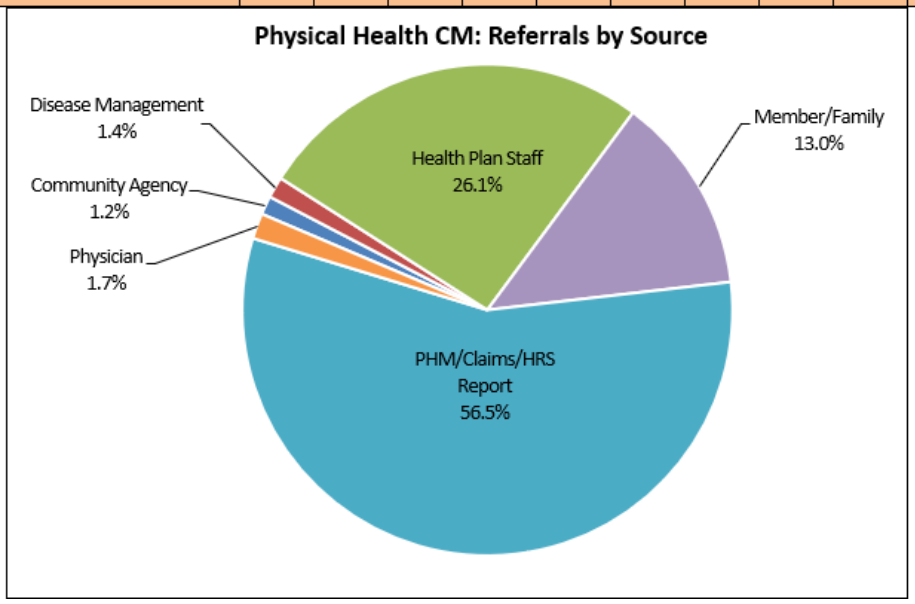


- Referral sources:
  - 26.1% of referrals came from within the Health Plan.
  - 56.5% Reports/PHM/HRS.
  - 1.7% Physician.
  - 13% Member and Family.
  - The remainder of physical health referrals were from a variety of sources – Disease Management and Community Agencies.

Table B. Physical Health CM Referrals by Source

CalViva Physical Health Care Management Referrals By Source: 1/1/2024 - 12/31/2024

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	3	0	5	3	7	6	10	6	3	1	1	0	**45**
Disease Management	2	7	1	4	3	1	8	5	6	7	4	3	**51**
Health Plan Staff	70	83	76	78	98	89	86	88	51	96	74	64	**953**
Member/Family	14	42	21	32	53	48	71	65	34	48	25	23	**476**
PHM/Claims/HRS Report	241	250	352	186	212	71	108	181	120	158	92	92	**2,063**
Physician	2	10	9	3	4	2	3	2	5	8	11	2	**61**
TOTAL REFERRALS	**332**	**392**	**464**	**306**	**377**	**217**	**286**	**347**	**219**	**318**	**207**	**184**	**3,649**

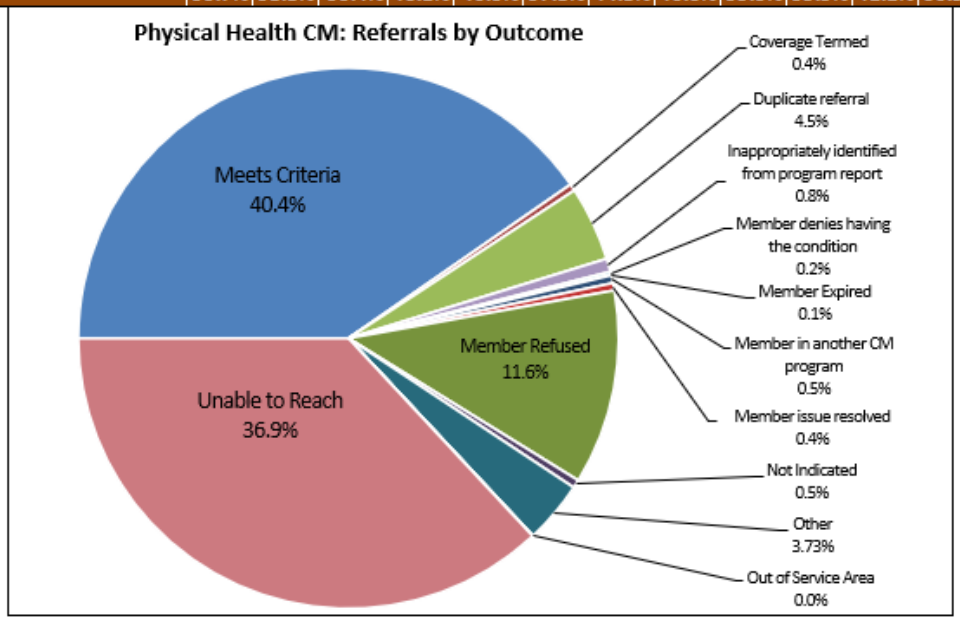


- Referral Outcome:
  - 40.4% meet criteria and agreed to CM.
  - 36.9% of the members were unable to be reached.
  - 11.6% of the members/representatives refused CM.
  - 11.1% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, other (including members requesting information only not a referral to CM), coverage termination, duplicate referrals, expired, member issue resolved.
  - 88% of members who met criteria and initially agreed to CM resulted in an open case.

Table C. Physical Health CM Referral Outcome

CalViva Physical Health Care Management Referrals By Outcome: 1/1/2024 - 12/31/2024

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	112	152	155	141	152	82	128	141	86	127	85	112	**1,473**
Coverage Termed	2	3	2	5	0	1	0	1	0	1	0	0	**15**
Duplicate referral	2	15	17	19	19	17	4	9	20	15	8	18	**163**
Inappropriately identified from prog	0	1	2	0	13	0	2	4	2	1	3	1	**29**
Member denies having the condition	4	0	0	0	0	0	0	0	0	0	1	1	**6**
Member Expired	1	1	0	0	0	0	0	0	0	0	0	0	**2**
Member in another CM program	1	2	1	2	4	3	0	2	1	1	0	0	**17**
Member issue resolved	2	3	5	2	1	1	0	0	0	0	2	0	**16**
Member Refused	26	39	45	30	40	19	26	53	31	52	42	22	**425**
Not Indicated	0	1	1	3	1	0	1	3	4	4	0	0	**18**
Other	16	10	18	11	15	7	16	10	10	11	5	7	**136**
Out of Service Area	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Unable to Reach	166	164	218	93	132	87	109	124	65	106	61	23	**1,348**
TOTAL REFERRALS	**332**	**392**	**464**	**306**	**377**	**217**	**286**	**347**	**219**	**318**	**207**	**184**	**3,649**
%Meets Criteria	**33.7%**	**38.8%**	**33.4%**	**46.1%**	**40.3%**	**37.8%**	**44.8%**	**40.6%**	**39.3%**	**39.9%**	**41.1%**	**60.9%**	**40.4%**



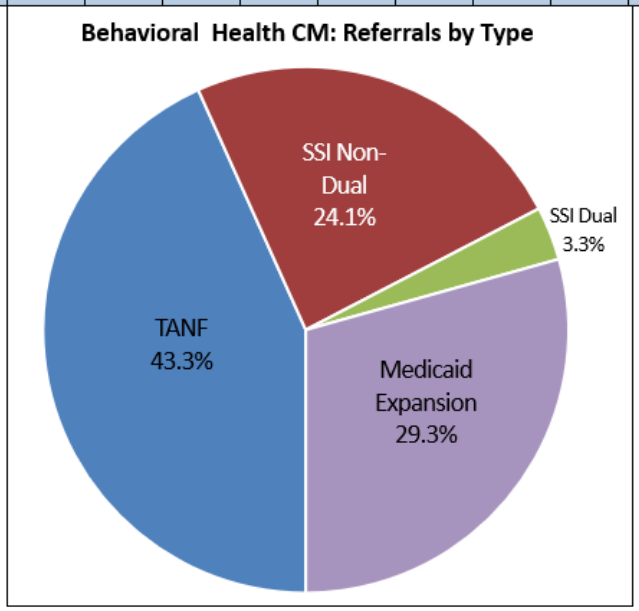
Behavioral Health

- Referrals by Type:
  - Total number of referrals 1,125.
  - 27.4% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 29.3% of the members referred were Medi-Cal Expansion.
  - 43.3% of the members referred were TANF.

Table D. Behavioral Health CM Referrals by Population Type

CalViva Behavioral Health Care Management Referrals By Type: 1/1/2024 - 12/31/2024

TYPE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	31	33	32	14	50	33	50	47	37	51	61	48	**487**
SSI Non-Dual	22	33	11	24	37	18	25	27	21	22	13	18	**271**
SSI Dual	4	4	3	2	6	2	5	1	0	5	3	2	**37**
Medicaid Expansion	21	19	24	26	50	29	30	43	22	29	22	15	**330**
TOTAL REFERRALS	**78**	**89**	**70**	**66**	**143**	**82**	**110**	**118**	**80**	**107**	**99**	**83**	**1,125**

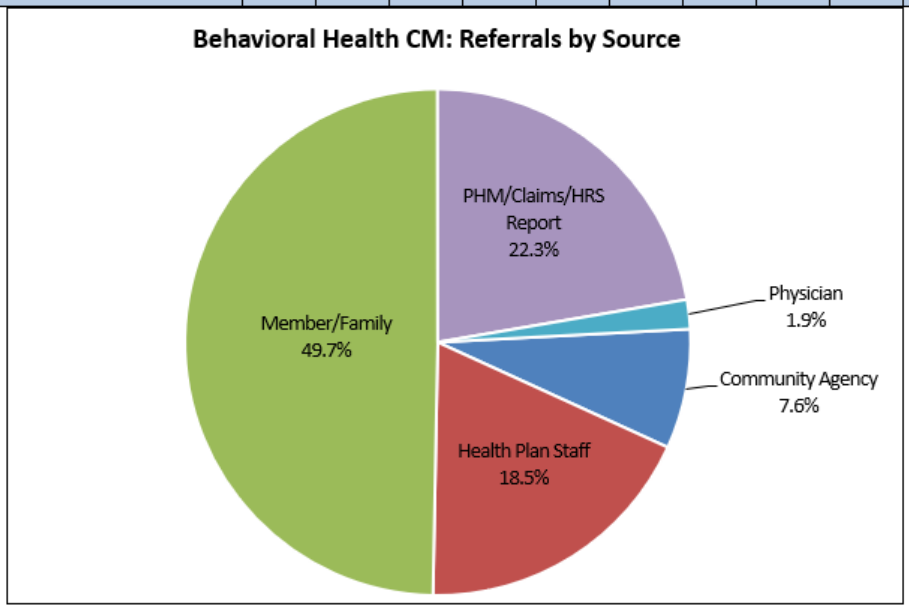


- Referral sources:
  - 18.5% of referrals came from within the Health Plan.
  - 7.6% Community agency.
  - 22.3% Reports/Impact Pro/HRS.
  - 49.7% Member and Family.
  - 1.9% Physician.

Table E. Behavioral Health CM Referrals by Source

CalViva Behavioral Health Care Management Referrals By Source: 1/1/2024 - 12/31/2024

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	5	2	7	7	7	7	10	4	5	13	13	6	**86**
Health Plan Staff	13	6	9	9	14	21	17	21	13	8	45	32	**208**
Member/Family	15	58	19	14	31	45	75	91	57	83	29	42	**559**
PHM/Claims/HRS Report	40	18	31	36	89	8	6	2	4	2	12	3	**251**
Physician	5	5	4	0	2	1	2	0	1	1	0	0	**21**
TOTAL REFERRALS	**78**	**89**	**70**	**66**	**143**	**82**	**110**	**118**	**80**	**107**	**99**	**83**	**1,125**

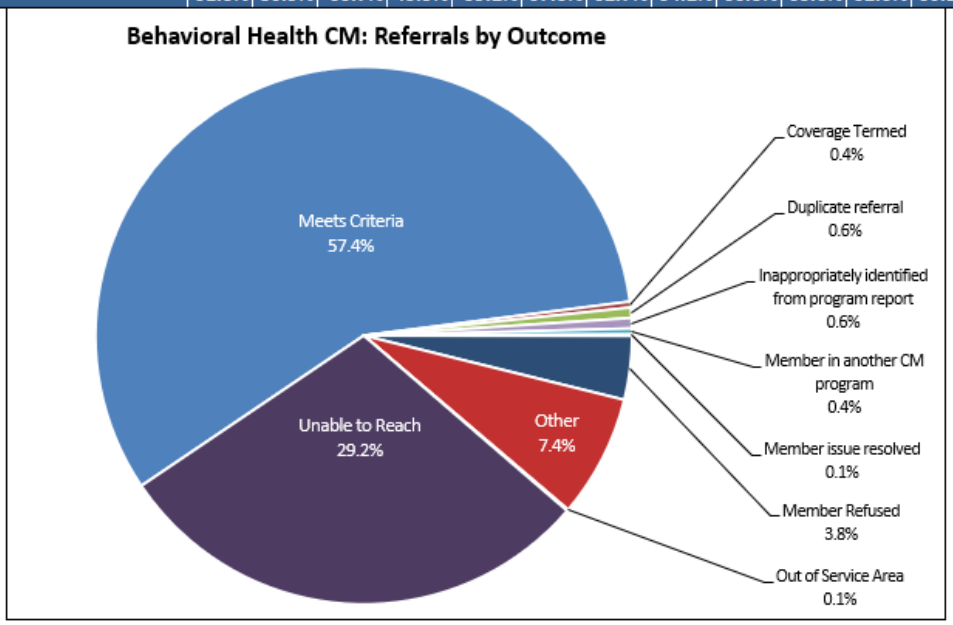


- Referral Outcome:
  - 57.4% meet criteria and agreed to CM.
  - 29.2% of the members were unable to be reached.
  - 3.8% of the members/representatives refused CM.
  - 9.6% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, coverage termination, duplicate referrals, expired, member issue resolved.
  - 96% of members who met criteria and initially agreed to CM resulted in an open case.

Table F. Behavioral Health CM Referral Outcome

CalViva Behavioral Health Care Management Referrals By Outcome: 1/1/2024 - 12/31/2024

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	40	72	46	29	56	47	69	64	53	68	52	50	**646**
Coverage Termed	0	0	0	0	0	0	0	1	0	2	1	0	**4**
Duplicate referral	0	0	0	2	2	0	0	1	0	1	1	0	**7**
Inappropriately identified from program	1	0	0	0	0	0	2	0	1	1	0	2	**7**
Member in another CM program	1	1	0	0	0	0	0	0	1	1	0	0	**4**
Member issue resolved	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Member Refused	5	1	2	8	10	0	2	2	0	1	6	6	**43**
Other	2	3	3	3	3	7	1	16	5	13	10	17	**83**
Out of Service Area	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Unable to Reach	29	12	19	24	72	27	36	34	20	20	28	8	**329**
TOTAL REFERRALS	**78**	**89**	**70**	**66**	**143**	**82**	**110**	**118**	**80**	**107**	**99**	**83**	**1,125**
%Meets Criteria	**51.3%**	**80.9%**	**65.7%**	**43.9%**	**39.2%**	**57.3%**	**62.7%**	**54.2%**	**66.3%**	**63.6%**	**52.5%**	**60.2%**	**57.4%**



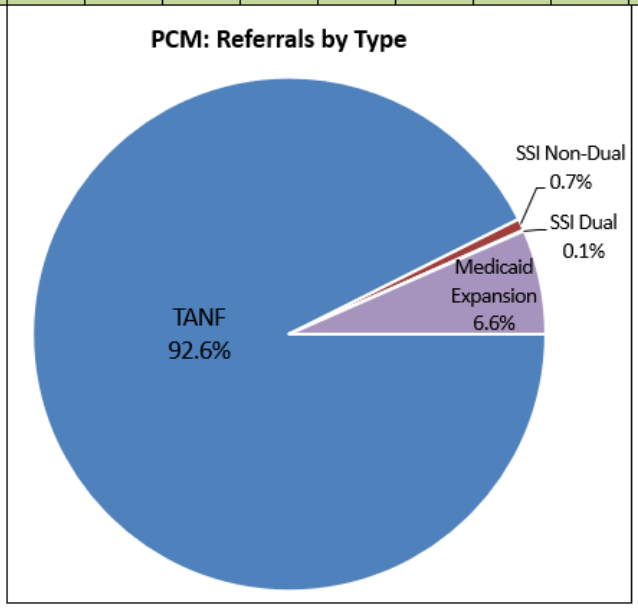
Perinatal Care Management

- Referrals by Type:
  - 1,639 referrals in 2024.
  - 0.8 % for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 6.6% of the members referred were Medi-Cal Expansion members.
  - 92.6% of the members referred were TANF members.

Table G. Perinatal CM Referrals by Population Type

CalViva Perinatal Care Management Referrals By Type: 1/1/2024 - 12/31/2024

TYPE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	217	147	112	160	148	60	100	103	136	128	109	98	**1,518**
SSI Non-Dual	2	2	1	1	1	1	1	0	0	1	0	2	**12**
SSI Dual	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Medicaid Expansion	13	2	6	7	8	2	6	6	17	15	14	12	**108**
TOTAL REFERRALS	**233**	**151**	**119**	**168**	**157**	**63**	**107**	**109**	**153**	**144**	**123**	**112**	**1,639**

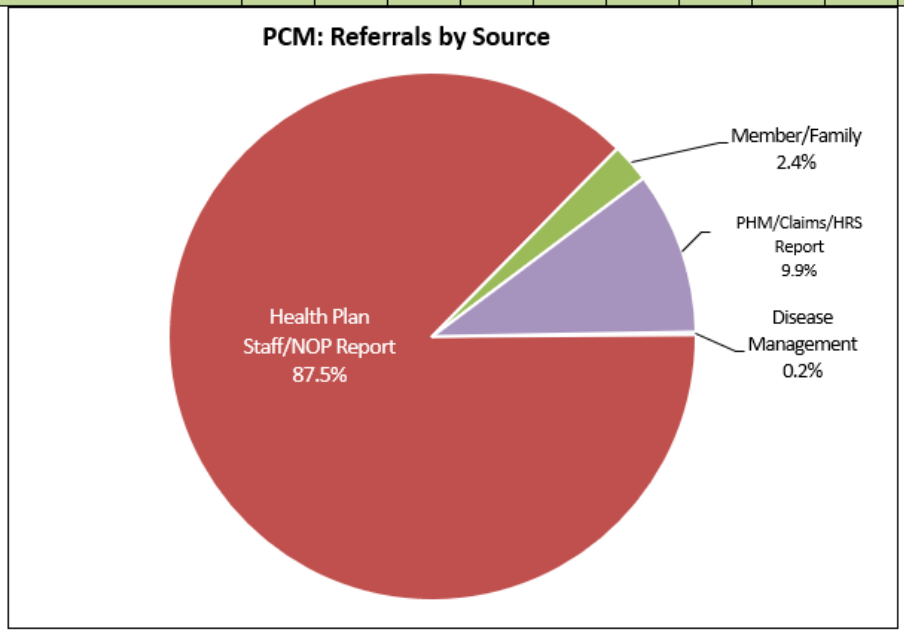


- Referral sources:
  - 87.5% of referrals came from within the Health Plan Staff and NOP report.
  - 9.9% Reports/Impact Pro/HRS.
  - 2.4% Members/Family
  - 0.2% of the remaining referrals to Perinatal CM were from Disease Management

Table H. Perinatal CM Referrals by Source

CalViva Perinatal Care Management Referrals By Source: 1/1/2024 - 12/31/2024

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Disease Management	0	2	0	1	0	0	0	0	0	0	0	0	**3**
Health Plan Staff/NOP Report	226	123	98	134	128	54	96	93	137	132	119	94	**1,434**
Member/Family	2	4	0	6	5	3	2	5	6	4	0	2	**39**
PHM/Claims/HRS Report	5	22	21	27	24	6	9	11	10	8	4	16	**163**
TOTAL REFERRALS	**233**	**151**	**119**	**168**	**157**	**63**	**107**	**109**	**153**	**144**	**123**	**112**	**1,639**

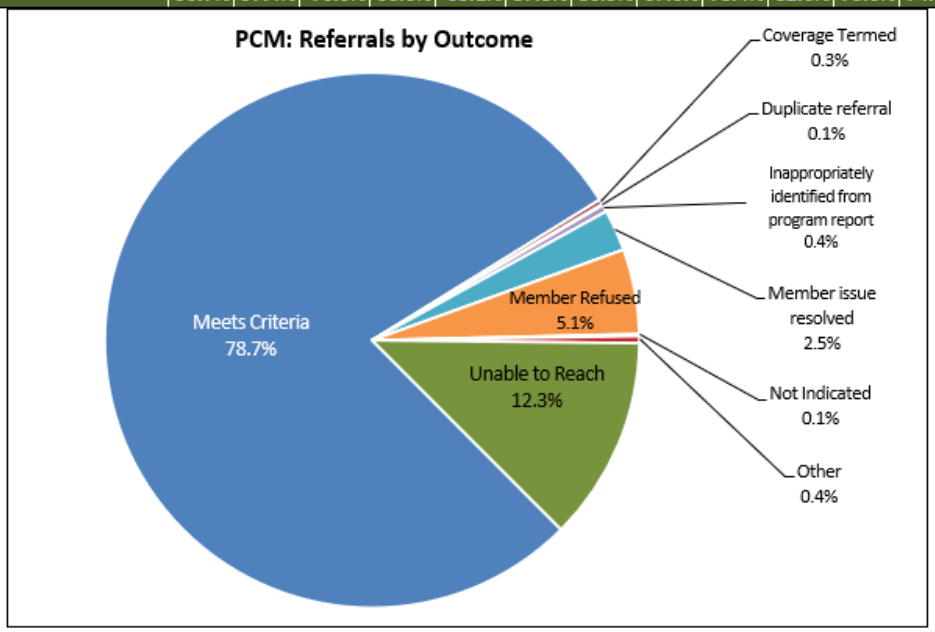


- Referral Outcome:
  - 12.3 % of the members were unable to be reached.
  - 78.7% meet criteria and agreed to CM outreach.
  - 5.1% of the members refused CM.
  - 3.9% Comprised of other, duplicate request, coverage termed, out of service area, not indicated (member reported not pregnant) and enrolled in another CM program.
  - 96% of members who met criteria and initially agreed to CM resulted in an open case.

Table I. Perinatal CM Referral Outcome

CalViva Perinatal Care Management Referrals By Outcome: 1/1/2024 - 12/31/2024

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	223	147	91	94	99	55	93	73	120	119	93	83	**1,290**
Coverage Termed	0	0	0	1	1	1	0	0	2	0	0	0	**5**
Duplicate referral	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Inappropriately identified from program	0	0	0	0	0	0	0	1	0	1	3	2	**7**
Member issue resolved	0	0	0	0	0	0	2	17	4	6	1	11	**41**
Member Refused	4	2	3	7	8	4	3	6	13	10	15	9	**84**
Not Indicated	0	0	0	0	0	0	2	0	0	0	0	0	**2**
Other	0	0	0	0	2	1	0	1	0	0	1	2	**7**
Unable to Reach	6	2	25	65	47	2	7	11	14	8	10	5	**202**
TOTAL REFERRALS	**233**	**151**	**119**	**168**	**157**	**63**	**107**	**109**	**153**	**144**	**123**	**112**	**1,639**
%Meets Criteria	**95.7%**	**97.4%**	**76.5%**	**56.0%**	**63.1%**	**87.3%**	**86.9%**	**67.0%**	**78.4%**	**82.6%**	**75.6%**	**74.1%**	**78.7%**



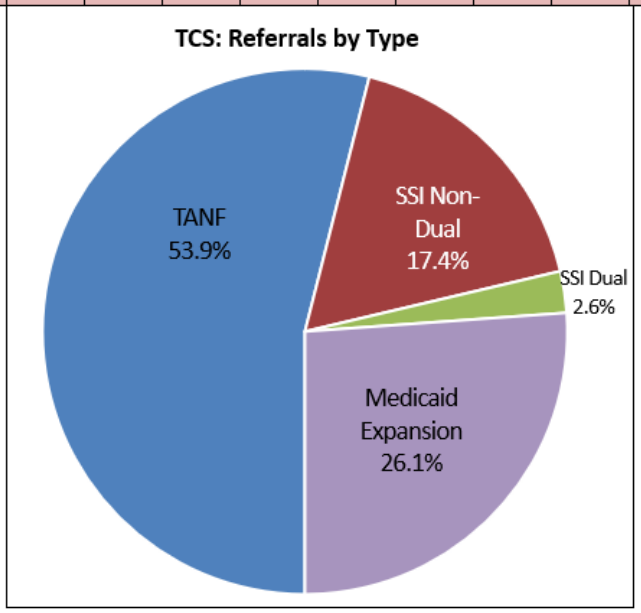
Transitional Care Services

- Referrals by Type:
  - 5,051 referrals in 2024.
  - 20 % for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 26.1% of the members referred were Medi-Cal Expansion members.
  - 53.9% of the members referred were TANF members.

Table J. Transitional Care Services Referrals by Population Type

CalViva Transitional Care Service Referrals By Type: 1/1/2024 - 12/31/2024

TYPE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	68	80	38	29	103	259	266	354	356	483	404	285	**2,725**
SSI Non-Dual	109	91	37	23	41	42	84	90	100	133	84	43	**877**
SSI Dual	6	5	11	2	9	11	10	22	15	14	16	8	**129**
Medicaid Expansion	85	83	45	44	53	103	118	147	159	220	158	105	**1,320**
TOTAL REFERRALS	**268**	**259**	**131**	**98**	**206**	**415**	**478**	**613**	**630**	**850**	**662**	**441**	**5,051**



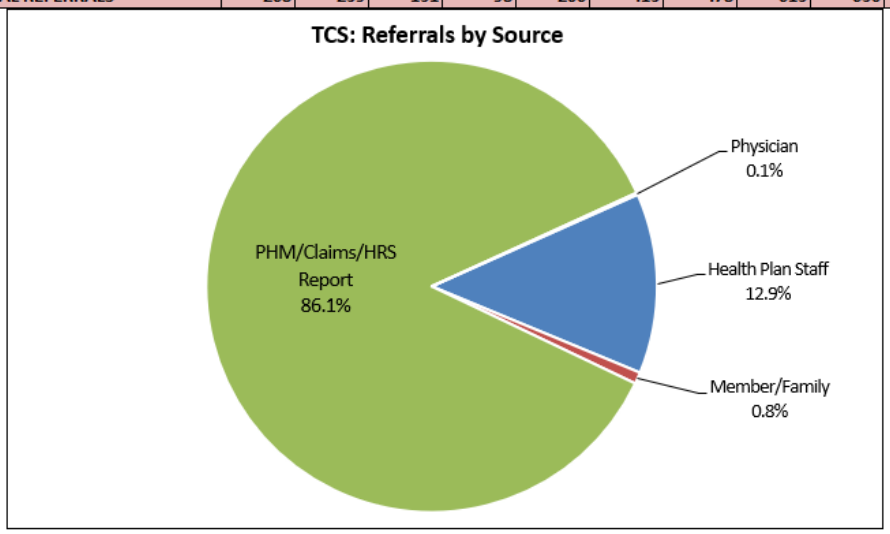
- Referral sources:
  - 86.1% of referrals came from Reports.
  - 12.9% Health Plan Staff.
  - 0.9% of the remaining referrals to TCS were from Physicians or Members

Table K. Transitional Care Services Referrals by Source

CalViva Transitional Care Service Referrals By Source: 1/1/2024 - 12/31/2024

Source: 427 Referrals

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Health Plan Staff	151	124	18	10	22	36	21	34	48	70	78	40	**652**
Member/Family	0	0	1	2	4	3	7	6	3	6	4	6	**42**
PHM/Claims/HRS Report	117	133	112	86	180	373	450	573	578	774	579	395	**4,350**
Physician	0	2	0	0	0	3	0	0	1	0	1	0	**7**
TOTAL REFERRALS	**268**	**259**	**131**	**98**	**206**	**415**	**478**	**613**	**630**	**850**	**662**	**441**	**5,051**

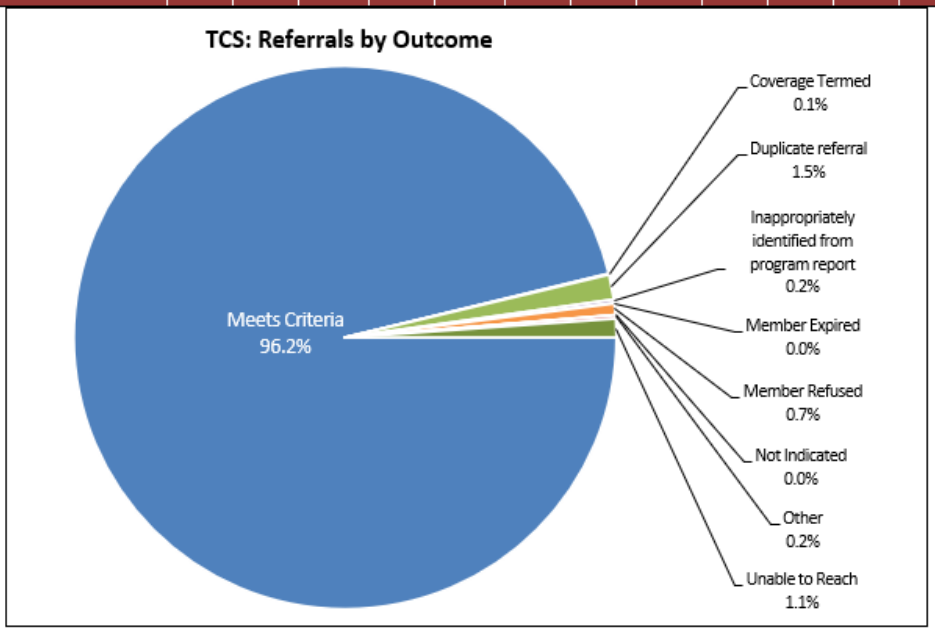


- Referral Outcome:
  - 96.2 % of the members meet criteria and agreed to CM outreach.
  - 1.5% were duplicate referrals.
  - 1.1% of the members were unable to be reached.
  - 1.2% Comprised of other, member refused, coverage termed, not indicated, inappropriately identified for program, member expired.
  - 61% of members who met criteria and initially agreed to CM resulted in an open case.

Table L. Transitional Care Services Referrals by Outcome

CalViva Transitional Care Service Referrals By Outcome: 1/1/2024 - 12/31/2024

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	263	254	129	96	183	351	463	600	618	829	645	429	**4,860**
Coverage Termed	0	0	0	0	1	0	0	1	0	0	1	0	**3**
Duplicate referral	1	2	1	1	7	2	7	8	11	19	12	4	**75**
Inappropriately identified from program	0	3	0	0	0	0	3	1	1	1	2	0	**11**
Member Expired	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Member Refused	2	0	0	0	2	18	4	0	0	0	1	7	**34**
Not Indicated	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Other	2	0	0	1	1	2	0	3	0	0	0	1	**10**
Unable to Reach	0	0	0	0	12	42	1	0	0	0	1	0	**56**
TOTAL REFERRALS	**268**	**259**	**131**	**98**	**206**	**415**	**478**	**613**	**630**	**850**	**662**	**441**	**5,051**
%Meets Criteria	**98.1%**	**98.1%**	**98.5%**	**98.0%**	**88.8%**	**84.6%**	**96.9%**	**97.9%**	**98.1%**	**97.5%**	**97.4%**	**97.3%**	**96.2%**



- Referral outcome comparison across programs:
  - Outcome category of "Other" for Physical Health, Behavioral Health CM, TCS, and Perinatal CM were appropriate and represented referrals for members who were already enrolled in CM, referrals created and/or closed in error, members requesting information only not a referral to CM, member delivered prior to referral, etc.
  - The number of program referrals was higher for all programs.
    - Physical Health CM increased 25% from 2,902 to 3,649
    - Behavioral Health CM increased 95% from 575 to 1,125
    - Perinatal CM increased 37% from 1,193 to 1,639
    - Transitional Care Services was new and had 5,051 referrals
  - The percentage of members unable to be reached was significantly lower for Perinatal CM (34.8%in 2023 to 12.3%in 2024), also lower in Behavior Health CM (34.6% in 2023 to 29.2% in 2024). Physical Health CM's unable to reach rate increased from 18.5% in 2023 to 36.9%

in 2024 which corresponds with the high report referral source in that program. Transitional Care Services had the lowest unable to reach rate at 1.1%.

- The percentage of members who met criteria and agreed to CM outreach was highest in the Transitional Care Services program followed by the Perinatal CM program.
- Actions taken that supported these improvements include:
    - Continuing to address variation of success rates among CMs through individual coaching and staff development.
    - Coached and re-trained outreach staff on how they are offering CM services; staff offer follow-up call from CM to review care gaps or chronic conditions with member, which improves engagement.
    - Re-educated staff on existing alternate sources of member contact information such as OMNI, pharmacy data, HIE.
    - Collaborated with UM, Health Net Behavioral Health, and TCS teams on strategy to continue to increase referrals to BH CM, as well other programs.

Managed Population

In 2024, CM focused on processes related to the number of members managed in CM as well as the number of high-risk members managed in the CVH pregnancy program. The measures were:

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

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

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

shall be referred to the care management program.

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

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

High Risk Populations Managed

The volume of high-risk members managed in the CM programs *across the combined Medi-Cal membership* was 10,751, meeting the goal of >7,800 in 2024. High risk was defined as those members stratified into PHM Pyramid Level 1 (Tier 1 and 2).

Table M. High-Risk Population Managed

Care Management Metrics Key Indicators	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	YTD	Definition
High Priority Unique Member Managed	923	890	703	715	854	711	861	983	1,048	1,208	957	898	10751	Member in PHM Pyramid Level 1 Tier 1&2

High Risk OB Population Managed

The volume of high-risk members managed in the Perinatal CM Program increased from 44.08% in 2023 to 45.13% in 2024. This report includes all high-risk members regardless of when the NOP was conducted during the reporting year.

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

CY 2024 CalViva Percent of High Risk NOP in Perinatal CM

CA412 Report Date	Denominator High Risk	Numorator Case Managed	Percentage
January 31, 2024	198	78	39.39%
February 29, 2024	216	92	42.59%
March 31, 2024	249	97	38.96%
April 30, 2024	225	81	36.00%
May 31, 2024	253	85	33.60%
June 30, 2024	261	89	34.10%
July 31, 2024	273	96	35.16%
August 31, 2024	261	130	49.81%
September 30, 2024	247	136	55.06%
October 31, 2024	208	125	60.10%
November 30, 2024	202	125	61.88%
December 31, 2024	177	116	65.54%
CY 2024 Average	**231**	**104**	**45.13%**

Overall Population Managed

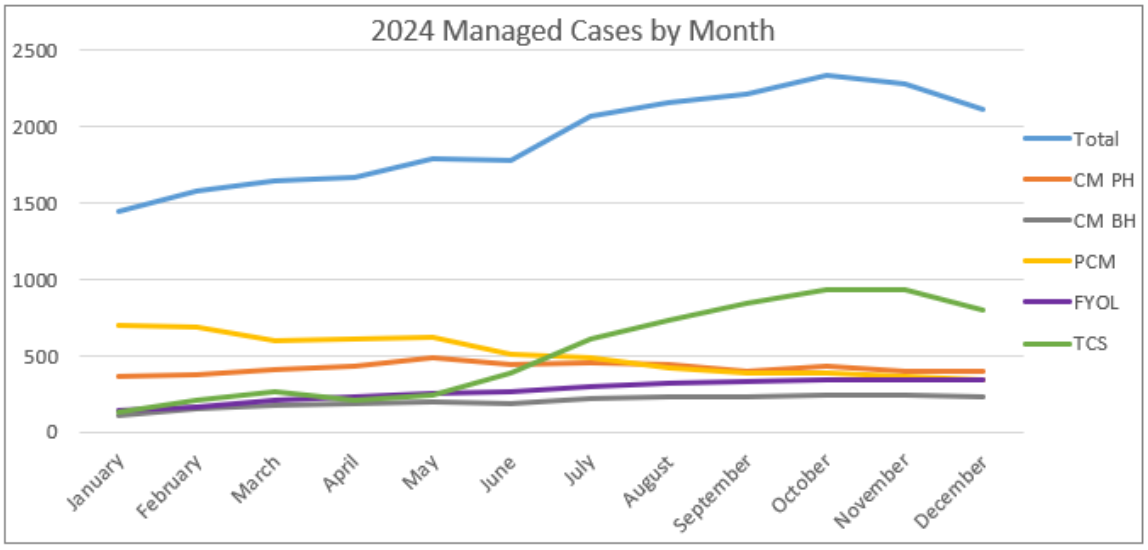
The table below reflects the number of cases managed each month per program. The number of cases managed each month includes cases active at any point during the month.

The average volume of cases managed by program per month in 2024 was:

- Physical Health CM (PH CM): 418
- Behavioral Health CM (BH CM): 200
- Perinatal CM (PCM): 510
- First Year of Life (FYOL): 271
- Transitional Care Services (TCS): 524
- Total average per month: 1924, an increase over 2023 avg of 1078

Table O. CM Managed Case Volume by Month and Program

Program	January	February	March	April	May	June	July	August	September	October	November	December
CM PH	360	372	405	435	484	441	450	444	402	429	401	398
CM BH	113	150	176	182	193	184	217	233	234	243	240	232
PCM	699	687	603	612	619	505	489	422	392	383	368	346
FYOL	143	169	207	232	250	265	301	321	332	342	345	346
TCS	126	204	260	211	245	387	608	735	849	938	932	797
Total	1441	1582	1651	1672	1791	1782	2065	2155	2209	2335	2286	2119



Source: CalViva Key Indicator Report.

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

- PH CM
  - 11% Cases Complex
  - 89% Noncomplex
  - 38% members managed were SPD (dual and non-dual) members, followed by 36.8% Medi-Cal Expansion and 25.2% TANF

- BH CM
  - 6.3% Cases Complex

  - 93.7% Noncomplex
  - 31% of members managed were SPD (dual and non-dual), followed by 30.5% Medi-Cal Expansion and 38.5% TANF
- PCM
  - 2.3% Cases Complex
  - 97.7% Noncomplex
  - 84.4% of the members managed were TANF members, followed by 14.9% Medi-Cal Expansion and 0.7% SPD (dual and non-dual)

- FYOL
  - 100% Noncomplex
  - 99% members managed were TANF members, followed by 0.09% Medi-Cal Expansion and 0.01% SPD (dual and non-dual)

- TCS
  - 100% Noncomplex
  - 45.2% of the members managed were TANF members, followed by 32.7% Medi-Cal Expansion and 22.1% SPD (dual and non-dual)

The goal of 10% complex cases was met for PH and was not met for BH in 2024. The goal of 3% complex for Perinatal CM was not met. The percentage of complex cases managed did improve in the BH CM program compared to 2023. The decline in complex cases in the Perinatal CM program was attributed to changes in staff responsibility as these staff also carry the FYOL cases as well. Actions that will be taken as a result of 2024 complex goals not being achieved include:

- Reviewing both the CM process for management of complex cases and expectations with the staff. Providing additional guidance to staff around complex case criteria.
- Teaching complex case processes to new staff at onboarding to not delay start of complex caseload (second half of the year)
- Performance management

Table P. CM Managed Population by Program and Category

CalViva CM Managed Population by Program and Population Type in 2024

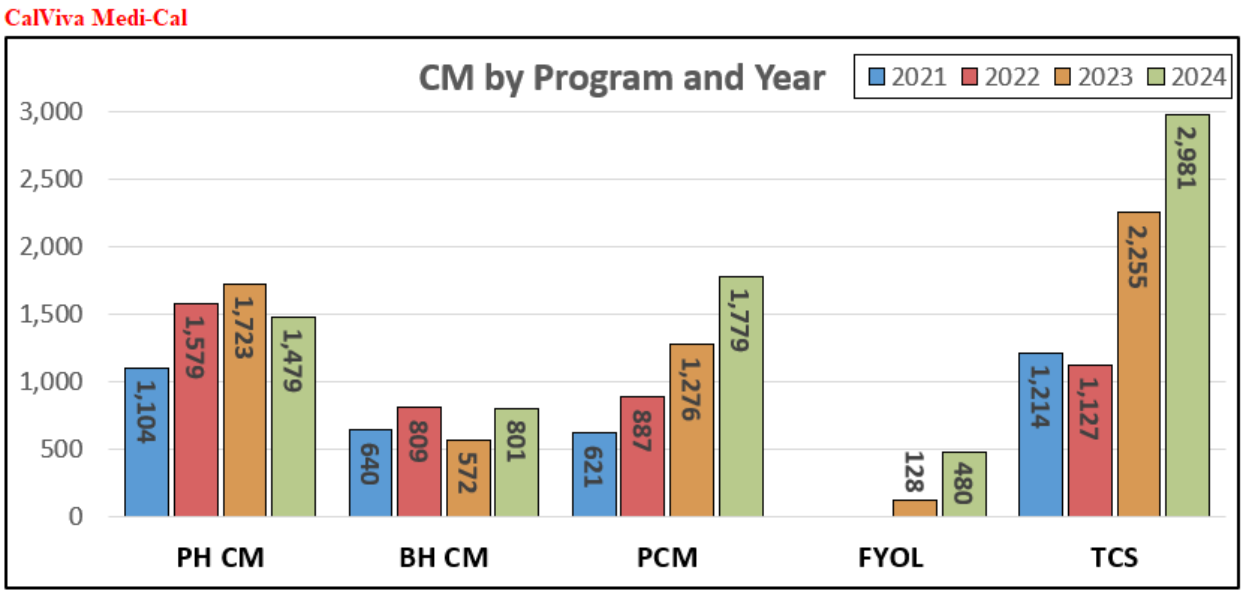
Program	Complex Case Management					Care Coordination					Total Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed
CM PH	0	66	70	40	**176**	0	479	492	332	**1,303**	0	545	562	372	**1,479**
CM BH	0	16	20	15	**51**	0	228	229	293	**750**	0	244	249	308	**801**
PCM	0	6	0	36	**42**	0	259	12	1,466	**1,737**	0	265	12	1,502	**1,779**
FYOL	0	0	0	0	**0**	0	4	1	475	**480**	0	4	1	475	**480**
TCS	0	0	0	0	**0**	0	974	661	1,346	**2,981**	0	974	661	1,346	**2,981**
Total	**0**	**88**	**90**	**91**	**269**	**0**	**1,944**	**1,395**	**3,912**	**7,251**	**0**	**2,032**	**1,485**	**4,003**	**7,520**

Source: CM Dossier and 412 NOP Reports

The volume of cases managed by program increased for most programs compared to prior years. Comparing 2024 specifically to 2023:

- PH CM demonstrated a 14% decrease.
- BH CM demonstrated a 40% increase.
- Perinatal CM demonstrated a 39% increase.
- FYOL demonstrated a 275% increase.
- TCS demonstrated a 32% increase.

Table Q. CM Cases Managed Year to Year by Program



Overall, 1.74% of the total population was managed in 2024 amongst all CM programs. The average population of members in 2024 was 433,417. The overall percentage of population managed in Physical Health CM was 0.34%. Behavioral Health demonstrated 0.18%. The population managed in Perinatal CM was 0.41%. First Year of Life managed 0.11%, and Transitional Care Services demonstrated 0.69%.

Table R. Percentage of Total Population Managed

Percentage of Total Population Managed by Program and Population Type in 2024

Program	Average # Members (Population)					% of Population Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL	CHIP	Medicaid Expansion	SPD	TANF	TOTAL
CM PH	0	120,596	46,004	266,817	**433,417**	0.00%	0.45%	1.22%	0.14%	**0.34%**
CM BH	0	120,596	46,004	266,817	**433,417**	0.00%	0.20%	0.54%	0.12%	**0.18%**
PCM	0	120,596	46,004	266,817	**433,417**	0.00%	0.22%	0.03%	0.56%	**0.41%**
FYOL	0	120,596	46,004	266,817	**433,417**	0.00%	0.00%	0.00%	0.18%	**0.11%**
TCS	0	120,596	46,004	266,817	**433,417**	0.00%	0.81%	1.44%	0.50%	**0.69%**
Total	**0**	**120,596**	**46,004**	**266,817**	**433,417**	**0.00%**	**1.68%**	**3.23%**	**1.50%**	**1.74%**

Care Management (CM) Quality Audit Scores

Complex and Non-Complex Care Management

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

Each month, audits of care management documentation are performed by the designated CM leads and or managers. In 2024, 33 audit elements were measured each quarter. Audit results for 2024 are comprised of 4 completed quarters. Typically, at least 2 unique cases that were open and actively managed for at least 60 days per care manager per month were audited. However, staff who maintained 90% or above on each of their two monthly audits for 3 consecutive months, were audited on a quarterly basis (at the beginning of each quarter). If an employee on quarterly audits fell below the 90% threshold monthly audits were resumed.

Table P Complex and Non-Complex Care Management Audit Results show the results of the average per quarter for each program. In 2024 there were 251 non-complex cases audited across all programs, and 58 complex cases audited across the PH, BH and Perinatal programs. Trends are assessed to monitor compliance with the care management process including demonstrating member and provider collaboration. The goal for audit scores is no less than 90%. The overall average score across programs for 2024 was 95%, meeting overall goal of ≥90%. The overall average score per program was: Physical Health 98%, Behavioral Health 93%, and Perinatal98%, and Transitional Care Services 93%.

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

2024 Audit Results	Physical Health				Behavioral Health				Perinatal				Transitional Care Services			
Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Complex	96%	97%	99%	99%	98%	86%	95%	94%	98%	98%	94%	97%	93%	95%	93%	92%
Complex	98%	97%	97%	99%	95%	93%	95%	89%	98%	100%	98%	100%	n/a	n/a	n/a	n/a
Overall Score	97%	97%	98%	99%	97%	90%	95%	92%	98%	99%	96%	99%	93%	95%	93%	92%

Barriers impacting audit scores:

- Staff not following the CM process (sending welcome letter to both member and PCP and/or documentation of discussing case closure with PCP/involved provider, completing medication review, and documenting follow up schedule/plan in notes).

Actions taken to mitigate the barriers:

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

Care Management Outcomes

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

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

Utilization and Clinical Outcome Measures

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

- Readmission rates
- ED utilization
- Overall health care costs

These parameters were measured 90 days prior to the member's enrollment in physical and behavioral health care management and 90 days after enrollment.
The members included in the outcome measures met the following criteria:

- Had an active or closed case on or between 1/1/2024 and 12/31/2024 with claims paid through 4/23/2025
- Remained eligible 90 days after Case Open Date

One thousand seven hundred forty two (1,742) members met the outcome criteria for the Physical and Behavioral Health CM programs. All cause admissions and readmissions were compared using claims data 90 days pre and post member enrollment into care management.

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Claims data demonstrated a reduction in readmissions for the care managed members, 2.3% decrease (pre 28.2% vs post 25.9%) in readmission rate based on claims. This was short of the 3% goal, however an improvement over 2023 which only achieved a reduction of 1.5%. There was also a 23% reduction in ED utilization for this population by 261 ED visits and a reduction of 599 ED visits per 1,000 members per year.

Table T. CM Readmission Outcomes

CALVIVA CASE MANAGEMENT OUTCOMES REPORT

Members Case Managed Between 1/1/2024 and 12/31/2024, claims paid through 4/23/2025

Measure for Case Management	Members	90 days prior to CM enrollment			90 days following CM enrollment			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	1,742	632	178	28.2%	274	71	25.9%	-2.3%

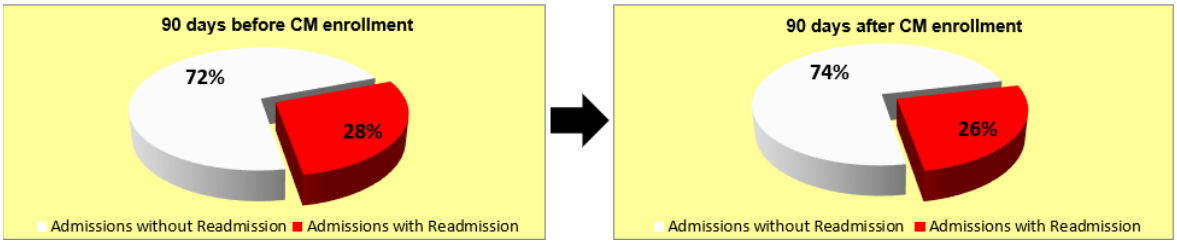
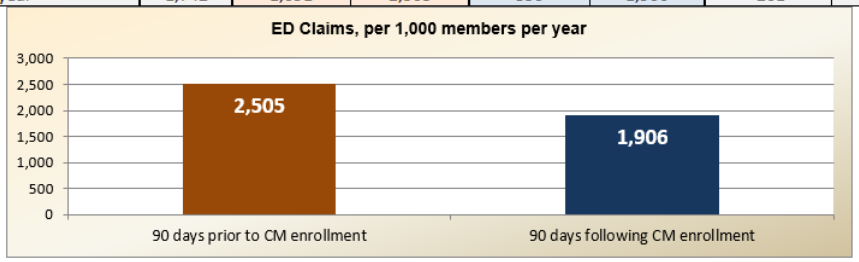


Table U. CM ED Utilization Outcomes

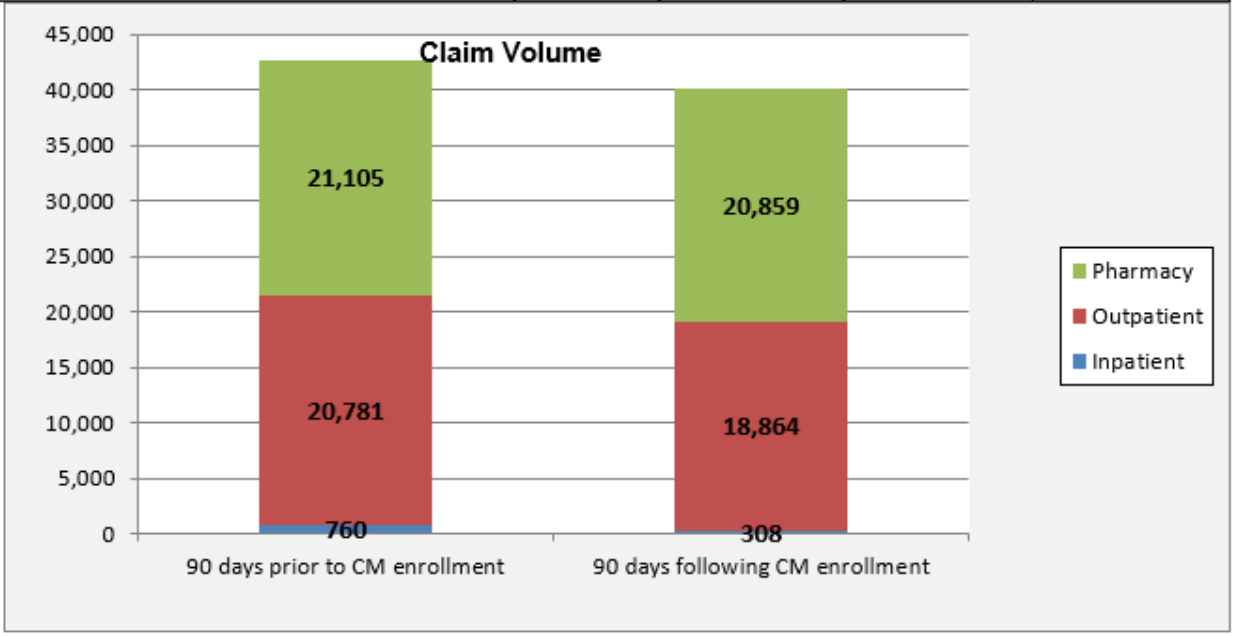
Measure for Case Management	Members	90 days prior to CM enrollment		90 days following CM enrollment		Difference		Difference
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	
Emergency Department (ED) Claims, per 1,000 members per year	1,742	1,091	2,505	830	1,906	-261	-599	-23.0%



Comparing health care costs, 90 days pre and post care management enrollment showed that managed members demonstrated a reduction in inpatient claims of 452, a decrease of 1,917 for outpatient services, and an decrease of 246 for pharmacy.

Table V. Physical and Behavioral Health CM Utilization Outcomes

Measure for Case Management	Members	90 days prior to CM	90 days following CM	Difference
		# Claims	# Claims	# Claims
Inpatient Paid Claims	1,742	760	308	-452
Outpatient/Other Paid	1,742	20,781	18,864	-1,917
Pharmacy Paid Claims	1,742	21,105	20,859	-246
TOTAL PAID CLAIMS	**1,742**	**42,646**	**40,031**	**-2,615**



The effectiveness of the Perinatal CM program was evaluated based on the members' compliance with completing their first prenatal visit within the first trimester and their post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery of high-risk members managed to high-risk members not managed was compared. Preterm is defined as delivery prior to 36 weeks.

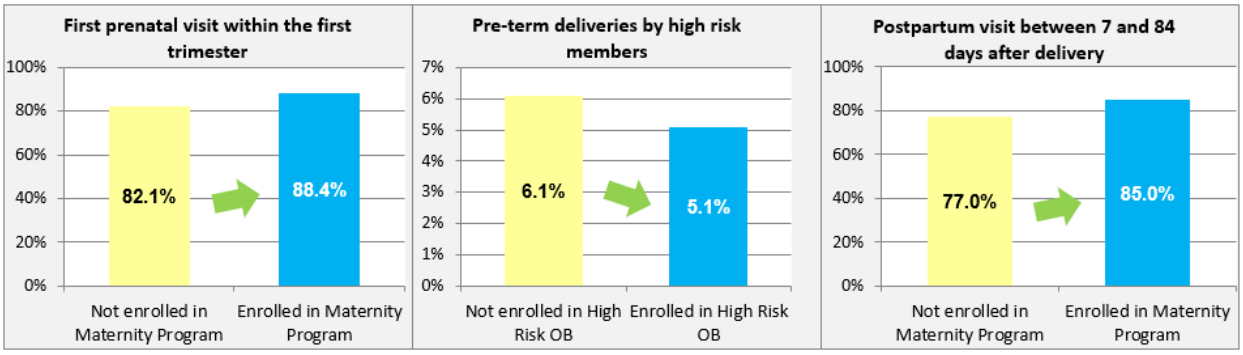
The members in the Perinatal CM program evaluated for compliance with the pre- and post-partum visits were limited to those who met the following criteria:

- Continuous enrollment
- For the prenatal metric were enrolled during their first trimester
- For the post-partum metric delivered prior to 12/31/2024.

Seven hundred eight members (708) met the criteria for both the pre-natal and the post-partum visit metrics and one hundred seventy-five (175) members met the criteria for the pre-term delivery metric.

Table W. Clinical Outcomes for High-Risk OB Members

Measure for Maternity Program	Members not enrolled in Maternity Program		Members enrolled in Maternity Program		Difference
	Members	Rate	Members	Rate	Rate
First prenatal visit within the first trimester	6,271	82.1%	708	88.4%	6.3%
Pre-term deliveries by high risk members	342	6.1%	175	5.1%	-1.0%
Postpartum visit between 7 and 84 days after delivery	6,271	77.0%	708	85.0%	8.0%



Members in the Perinatal CM program demonstrated a 6.3% percentage increase in compliance with completing the first prenatal visit in their first trimester meeting goal of ≥5%. The percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program was 8.0% which met the goal of ≥5%. There were 1.0% fewer pre-term deliveries for high-risk members managed than high-risk members not managed which was short of the 2% reduction goal.

Member Satisfaction

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

Care Management Satisfaction Survey

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

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

Care Team Satisfaction:

1. How happy are you with the Care Management Program?

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

Table X. Care Team Satisfaction

CM SATISFACTION SURVEY REPORT **CalViva** **1/1/2024 - 12/31/2024**

Question	Responses	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	% Satisfied or Better
How happy are you with the Care Management Program?	72	51	14	5	2	90%
How happy are you with the help you are getting or have gotten from your Care Manager	66	47	17	1	1	97%
How happy are you with the information you received from your Care Manager?	57	36	15	4	2	89%
How happy are you with your ability to reach your Care Manager?	56	36	12	6	2	86%
Question	Responses	Yes	No	% Yes		
Do you feel more in control of your health now that you have started the Care Management Program?	48	45	3	94%		
Did your Care Manager care about your beliefs and values?	54	48	6	89%		
Did your Care Manager give you helpful tools to take care of your health?	53	47	6	89%		
Did your Care Manager Program help you reach your health goals?	54	45	9	83%		
Do you feel your care management team helped you organize the care between you and your doctors or other caregivers?	54	48	6	89%		
Question	Responses	Yes	No	% No		
Is there anything that stopped you from taking your Care Managers Advice to better your health?	52	12	40	77%		
Question	Responses	5	4	3	2	1
On a scale 1 to 5, how likely are you to recommend the Care Management Program to family and friend?	51	34	5	2	4	6
Question	Responses	Yes	No			
Is there anything else you would like to share about Care Manager Program or your Care Manager?	0	0	0			
Do you have any ideas to help us give you better service?	0	0	0			

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

Care Team Satisfaction (Table U) demonstrate 72 members were surveyed in 2024. Responses were not captured for all questions. The discrepancy in the number of members responding to the individual questions is attributed to members not answering all the questions or the response was not captured during data entry.

- 72 members responded to questions in the Care Team Satisfaction
    - 90% (65/72) of respondents were satisfied with the Care Management Program.
    - 97% (64/66) of respondents were satisfied with the help they received from CM.
    - 89% (51/57) reported they were satisfied with the information given by Care Manager.

- 86% (48/56) reported they were satisfied with their ability to reach their Care Manager.
- 94% (45/48) reported they feel more in control of their health now that they have started the Care Management Program.
- 89% (48/54) reported the Care Manager cared about their beliefs and values.
- 89% (47/53) reported Care Manager gave them helpful tools to take care of their health.
- 83% (45/54) reported the Care Manager helped them reach their health goals.
- 89% (48/54) reported they feel their care management team helped them organize the care between them and their doctor or other caregivers.
- 77% (40/52) reported nothing stopped them from taking their Care Managers Advice to better their health.
- 51 members provided a rating of how likely they would recommend the Care management Program to family and friends.
- 0 Members responded to the last two questions:
  - Is there anything else they would like to care about the Care Management Program or their Care Manager?
  - Do you have any ideas to help them receive better service?
- Care Team Satisfaction section met goal of >90% met in 3/10 questions.

Care Management Complaints/Grievances

There were two grievances related to care management in 2024. The goal for member complaints/grievances < 1/10,000 members was met.

Table Y. CM Grievances/Complaints

Member Complaints Against Plan CM

	Quarter 1 2024		Quarter 2 2024		Quarter 3 2024		Quarter 4 2024	
CM Complaints	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.
	1	0.023	0	0	1	0.022	0	0

*Based on average CalViva membership from https://cnet.centene.com/sites/CAMedi-calDataAnalytics: 2024: Q1 434,441; Q2 434,006; Q3 435,065; Q4 431,003

Special Programs

Perinatal CM

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

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

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

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

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

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

After consent for program participation and program enrollment was completed, ongoing telephonic contact was established with frequency varying depending on member need and acuity. Ongoing reassessment of need and progress was reviewed at least monthly with updates and adjustments to the plan of care occurring as needed.

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

Metrics associated with the Perinatal CM program managed

Analytics provided data related to NOP Completion and Percentage of Deliveries with NOP.

NOP Completion – The number of NOPs completed. NOPs can be submitted by members and providers and may also be completed during CM telephonic outreach to members identified as pregnant on the **413 No NOP** report. In 2024 1,354 NOPs were completed.

Table Z. NOP Completion per Month

2024 Pregnancy Program HBR: Members with a Completed NOP Assessment

Source: 412 NOP report

By Month of Frist NOP Assessment date

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CalViva	110	138	139	107	162	143	150	88	94	86	74	63	1,354

Percentage of Deliveries with an NOP - The percentage of births with an NOP completed within eight months prior to delivery. There was variation in performance from a low of 28.3% in August to a high of 37.4% in October. The total at year-end average was 32.2%; a decrease from 44.8% in 2023. Some of this decrease may be attributed to the PCM team prioritizing outreach to members identified as high-risk on the NOP report and outreaching to members on the No-NOP report as a secondary priority.

Table AA. Percentage of Deliveries with NOP

2024 Pregnancy Program HBR: % of Deliveries with NOP

Sources: 412 NOP report and IP Validation Report

By Month of Delivery Date

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CalViva	32.6%	32.2%	30.5%	33.3%	31.2%	31.4%	32.5%	28.3%	33.6%	37.4%	31.4%	32.0%	32.2%
NUMERATOR	149	131	134	136	135	140	163	129	166	174	128	132	1,717
DENOMINATOR	457	407	440	409	433	446	501	456	494	465	408	412	5,328

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

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

Neonatal Rate - Percentage of NICU admits per delivery.

Enrollment in this program in 2024 was 1306. We continued to make outreach to all risk categories including low risk. We found this to be of great importance and superior customer service as it allowed us to reach members that may need assistance who were not identified through the NOP. Overall, there were 12,676 pregnancy related materials mailed in 2024. Members may sign up for mailings outside of care management which explains more material being sent than members managed. Mailings are based on the completion of an NOP for the Pregnancy mailing and presence of a completed Birth Event in TruCare for the Post-delivery Packet.

Table AB. Perinatal CM Outreach

Educational Packet	*Number of Packets Sent in 2024*
NOP mailings	7,988
Pregnancy mailings	1,141
Post-delivery packets	3,547
Total	12,676

Transition Care Services Program

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

The TCS Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidence-based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The program includes:

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

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

In 2024 2,079 members were referred to the Transitional Care Services Program and 1,032 (54%) participated. The number of members participating in the program decreased from 1,760 in 2023. The decrease in participation is a result of only including members actively participating in the program and no longer including members we could not reach but coordinated care with providers on.

Care Coordination Activities

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

California Children Services

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

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

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

Regional Centers

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

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

In 2024 the CM team began receiving an Early Intervention/Developmentally Disabled member list. The team filters the list for any members under the age of 12 months, and those members are outreached by our First Year of Life program staff. The remaining members on the list are reviewed by any diagnosis and risk category information that may be available in the report, to help determine if any of the members would be appropriate for CM outreach. In 2025 we will work on ways to identify this population in our reporting.

Targeted Case Management

Support continued for collaboration in counties that continue to offer targeted case management. Programs offered through targeted case management vary by county. There continued to be very limited participation on behalf of the counties in 2024. The CalViva counties offering targeted case management include Madera. The Service Coordination liaison continued efforts to re-engage related activities with these counties with limited success. Support for collaborative activities will continue in 2025.

CalAIM

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

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

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

Population Health Management

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

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

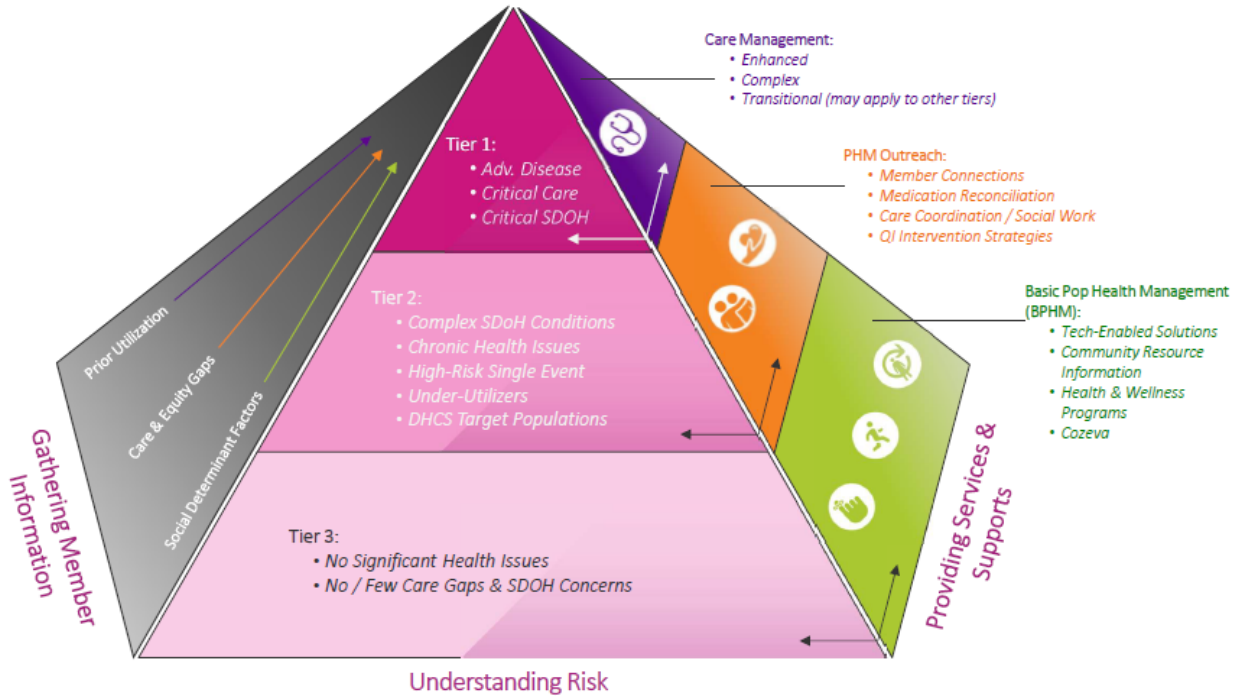
A population assessment is completed which provides the interdisciplinary team with a vehicle by which to analyze and prioritize health needs. Review of this information facilitates the identification of new initiatives, the ability to establish goals, evaluate and measure progress, while improving the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

Population Assessment and CM Criteria

In 2024, we continued to utilize a comprehensive Population Health Management report to support an integrated care model; care management being one component. This data is used to identify members for various programs. Impact pro data is included in the algorithm for this report.

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

[2] IBID.



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

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

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

shall be referred to the care management program.

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

III. Summary and Priorities

In 2024, the key accomplishments for the CM Program were:

- Successful coordination of CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Filled open CM positions.
- Managed more members compared to 2023 in BH, Perinatal, TCS, and FYOL programs
- Enhanced the Transitional Care Services program to meet PHM requirements:
    - Outreach for all Acute Inpatient Admissions
    - Onsite staff at Community Regional Medical Center
    - Increased engagement in programs
    - Enhanced coordination with Telehealthdocs for post discharge follow up referrals.

The primary goals for 2025 are to complete activities related to:

- Increase member enrollment in Transitional Care Services program.
    - Increase the number of hospitals we have on site staff presence at.
- Manage more members across CM programs.
- Launch texting program with members
- Increase the reduction in readmissions and ED visits for members in CM
- Increase Prenatal and Postpartum visit goals for Perinatal program.
- Support CalAIM Community Supports programs and referral for members through FindHelp.

Item #11
Attachment 11.A

Long Term Care

2025 Quality Assurance
Performance Improvement Plan

Attachment Z

CalViva Health Long Term Care

Quality Assurance and Performance Improvement Plan

April 2025

CalViva Health Long Term Care

Quality Assurance and Performance Improvement Plan

April 2025

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera. Under California's Medi-Cal managed care program, the RHA dba CalViva Health ("CalViva") is a National Committee for Quality Assurance (NCQA) accredited Medi-Cal managed care plan and is designated as the Local Initiative.

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

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

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

Element 1: Design and Scope

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

The QAPI program incorporates data and information from the following:

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

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

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

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

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

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

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

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

Element 2: Governance and Leadership

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

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

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

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

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

Element 3: Feedback, Data Systems, and Monitoring

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

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

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

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

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

Element 4: Performance Improvement Projects (PIPs)

Opportunities for improvement are generally identified through ongoing monitoring activities (dashboard) or by assignment, from DHCS, with at least two (2) Performance Improvement Projects (PIPs) in progress for the organization on an annual basis. PIPs may be clinically or non-clinically focused. Other more short-term improvement projects following the Rapid Cycle Improvement process may also be initiated or assigned.

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

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

Element 5: Systemic Analysis and Systemic Action

The Plan employs a structured, data-driven approach to identify performance trends, prioritize improvement efforts, and support sustainable quality across its SNF network. Using the QAPI dashboard, the Plan systematically monitors key quality indicators, including outcomes from CDPH certification and recertification surveys, claims-based metrics, Title 22/42 survey data, Potential Quality Issues (PQIs), and critical incident reports.

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

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

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

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

Element 6: Additional Information

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

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

Community Integration
CalViva implements a robust Population Health Management (PHM) Program designed to ensure that long-term care Members receive a comprehensive set of services aligned with their clinical and social needs. This includes integration of Behavioral Health Management (BHM), Transitional Care Services (TCS), care management programs, and Community Supports to promote stable placement, health improvement, and

independence where possible. The PHM approach emphasizes whole-person care by addressing both medical and social determinants of health and prioritizing member engagement, cultural responsiveness, and shared decision-making.

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

Additional Policies

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

- UM-011 Long Term Care
- FN-107 Skilled Nursing Facility Workforce Quality Incentive Program
- PH-062 Non-Emergency-Non-Medical Transportation Assistance Coordination

Fresno-Kings-Madera Regional Health Authority Approval

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

_____ _____

David Hodge, MD, Fresno County Date

Regional Health Authority Commission Chairperson

_____ _____

Patrick Marabella, MD, Chief Medical Officer Date

Chair, CalViva Health QIUM Committee

Item #12
Attachment 12.A

Financials as of
May 31, 2025

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of May 31, 2025

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	187,853,965.98
5	Total Bank Accounts	$ 187,853,965.98
6	Accounts Receivable	
7	Accounts Receivable	282,593,062.89
8	Total Accounts Receivable	$ 282,593,062.89
9	Other Current Assets	
10	Interest Receivable	551,942.74
11	Investments - CDs	0.00
12	Prepaid Expenses	298,090.35
13	Security Deposit	0.00
14	Total Other Current Assets	$ 850,033.09
15	Total Current Assets	$ 471,297,061.96
16	Fixed Assets	
17	Buildings	5,672,772.97
18	Computers & Software	18,666.59
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	117,969.80
22	Total Fixed Assets	$ 8,970,828.46
23	Other Assets	
24	Investment -Restricted	302,546.08
25	Lease Receivable	1,566,395.35
26	Total Other Assets	$ 1,868,941.43
27	TOTAL ASSETS	$ 482,136,831.85
28	LIABILITIES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	57,674.83
33	Accrued Admin Service Fee	4,785,979.00
34	Capitation Payable	129,968,922.01
35	Claims Payable	161,170.38
36	Directed Payment Payable	742,751.12
37	Total Accounts Payable	$ 135,716,497.34
38	Other Current Liabilities	
39	Accrued Expenses	2,169,553.93
40	Accrued Payroll	67,648.20
41	Accrued Vacation Pay	433,020.67
42	Amt Due to DHCS	35,100,349.49
43	IBNR	667,951.84
44	Loan Payable-Current	0.00
45	Premium Tax Payable	0.00
46	Premium Tax Payable to BOE	325,404.28
47	Premium Tax Payable to DHCS	125,583,333.34
48	Total Other Current Liabilities	$ 164,347,261.75
49	Total Current Liabilities	$ 300,063,759.09
50	Long-Term Liabilities	
51	Renters' Security Deposit	25,906.79
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	$ 25,906.79
54	Total Liabilities	$ 300,089,665.88
55	Deferred Inflow of Resources	1,169,533.89
56	Equity	
57	Retained Earnings	161,689,933.96
58	Net Income	19,187,698.12
59	Total Equity	$ 180,877,632.08
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 482,136,831.85

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2024 - May 2025

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	10,840,106.52	3,700,000.00	7,140,106.52
3	Premium/Capitation Income	2,136,245,257.35	1,667,900,884.00	468,344,373.35
4	**Total Income**	**2,147,085,363.87**	**1,671,600,884.00**	**475,484,479.87**
5	Cost of Medical Care			
6	Capitation - Medical Costs	1,271,072,792.48	1,078,777,005.00	192,295,787.48
7	Medical Claim Costs	7,010,819.82	5,500,000.00	1,510,819.82
8	**Total Costs of Medical Care**	**1,278,083,612.30**	**1,084,277,005.00**	**193,806,607.30**
9	**Gross Margin**	**869,001,751.57**	**587,323,879.00**	**281,677,872.57**
10	Expenses			
11	Admin Service Agreement Fees	52,622,812.00	49,346,825.00	3,275,987.00
12	Bank Charges	0.00	6,600.00	(6,600.00)
13	Computer & IT Services	136,186.36	236,463.37	(100,277.01)
14	Consulting & Accreditation Fees	49,013.00	366,666.63	(317,653.63)
15	Depreciation Expense	312,016.70	341,000.00	(28,983.30)
16	Dues & Subscriptions	220,286.81	272,800.00	(52,513.19)
17	Grants	4,042,107.25	4,068,182.00	(26,074.75)
18	Insurance	324,343.48	410,273.38	(85,929.90)
19	Labor	3,908,425.36	4,564,954.00	(656,528.64)
20	Legal & Professional Fees	157,745.03	295,900.00	(138,154.97)
21	License Expense	1,363,110.18	1,306,393.88	56,716.30
22	Marketing	1,186,618.55	1,375,000.00	(188,381.45)
23	Meals and Entertainment	17,104.79	27,625.00	(10,520.21)
24	Office Expenses	87,578.49	104,500.00	(16,921.51)
25	Parking	328.37	1,430.00	(1,101.63)
26	Postage & Delivery	1,716.70	4,510.00	(2,793.30)
27	Printing & Reproduction	2,309.71	4,510.00	(2,200.29)
28	Recruitment Expense	(90.00)	144,375.00	(144,465.00)
29	Rent	0.00	11,000.00	(11,000.00)
30	Seminars & Training	11,901.67	26,800.00	(14,898.33)
31	Supplies	10,616.37	11,916.63	(1,300.26)
32	Taxes	785,583,333.34	516,770,833.37	268,812,499.97
33	Telephone & Internet	44,719.41	38,500.00	6,219.41
34	Travel	18,926.87	24,800.00	(5,873.13)
35	**Total Expenses**	**850,101,110.44**	**579,761,858.26**	**270,339,252.18**
36	**Net Operating Income**	**18,900,641.13**	**7,562,020.74**	**11,338,620.39**
37	Other Income			
38	Other Income	287,056.99	398,750.00	(111,693.01)
39	**Total Other Income**	**287,056.99**	**398,750.00**	**(111,693.01)**
40	**Net Other Income**	**287,056.99**	**398,750.00**	**(111,693.01)**
41	**Net Income**	**19,187,698.12**	**7,960,770.74**	**11,226,927.38**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

July 2024 - May 2025

		Total	
		July 2024 - May 2025	July 2023 - May 2024 (PY)
1	Income		
2	Interest Income	10,840,106.52	7,617,872.06
3	Premium/Capitation Income	2,136,245,257.35	1,922,653,343.69
4	**Total Income**	**2,147,085,363.87**	**1,930,271,215.75**
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,271,072,792.48	1,236,242,750.42
7	Medical Claim Costs	7,010,819.82	1,230,161.58
8	**Total Costs of Medical Care**	**1,278,083,612.30**	**1,237,472,912.00**
9	**Gross Margin**	**869,001,751.57**	**692,798,303.75**
10	Expenses		
11	Admin Service Agreement Fees	52,622,812.00	52,799,527.00
12	Computer & IT Services	136,186.36	136,482.79
13	Consulting & Accreditation Fees	49,013.00	165,988.00
14	Depreciation Expense	312,016.70	300,241.70
15	Dues & Subscriptions	220,286.81	218,507.21
16	Grants	4,042,107.25	3,665,454.54
17	Insurance	324,343.48	321,935.31
18	Labor	3,908,425.36	3,407,961.32
19	Legal & Professional Fees	157,745.03	84,501.32
20	License Expense	1,363,110.18	1,159,626.44
21	Marketing	1,186,618.55	1,188,522.76
22	Meals and Entertainment	17,104.79	13,662.45
23	Office Expenses	87,578.49	65,827.07
24	Parking	328.37	127.00
25	Postage & Delivery	1,716.70	2,243.47
26	Printing & Reproduction	2,309.71	2,116.42
27	Recruitment Expense	(90.00)	83,384.17
28	Rent	0.00	0.00
29	Seminars & Training	11,901.67	6,909.10
30	Supplies	10,616.37	10,029.47
31	Taxes	785,583,333.34	611,300,820.37
32	Telephone & Internet	44,719.41	29,708.97
33	Travel	18,926.87	14,253.21
34	**Total Expenses**	**850,101,110.44**	**674,977,830.09**
35	**Net Operating Income**	**18,900,641.13**	**17,820,473.66**
36	Other Income		
37	Other Income	287,056.99	525,599.88
38	**Total Other Income**	**287,056.99**	**525,599.88**
39	**Net Other Income**	**287,056.99**	**525,599.88**
40	**Net Income**	**19,187,698.12**	**18,346,073.54**

Item #12
Attachment 12.B

Medical Management

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2025

Current as of End of the Month: May
Revised Date: 06/16/2025

CalViva - 2025																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2025 YTD**	**2024**
Expedited Grievances Received	7	6	8	21	5	9	0	14	0	0	0	0	0	0	0	0	35	126
Standard Grievances Received	184	202	217	603	187	168	0	355	0	0	0	0	0	0	0	0	958	1761
Total Grievances Received	**191**	**208**	**225**	**624**	**192**	**177**	**0**	**369**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**993**	**1887**
Grievance Ack Letters Sent Noncompliant	1	2	2	5	1	0	0	1	0	0	0	0	0	0	0	0	6	10
Grievance Ack Letter Compliance Rate	**99.5%**	**99.0%**	**99.1%**	**99.2%**	**99.5%**	**100.0%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.37%**	**99.4%**
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	7	5	9	21	4	9	0	13	0	0	0	0	0	0	0	0	34	126
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	138	165	212	515	221	194	0	415	0	0	0	0	0	0	0	0	930	1702
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.9%**
Total Grievances Resolved	**145**	**170**	**221**	**536**	**225**	**203**	**0**	**428**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**964**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**130**	**161**	**208**	**499**	**210**	**185**	**0**	**395**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**894**	**1468**
Access - Other - DMHC	28	22	18	68	29	39	0	68	0	0	0	0	0	0	0	0	136	270
Access - PCP - DHCS	5	18	13	36	18	17	0	35	0	0	0	0	0	0	0	0	71	118
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	2	9	7	18	6	5	0	11	0	0	0	0	0	0	0	0	29	78
Administrative	21	30	52	103	41	36	0	77	0	0	0	0	0	0	0	0	180	186
Balance Billing	23	22	34	79	45	30	0	75	0	0	0	0	0	0	0	0	154	0
CalAim	4	6	1	11	4	11	0	15	0	0	0	0	0	0	0	0	26	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	6	16	14	36	18	14	0	32	0	0	0	0	0	0	0	0	68	122
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	9	7	33	49	13	8	0	21	0	0	0	0	0	0	0	0	70	339
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	1	1	3	5	2	0	0	2	0	0	0	0	0	0	0	0	7	0
Transportation - Access	15	13	5	33	7	8	0	15	0	0	0	0	0	0	0	0	48	175
Transportation - Behavior	5	3	2	10	3	3	0	6	0	0	0	0	0	0	0	0	16	89
Transportation - Other	11	14	26	51	24	14	0	38	0	0	0	0	0	0	0	0	89	86
Quality Of Care Grievances	**15**	**9**	**13**	**37**	**15**	**18**	**0**	**33**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**70**	**361**
Access - Other - DMHC	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	3
Access - PCP - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Behavioral Health	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Other	4	2	1	7	0	3	0	3	0	0	0	0	0	0	0	0	10	60
PCP Care	5	1	7	13	8	7	0	15	0	0	0	0	0	0	0	0	28	94
PCP Delay	2	1	3	6	1	3	0	4	0	0	0	0	0	0	0	0	10	116
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	2	1	6	2	3	0	5	0	0	0	0	0	0	0	0	11	60
Specialist Delay	1	2	0	3	2	1	0	3	0	0	0	0	0	0	0	0	6	24
SNF-Long Term Care	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0
Exempt Grievances Received	**183**	**214**	**201**	**598**	**116**	**155**	0	**271**	0	0	0	**0**	0	0	0	**0**	**869**	1885
Access - Avail of Appt w/ PCP	1	1	4	**6**	2	5	0	**7**	0	0	0	**0**	0	0	0	**0**	**13**	15
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	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	0
Access - Wait Time - wait too long on telephone	1	0	1	**2**	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	**4**	7
Access - Wait Time - in office for appt	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2
Access - Panel Disruption	3	3	5	**11**	3	5	0	**8**	0	0	0	**0**	0	0	0	**0**	**19**	15
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	0
Access - Geographic/Distance Access PCP	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	3
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**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	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	2	2	1	**5**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**7**	14
Attitude/Service - Provider	10	9	15	**34**	10	6	0	**16**	0	0	0	**0**	0	0	0	**0**	**50**	43
Attitude/Service - Office Staff	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	5
Attitude/Service - Vendor	0	0	0	**0**	10	6	0	**16**	0	0	0	**0**	0	0	0	**0**	**16**	4
Attitude/Service - Health Plan	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	12
Authorization - Authorization Related	1	2	1	**4**	2	2	0	**4**	0	0	0	**0**	0	0	0	**0**	**8**	6
Eligibility Issue - Member not eligible per Health Plan	0	32	2	**34**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**34**	4
Eligibility Issue - Member not eligible per Provider	3	29	5	**37**	10	6	0	**16**	0	0	0	**0**	0	0	0	**0**	**53**	48
Health Plan Materials - ID Cards-Not Received	27	23	20	**70**	14	26	0	**40**	0	0	0	**0**	0	0	0	**0**	**110**	210
Health Plan Materials - ID Cards-Incorrect Information on Card	1	1	2	**4**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**6**	2
Health Plan Materials - Other	2	0	0	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	4
Behavioral Health Related	0	0	0	**0**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**3**	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	58	60	72	**190**	31	45	0	**76**	0	0	0	**0**	0	0	0	**0**	**266**	652
PCP Assignment/Transfer - HCO Assignment - Change Request	19	15	17	**51**	3	11	0	**14**	0	0	0	**0**	0	0	0	**0**	**65**	301
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	2	1	2	**5**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**8**	37

PCP Assignment/Transfer - Rollout of PPG	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	7
PCP Assignment/Transfer - Mileage Inconvenience	2	0	6	**8**	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	**11**	14
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**	1
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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	65
Transportation - Access - Provider Late	1	0	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	32
Transportation - Behaviour	1	1	0	**2**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	76
Transportation - Other	9	11	9	**29**	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	**31**	53
OTHER - Other	2	2	6	**10**	2	2	0	**4**	0	0	0	**0**	0	0	0	**0**	**14**	14
Claims Complaint - Balance Billing from Provider	30	20	32	**82**	19	28	0	**47**	0	0	0	**0**	0	0	0	**0**	**129**	235

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	2	6	3	11	5	3	0	8	0	0	0	0	0	0	0	0	19	34
Standard Appeals Received	59	38	43	140	42	53	0	95	0	0	0	0	0	0	0	0	235	331
Total Appeals Received	**61**	**44**	**46**	**151**	**47**	**56**	**0**	**103**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**254**	**365**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.4%**
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	2	3	6	11	5	3	0	**8**	0	0	0	**0**	0	0	0	0	19	35
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Resolved Compliant	42	52	39	133	45	45	0	90	0	0	0	0	0	0	0	0	223	325
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.8%**
Total Appeals Resolved	**44**	**55**	**45**	**144**	**50**	**48**	**0**	**98**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**242**	**361**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**55**	**45**	**142**	**50**	**47**	**0**	**97**	**0**	**0**	**0**	0	**0**	**0**	**0**	0	**239**	353
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Consultation	1	0	2	3	2	0	0	2	0	0	0	0	0	0	0	0	**5**	9
CalAim	5	6	5	16	8	7	0	15	0	0	0	0	0	0	0	0	**31**	0
DME	10	11	8	29	11	12	0	23	0	0	0	0	0	0	0	0	**52**	37
Experimental/Investigational	1	5	5	11	6	0	0	6	0	0	0	0	0	0	0	0	**17**	0
Behavioral Health	0	1	0	1	0	3	0	3	0	0	0	0	0	0	0	0	**4**	1
Advanced Imaging	7	20	1	28	11	13	0	24	0	0	0	0	0	0	0	0	**52**	162
Other	6	2	5	13	4	3	0	7	0	0	0	0	0	0	0	0	**20**	35
Pharmacy/RX Medical Benefit	3	6	6	15	4	3	0	7	0	0	0	0	0	0	0	0	**22**	47
Surgery	7	4	9	20	4	5	0	9	0	0	0	0	0	0	0	0	**29**	62
SNF-Long Term Care	1	0	4	5	0	1	0	1	0	0	0	0	0	0	0	0	**6**	0
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Post Service Appeals	**2**	**0**	**0**	**2**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Mental Health	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	7
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	1	0	1	0	0	0	0	0	0	0	0	**1**	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	22	22	19	**63**	23	18	0	41	0	0	0	0	0	0	0	0	104	156
Uphold Rate	**50.0%**	**40.0%**	**42.2%**	**43.8%**	**46.0%**	**37.5%**	**0.0%**	**41.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**43.0%**	**43.2%**
Overturns - Full	18	28	22	**68**	25	26	0	**51**	0	0	0	**0**	0	0	0	**0**	119	194
Overturn Rate - Full	**40.9%**	**50.9%**	**48.9%**	**47.2%**	**50.0%**	**54.2%**	**0.0%**	**52.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**49.2%**	**53.7%**
Overturns - Partials	0	2	4	**6**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	9	10
Overturn Rate - Partial	**0.0%**	**3.6%**	**8.9%**	**4.2%**	**2.0%**	**4.2%**	**0.0%**	**3.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**3.7%**	**2.8%**
Withdrawal	4	3	0	**7**	1	2	0	**3**	0	0	0	**0**	0	0	0	0	10	1
Withdrawal Rate	**9.1%**	**5.5%**	**0.0%**	**4.9%**	**2.0%**	**4.2%**	**0.0%**	**3.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.1%**	**0.3%**
Membership	428,829	430,593	431,030		430,849	432549	0		0	0	0	**0**	0	0	0	**0**		
Appeals - PTMPM	0.10	0.13	0.10	**0.11**	0.12	0.11	0	**0.11**	0	0	0	-	0	0	0	-	**0.11**	**0.09**
Grievances - PTMPM	0.34	0.39	0.51	**0.42**	0.52	0.47	0	**0.50**	0	0	0	-	0	0	0	-	**0.45**	**0.24**

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**	**2025 YTD**	**2024**
Expedited Grievances Received	4	6	7	**17**	4	8	0	12	0	0	0	0	0	0	0	0	**29**	71
Standard Grievances Received	147	173	181	**501**	154	140	0	294	0	0	0	0	0	0	0	0	**795**	1694
Total Grievances Received	**151**	**179**	**188**	**518**	**158**	**148**	**0**	**306**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**824**	**1765**
Grievance Ack Letters Sent Noncompliant	1	2	1	**4**	1	0	0	1	0	0	0	0	0	0	0	0	**5**	0
Grievance Ack Letter Compliance Rate	**99.3%**	**98.8%**	**99.4%**	**99.2%**	**99.4%**	**100.0%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.4%**	**100.00%**
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	4	5	8	17	4	7	0	11	0	0	0	0	0	0	0	0	**28**	71
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Standard Grievances Resolved Compliant	110	132	183	425	181	158	0	339	0	0	0	0	0	0	0	0	**764**	1713
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.9%**
Total Grievances Resolved	**114**	**137**	**191**	**442**	**185**	**165**	**0**	**350**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**792**	**1785**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**101**	**131**	**179**	**411**	**172**	**150**	**0**	**322**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**733**	**1537**
Access - Other - DMHC	21	22	15	58	23	30	0	53	0	0	0	0	0	0	0	0	**111**	228
Access - PCP - DHCS	4	16	11	31	16	15	0	31	0	0	0	0	0	0	0	0	**62**	116
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	7	7	14	5	5	0	10	0	0	0	0	0	0	0	0	**24**	62
Administrative	16	23	42	81	33	32	0	65	0	0	0	0	0	0	0	0	**146**	364
Balance Billing	18	18	31	67	36	24	0	60	0	0	0	0	0	0	0	0	**127**	244
CalAim	4	3	1	8	3	11	0	14	0	0	0	0	0	0	0	0	**22**	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Interpersonal	5	11	11	27	17	10	0	27	0	0	0	0	0	0	0	0	**54**	155
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Other	8	6	31	45	11	8	0	19	0	0	0	0	0	0	0	0	**64**	121
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	3
SNF-Long Term Care	1	1	3	5	2	0	0	2	0	0	0		0	0	0	0	**7**	
Transportation - Access	12	12	5	29	6	4	0	10	0	0	0	0	0	0	0	0	**39**	92
Transportation - Behaviour	3	3	2	8	3	2	0	5	0	0	0	0	0	0	0	0	**13**	38
Transportation - Other	9	9	20	38	17	9	0	26	0	0	0	0	0	0	0	0	**64**	113
Quality Of Care Grievances	**13**	**6**	**12**	**31**	**13**	**15**	**0**	**28**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**59**	**248**
Access - Other - DMHC	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	**1**	1
Access - PCP - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	**1**	2
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	1
Behavioral Health	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	2
Other	3	2	1	6	0	2	0	2	0	0	0	0	0	0	0	0	**8**	30
PCP Care	4	1	6	11	6	6	0	12	0	0	0	0	0	0	0	0	**23**	90
PCP Delay	2	1	3	6	1	2	0	3	0	0	0	0	0	0	0	0	**9**	62
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Specialist Care	3	0	1	4	2	3	0	5	0	0	0	0	0	0	0	0	**9**	39
Specialist Delay	1	2	0	3	2	1	0	3	0	0	0	0	0	0	0	0	**6**	21
SNF-Long Term Care	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	**1**	**0**

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	2025 YTD	2024
Expedited Appeals Received	2	6	2	10	5	2	0	7	0	0	0	0	0	0	0	0	**17**	22
Standard Appeals Received	43	26	35	104	36	40	0	76	0	0	0	0	0	0	0	0	**180**	375
Total Appeals Received	**45**	**32**	**37**	**114**	**41**	**42**	**0**	**83**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**197**	**397**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Expedited Appeals Resolved Compliant	2	3	5	10	5	2	0	7	0	0	0	0	0	0	0	0	**17**	22
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
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	35	37	27	99	38	38	0	76	0	0	0	**0**	0	0	0	**0**	**175**	346
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**37**	**40**	**32**	**109**	**43**	**40**	**0**	**83**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**192**	**368**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**35**	**40**	**32**	**107**	**43**	**39**	**0**	**82**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**189**	**366**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Consultation	1	0	2	3	2	0	0	2	0	0	0	0	0	0	0	0	**5**	28
CalAim	5	3	2	10	6	6	0	12	0	0	0	0	0	0	0	0	**22**	0
DME	8	7	7	22	10	10	0	20	0	0	0	0	0	0	0	0	**42**	63
Experimental/Investigational	1	5	3	9	5	0	0	5	0	0	0	0	0	0	0	0	**14**	9
Behavioral Health	0	1	0	1	0	3	0	3	0	0	0	0	0	0	0	0	**4**	1
Advanced Imaging	5	17	1	23	11	12	0	23	0	0	0	0	0	0	0	0	**46**	130
Other	5	1	3	9	4	1	0	5	0	0	0	0	0	0	0	0	**14**	65
Pharmacy/RX Medical Benefit	3	3	4	10	4	2	0	6	0	0	0	0	0	0	0	0	**16**	30
Surgery	5	3	7	15	1	5	0	6	0	0	0	0	0	0	0	0	**21**	40
SNF-Long Term Care	1	0	3	4	0	0	0	0	0	0	0	0	0	0	0	0	**4**	0
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Post Service Appeals	**2**	**0**	**0**	**2**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**3**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
CalAim	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	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	3
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	1	0	1	0	0	0	0	0	0	0	0	**1**	0
SNF-Long Term Care	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	19	18	11	**48**	18	13	0	**31**	0	0	0	**0**	0	0	0	**0**	**79**	134
Uphold Rate	**51.4%**	**45.0%**	**34.4%**	**44.0%**	**41.9%**	**32.5%**	**0.0%**	**37.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**41.1%**	**36.4%**
Overturns - Full	14	21	17	**52**	23	23		**46**									**98**	213
Overturn Rate - Full	**37.8%**	**52.5%**	**53.1%**	**47.7%**	**53.5%**	**57.5%**	**0.0%**	**55.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**51.0%**	**57.9%**
Overturns - Partials	0	1	4	**5**	1	2		**3**									**8**	15
Overturn Rate - Partial	**0.0%**	**2.5%**	**12.5%**	**4.6%**	**2.3%**	**5.0%**	**0.0%**	**3.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.2%**	**4.1%**
Withdrawal	4	0	0	**4**	1	2		**3**									**7**	6
Withdrawal Rate	**10.8%**	**0.0%**	**0.0%**	**3.7%**	**2.3%**	**5.0%**	**0.0%**	**3.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.6%**	**1.6%**
Membership	340,965	342,423	342,628		342,378	343,598	0		0	0	0	**0**	0	0	0			
Appeals - PTMPM	0.11	0.12	0.09	**0.14**	0.13	0.12	0	**0.12**	0	0	0	0.00	0	0	0	0.00	**0.06**	0.06
Grievances - PTMPM	0.33	0.40	0.56	**0.55**	0.54	0.48	0	**0.51**	0	0	0	0.00	0	0	0	0.00	**0.27**	0.32

CalViva Health Appeals and Grievances Dashboard (Kings County)

Kings County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2025 YTD**	**2024**
Expedited Grievances Received	1	0	0	1	1	1	0	2	0	0	0	0	0	0	0	0	3	8
Standard Grievances Received	15	13	16	44	12	18	0	30	0	0	0	0	0	0	0	0	74	143
Total Grievances Received	**16**	**13**	**16**	**45**	**13**	**19**	**0**	**32**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**77**	**151**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**1**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	0	1	0	2	0	2	0	0	0	0	0	0	0	0	3	8
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	15	12	13	40	17	14	0	31	0	0	0	0	0	0	0	0	71	144
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**16**	**12**	**13**	**41**	**17**	**16**	**0**	**33**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**74**	**152**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**11**	**12**	**38**	**17**	**14**	**0**	**31**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**69**	**137**
Access - Other - DMHC	2	0	1	3	3	5	0	8	0	0	0	0	0	0	0	0	11	18
Access - PCP - DHCS	1	2	1	4	1	0	0	1	0	0	0	0	0	0	0	0	5	8
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	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Administrative	3	2	5	10	3	1	0	4	0	0	0	0	0	0	0	0	14	33
Balance Billing	4	0	0	4	3	1	0	4	0	0	0	0	0	0	0	0	8	16
CalAim	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	3	1	5	1	2	0	3	0	0	0	0	0	0	0	0	8	11
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	1	2	1	0	0	1	0	0	0	0	0	0	0	0	3	9
Pharmacy/RX Medical Benefit	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 - Access	1	0	0	1	0	3	0	3	0	0	0	0	0	0	0	0	4	11
Transportation - Behaviour	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	5
Transportation - Other	1	1	3	5	5	1	0	6	0	0	0	0	0	0	0	0	11	22
Quality Of Care Grievances	**1**	**1**	**1**	**3**	**0**	**2**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**15**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	2
PCP Care	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
PCP Delay	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	4
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1
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 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	2
Standard Appeals Received	2	3	2	7	1	4	0	5	0	0	0	0	0	0	0	0	12	21
Total Appeals Received	**2**	**3**	**3**	**8**	**1**	**5**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	14	**23**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**1**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	2
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	1	2	3	6	2	1	0	3	0	0	0	0	0	0	0	0	9	21
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Appeals Resolved	**1**	**2**	**4**	**7**	**2**	**2**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11**	**23**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**1**	**2**	**4**	**7**	**2**	**2**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11**	**23**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
CalAim	0	2	1	3	1	0	0	1	0	0	0	0	0	0	0	0	4	
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Experimental/Investigational	0	0	1	1	1	0	0	1	0	0	0	0	0	0	0	0	2	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
SNF-Long Term Care	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	0	1	3	**4**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	7	11
Uphold Rate	**0.0%**	**50.0%**	**75.0%**	**57.1%**	**50.0%**	**100.0%**	**0.0%**	**75.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**63.6%**	**47.8%**
Overturns - Full	1	1	1	**3**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	4	11
Overturn Rate - Full	**100.0%**	**50.0%**	**25.0%**	**42.9%**	**50.0%**	**0.0%**	**0.0%**	**25.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**36.4%**	**47.8%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.3%**
Membership	**38,244**	**38,318**	**38,427**		38,410	38,514	0		0	0	0	**0**	0	0	0	**0**		
Appeals - PTMPM	0.03	0.05	0.10	**0.06**	0.05	0.05	0	**0.05**	0	0	0	0.00	0	0	0	0.00	**0.03**	**0.05**
Grievances - PTMPM	0.42	0.31	0.34	**0.36**	0.44	0.42	0	**0.43**	0	0	0	0.00	0	0	0	0.00	**0.20**	**0.33**

Madera County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2025 YTD**	**2024**
Expedited Grievances Received	2	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	7
Standard Grievances Received	22	16	20	58	21	10	0	31	0	0	0	0	0	0	0	0	89	189
Total Grievances Received	**24**	**16**	**21**	**61**	**21**	**10**	**0**	**31**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**92**	**196**
Grievance Ack Letters Sent Noncompliant	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.0%**	**98.3%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.9%**	**100.0%**
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	2	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	7
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
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	13	21	16	50	23	22	0	45	0	0	0	0	0	0	0	0	95	190
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**21**	**17**	**53**	**23**	**22**	**0**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**98**	**197**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**19**	**17**	**50**	**21**	**21**	**0**	**42**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**92**	**168**
Access - Other - DMHC	5	0	2	7	3	4	0	7	0	0	0	0	0	0	0	0	14	25
Access - PCP - DHCS	0	0	1	1	1	2	0	3	0	0	0	0	0	0	0	0	4	13
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	1	1	0	2	1	0	0	1	0	0	0	0	0	0	0	0	3	7
Administrative	2	5	5	12	5	3	0	8	0	0	0	0	0	0	0	0	20	33
Balance Billing	1	4	3	8	6	5	0	11	0	0	0	0	0	0	0	0	19	20
CalAim	0	1	0	1	1	0	0	1	0	0	0	0	0	0	0	0	2	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	2	2	4	0	2	0	2	0	0	0	0	0	0	0	0	6	15
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	1	2	1	0	0	1	0	0	0	0	0	0	0	0	3	14
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access	2	1	0	3	1	1	0	2	0	0	0	0	0	0	0	0	5	23
Transportation - Behaviour	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
Transportation - Other	1	4	3	8	2	4	0	6	0	0	0	0	0	0	0	0	14	11
Quality Of Care Grievances	**1**	**2**	**0**	**3**	**2**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**29**
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	1
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
PCP Care	1	0	0	1	2	1	0	3	0	0	0	0	0	0	0	0	4	7
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	5
Specialist Delay	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

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	2025 YTD	2024
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Received	14	9	6	29	5	9	0	14	0	0	0	0	0	0	0		43	66
Total Appeals Received	**14**	**9**	**6**	**29**	**5**	**9**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	43	**67**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	6	13	9	28	5	6	0	11	0	0	0	**0**	0	0	0	**0**	39	63
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**6**	**13**	**9**	**28**	**5**	**6**	**0**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**	**64**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**6**	**13**	**9**	**28**	**5**	**6**	**0**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**	**64**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
CalAim	0	1	2	3	1	1	0	2	0	0	0	0	0	0	0	0	5	0
DME	2	4	1	7	1	2	0	3	0	0	0	0	0	0	0	0	10	11
Experimental/Investigational	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	3	0	5	0	1	0	1	0	0	0	0	0	0	0	0	6	27
Other	1	1	1	3	0	1	0	1	0	0	0	0	0	0	0	0	4	7
Pharmacy/RX Medical Benefit	0	3	2	5	0	1	0	1	0	0	0	0	0	0	0	0	6	9
Surgery	1	1	2	4	3	0	0	3	0	0	0	0	0	0	0	0	7	4
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SNF-Long Term Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	3	3	5	**11**	4	3	0	7	0	0	0		0	0	0		**18**	**25**
Uphold Rate	**50.0%**	**23.1%**	**55.6%**	**39.3%**	**80.0%**	**50.0%**	**0.0%**	**63.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**46.2%**	**39.1%**
Overturns - Full	3	6	4	**13**	1	3	0	4	0	0	0	**0**	0	0	0	**0**	**17**	35
Overturn Rate - Full	**50.0%**	**46.2%**	**44.4%**	**46.4%**	**20.0%**	**50.0%**	**0.0%**	**36.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**43.6%**	**54.7%**
Overturns - Partials	0	1	0	**1**	0	0	0	0	0	0	0	**0**	0	0	0	**0**	**1**	4
Overturn Rate - Partial	**0.0%**	**7.7%**	**0.0%**	**3.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.6%**	**6.3%**
Withdrawal	0	3	0	**3**	0	0	0	0	0	0	0	**0**	0	0	0	**0**	**3**	0
Withdrawal Rate	**0.0%**	**23.1%**	**0.0%**	**10.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**7.7%**	**0.0%**
Membership	49,620	49,852	49,975		50,061	50,437	0		0	0	0	**0.00%**	0	0	0	**0.00%**		
Appeals - PTMPM	0.12	0.26	0.18	**0.56**	0.10	0.12	0	**0.11**	0	0	0	0.00	0	0	0	0.00	**0.17**	**0.11**
Grievances - PTMPM	0.30	0.42	0.34	**1.06**	0.46	0.44	0	**0.45**	0	0	0	0.00	0	0	0	0.00	**0.38**	**0.33**

CalViva SPD only																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2025 YTD**	**2024**
Expedited Grievances Received	1	1	2	4	3	1	0	4	0	0	0	0	0	0	0	0	8	19
Standard Grievances Received	59	56	67	182	50	56	0	106	0	0	0	0	0	0	0	0	288	612
Total Grievances Received	**60**	**57**	**69**	186	**53**	**57**	**0**	**110**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**296**	**631**
Grievance Ack Letters Sent Noncompliant	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Grievance Ack Letter Compliance Rate	**100.0%**	**98.2%**	**98.5%**	**98.9%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.3%**	**100.00%**
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	1	2	4	3	1	0	4	0	0	0	0	0	0	0	0	8	19
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	51	51	62	164	63	58	0	121	0	0	0	0	0	0	0	0	285	607
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.8%**
Total Grievances Resolved	**52**	**52**	**64**	**168**	**66**	**59**	**0**	**125**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**293**	**627**
Grievance Descriptions - Resolved Cases	**52**	**52**	**64**	**168**	**66**	**59**	**0**	**125**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**293**	**627**
Access to primary care	0	4	2	6	7	5	0	12	0	0	0	0	0	0	0	0	18	35
Access to specialists	0	0	0	0	1	2	0	3	0	0	0	0	0	0	0	0	3	87
Continuity of Care	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	1
Other	26	22	16	64	28	20	0	48	0	0	0	0	0	0	0	0	112	151
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	2	5	9	1	3	0	4	0	0	0	0	0	0	0	0	13	55
QOS Non Access	24	24	41	89	29	29	0	58	0	0	0	0	0	0	0	0	147	280
Exempt Grievances Received	**26**	**49**	**33**	**108**	16	25	0	**41**	0	0	0	**0**	0	0	0	**0**	**149**	**187**
Access - Avail of Appt w/ PCP	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	1
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	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	4
Access - Wait Time - in office for appt	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Access - Panel Disruption	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	1	0
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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	1
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
Attitude/Service - Provider	0	1	2	**3**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	5	24
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Attitude/Service - Vendor	0	0	0	**0**	4	3	0	**7**	0	0	0	**0**	0	0	0	**0**	7	22
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Authorization - Authorization Related	1	1	1	**3**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	4	5
Eligibility Issue - Member not eligible per Health Plan	0	11	0	**11**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	11	2
Eligibility Issue - Member not eligible per Provider	0	10	2	**12**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	13	6
Health Plan Materials - ID Cards-Not Received	5	5	2	**12**	1	3	0	**4**	0	0	0	**0**	0	0	0	**0**	16	26
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	1	1
Health Plan Materials - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Behavioral Health	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	0
PCP Assignment/Transfer - Health Plan Assignment - Change Request	1	6	8	**15**	3	6	0	**9**	0	0	0	**0**	0	0	0	**0**	24	18
PCP Assignment/Transfer - HCO Assignment - Change Request	2	1	2	**5**	0	3	0	**3**	0	0	0	**0**	0	0	0	**0**	8	25
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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
PCP Assignment/Transfer - Rollout of PPG	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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

CalViva Health Appeals and Grievances Dashboard (SPD)

Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Transportation - Behaviour	7	0	0	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	7	0
Transportation - Other	1	7	5	**13**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	14	2
OTHER - Other	0	2	2	**4**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	5	15
Claims Complaint - Balance Billing from Provider	4	4	6	**14**	5	5	0	**10**	0	0	0	**0**	0	0	0	**0**	24	30

CalViva Health Appeals and Grievances Dashboard (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2025 YTD	2024
Expedited Appeals Received	0	2	3	5	1	0	0	1	0	0	0	0	0	0	0	0	6	3
Standard Appeals Received	23	8	13	44	13	11	0	24	0	0	0	0	0	0	0	0	68	132
Total Appeals Received	**23**	**10**	**16**	**49**	**14**	**11**	**0**	**25**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	74	**135**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	1	4	5	1	0	0	1	0	0	0	0	0	0	0	0	6	3
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard 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	13	17	8	38	15	11	0	26	0	0	0	**0**	0	0	0	**0**	64	126
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**13**	**18**	**12**	**43**	**16**	**11**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**70**	**129**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**9**	**18**	**12**	**39**	**0**	**11**	**0**	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**50**	**125**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17
CalAim	0	2	1	3	0	2	0	2	0	0	0	0	0	0	0	0	5	0
DME	4	5	4	13	0	4	0	4	0	0	0	0	0	0	0	0	17	37
Experimental/Investigational	0	2	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	1
Behavioral Health	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Advanced Imaging	2	3	0	5	0	4	0	4	0	0	0	0	0	0	0	0	9	29
Other	2	0	4	6	0	0	0	0	0	0	0	0	0	0	0	0	6	25
Pharmacy/RX Medical Benefit	0	4	1	5	0	1	0	1	0	0	0	0	0	0	0	0	6	6
Surgery	1	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	10
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
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
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	8	7	7	**22**	9	2	0	**11**	0	0	0	**0**	0	0	0	**0**	**33**	51
Uphold Rate	**61.5%**	**38.9%**	**58.3%**	**51.2%**	**56.3%**	**18.2%**	**0.0%**	**40.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**47.1%**	**39.5%**
Overturns - Full	4	7	4	**15**	7	8	0	**15**	0	0	0	**0**	0	0	0	**0**	**30**	72
Overturn Rate - Full	**30.8%**	**38.9%**	**33.3%**	**34.9%**	**43.8%**	**72.7%**	**0.0%**	**55.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.9%**	**55.81%**
Overturns - Partials	0	1	1	**2**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	6
Overturn Rate - Partial	**0.0%**	**5.6%**	**8.3%**	**4.7%**	**0.0%**	**9.1%**	**0.0%**	**3.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.3%**	**4.7%**
Withdrawal	1	3	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	5
Withdrawal Rate	**7.7%**	**16.7%**	**0.0%**	**9.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**5.7%**	**3.9%**
Membership	47,731	47,867	47,918		47,871	48,091	0		0	0	0	**0**	0	0	0	**0**		
Appeals - PTMPM	0.27	0.38	0.25	**0.90**	0.33	0.23	0	0.28	0	0	0	0.00	0	0	0	0.00	**0.30**	**0.15**
Grievances - PTMPM	1.09	1.09	1.34	**3.51**	1.38	1.23	0	1.30	0	0	0	0.00	0	0	0	0.00	**1.20**	**0.65**

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.C

Medical Management

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 5/01/2025 to 5/31/2025

Report created 6/23/2025

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

Exhibits:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Loren Hillburn
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.con

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/01/2025 to 5/31/2025
Report created 6/23/2025

ER utilization based on Claims data	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-02	2025-03	2025-04	2025-05	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
MEMBERSHIP																Quarterly Averages						Annual Averages		
Expansion Mbr Months	120,279	120,769	122,044	122,125	122,163	122,244	121,961	121,430		121,277	121,332	122,118	122,345	123,026		118,378	120,374	122,111	121,878	121,576		120,685	152,525	
Adult/Family/O TLIC Mbr Mos	266,454	266,050	266,607	265,991	264,882	264,720	263,023	261,420		261,031	262,374	262,053	261,911	261,692		265,833	266,571	265,827	263,054	261,819		265,321	327,265	
Aged/Disabled Mbr Mos	46,026	46,962	47,175	47,366	47,622	47,822	48,280	48,512		47,624	47,618	47,808	47,837	48,038		47,003	46,643	47,388	48,205	47,683		47,310	59,731	
COUNTS																								
Admits - Count	2,204	2,194	2,298	2,238	2,187	2,151	2,102	2,130		2,272	2,000	2,036	1,988	1,968		2,188	2,144	2,241	2,128	2,103		2,175	2,188	
Expansion	750	759	770	783	719	708	701	738		850	720	709	704	693		710	728	757	716	760		728	784	
Adult/Family/O TLIC	932	904	946	909	974	911	886	863		919	885	896	858	887		909	900	943	887	900		910	948	
Aged/Disabled	522	531	582	546	494	532	515	529		503	395	431	426	388		569	516	541	525	443		538	456	
Admits Acute - Count	1,459	1,435	1,525	1,471	1,399	1,389	1,410	1,420		1,536	1,297	1,324	1,367	1,291		1,437	1,427	1,433	1,429	1,473		1,434	1,446	
Expansion	594	597	606	606	573	546	565	598		681	557	558	576	559		541	575	595	570	599		570	623	
Adult/Family/O TLIC	467	423	469	412	418	425	444	386		460	440	427	440	409		469	447	433	418	442		442	461	
Aged/Disabled	398	415	450	453	408	418	401	436		395	300	339	351	323		427	407	437	418	345		422	362	
Readmit 30 Day - Count	258	276	242	267	238	262	242	257		248	209	210	214	140		247	254	249	254	222		251	204	
Expansion	109	124	100	106	83	85	93	108		111	95	97	90	57		94	107	96	95	101		98	90	
Adult/Family/O TLIC	51	44	37	43	49	51	40	41		41	37	32	32	23		40	48	43	44	37		44	33	
Aged/Disabled	98	108	105	118	106	126	109	108		96	77	81	92	60		113	98	110	114	85		109	81	
**ER Visits - Count	15,883	15,037	14,747	14,383	14,711	14,614	13,834	14,732		15,470	14,622	15,016	13,624	6,625		14,085	15,272	14,614	14,393	15,036		14,591	13,071	
Expansion	4,188	4,239	4,442	4,351	4,312	4,210	3,767	4,057		4,409	3,945	4,198	3,902	2,042		3,707	4,125	4,368	4,011	4,184		4,053	3,699	
Adult/Family/O TLIC	9,638	8,694	8,153	8,184	8,641	8,681	8,377	8,828		9,240	9,022	9,115	8,118	3,971		8,479	9,104	8,326	8,629	9,126		8,635	7,893	
Aged/Disabled	2,057	2,104	2,152	1,848	1,758	1,723	1,690	1,847		1,821	1,655	1,703	1,604	612		1,899	2,043	1,919	1,753	1,726		1,904	1,479	
PER/K																								
Admits Acute - PTMPY	40.5	39.7	42.0	40.5	38.6	38.3	39.1	39.5		42.9	36.1	36.8	38.0	35.8		40.0	39.5	39.5	39.6	41.0		39.7	40.2	
Expansion	59.3	59.3	59.6	59.5	56.3	53.6	55.6	59.1		67.4	55.1	54.8	56.5	54.5		54.8	57.3	58.5	56.1	59.1		56.7	49.0	
Adult/Family/O TLIC	21.0	19.1	21.1	18.6	18.9	19.3	20.3	17.7		21.1	20.1	19.6	20.2	18.8		21.2	20.1	19.5	19.1	20.3		20.0	16.9	
Aged/Disabled	103.8	106.0	114.5	114.8	102.8	104.9	99.7	107.8		99.5	75.6	85.1	88.0	80.7		108.9	104.6	110.7	104.1	86.7		107.1	72.6	
Bed Days Acute - PTMPY	204.0	208.1	207.4	200.6	189.2	183.8	195.2	204.9		220.6	173.9	190.7	207.9	190.1		216.5	203.8	199.1	194.6	195.0		203.5	207.3	
Expansion	294.8	340.8	318.5	290.2	289.4	247.6	301.4	326.2		370.7	295.5	310.2	314.9	301.3		326.2	311.4	299.3	291.6	325.4		307.0	268.5	
Adult/Family/O TLIC	83.3	66.8	72.7	69.3	70.7	75.3	72.9	70.9		82.7	68.9	72.9	95.4	78.6		79.5	74.5	70.9	73.0	74.8		74.5	67.5	
Aged/Disabled	665.4	667.9	681.2	707.1	591.9	621.3	593.0	622.9		594.4	442.3	531.1	549.6	512.6		714.6	665.5	659.9	612.4	522.6		662.8	442.2	
ALOS Acute	5.0	5.2	4.9	4.9	4.9	4.8	5.0	5.2		5.1	4.8	5.2	5.5	5.3		5.4	5.2	5.0	4.9	4.8		5.1	5.2	
Expansion	5.0	5.7	5.3	4.9	5.1	4.6	5.4	5.5		5.5	5.4	5.7	5.6	5.5		5.9	5.4	5.1	5.2	5.5		5.4	5.5	
Adult/Family/O TLIC	4.0	3.5	3.4	3.7	3.7	3.9	3.6	4.0		3.9	3.4	3.7	4.7	4.2		3.8	3.7	3.6	3.8	3.7		3.7	4.0	
Aged/Disabled	6.4	6.3	6.0	6.2	5.8	5.9	6.0	5.8		6.0	5.9	6.2	6.2	6.4		6.6	6.4	6.0	5.9	6.0		6.2	6.1	
Readmit % 30 Day	11.7%	12.6%	10.5%	11.9%	10.9%	12.2%	11.5%	12.1%		10.9%	10.5%	10.3%	10.8%	7.1%		11.3%	11.8%	11.1%	11.9%	10.6%		11.5%	9.3%	
Expansion	14.5%	16.3%	13.0%	13.5%	11.5%	12.0%	13.3%	14.6%		13.1%	13.2%	13.7%	12.8%	8.2%		13.3%	14.7%	12.7%	13.3%	13.3%		13.5%	11.5%	
Adult/Family/O TLIC	5.5%	4.9%	3.9%	4.7%	5.0%	5.6%	4.5%	4.8%		4.5%	4.2%	3.6%	3.7%	2.6%		4.4%	5.4%	4.6%	5.0%	4.1%		4.8%	3.5%	
Aged/Disabled	18.8%	20.3%	18.0%	21.6%	21.5%	23.7%	21.2%	20.4%		19.1%	19.5%	18.8%	21.6%	15.5%		19.8%	19.0%	20.3%	21.8%	19.1%		20.2%	17.8%	
**ER Visits - PTMPY	440.4	416.0	406.0	396.3	406.1	403.3	383.2	409.8		431.8	406.8	417.1	378.4	183.7		392.0	422.7	402.8	398.8	418.6		404.1	363.4	
Expansion	417.8	421.2	436.8	427.5	423.6	413.3	370.6	400.9		436.3	390.2	412.5	382.7	199.2		375.7	411.3	429.3	395.0	413.0		403.0	291.0	
Adult/Family/O TLIC	434.1	392.1	367.0	369.2	391.5	393.5	382.2	405.2		424.8	412.6	417.4	371.9	182.1		382.8	409.8	375.9	393.6	418.3		390.5	289.4	
Aged/Disabled	536.3	537.6	547.4	468.2	443.0	432.4	420.0	456.9		458.8	417.1	427.5	402.4	152.9		484.8	525.5	486.0	436.5	434.4		482.8	297.1	
Services	TAT Compliance Goal: 100%									TAT Compliance Goal: 100%						TAT Compliance Goal: 100%						TAT Compliance Goal: 100%		
Preservice Routine	100.0%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	96.0%	100.0%		100.0%	94.6%	100.0%	100.0%	100.0%				
Preservice Urgent	98.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		98.2%	96.9%	99.1%	100.0%	100.0%				
Postservice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	98.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		94.0%	98.0%	97.7%	74.5%	66.0%		100.0%	99.1%	99.1%	100.0%	96.5%				
Deferrals - Urgent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	75.0%	80.0%	100.0%		100.0%	100.0%	100.0%	100.0%	87.5%				
	CCS ID RATE									CCS ID RATE						CCS ID RATE						CCS ID RATE		
CCS %	8.53%	8.47%	8.50%	8.52%	8.51%	8.52%	8.55%	8.51%		8.43%	8.57%	8.42%	8.34%	8.43%		7.59%	8.52%	8.51%	8.51%	8.47%		8.28%	8.43%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand									Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand						Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand								
Births	13.9	14.8	15.3	15.6	16.7	15.4	13.9	14.9		15.1	14.0	14.1	12.4	14.1		13.8	13.8	15.9	14.7	14.4		14.5		
OB % Days	3.2%	2.7%	3.4%	4.2%	5.5%	5.0%	4.0%	5.1%		5.0%	4.5%	6.1%	6.4%	9.2%		2.0%	3.1%	4.4%	4.7%	5.2%		17.0%		
OB % Admits	22.5%	23.7%	23.9%	24.9%	27.2%	25.4%	23.4%	24.7%		23.4%	24.4%	24.3%	22.1%	25.3%		21.9%	22.7%	25.4%	24.5%	24.0%		30.0%		

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/01/2025 to 5/31/2025
Report created 6/23/2025

ER utilization based on Claims data	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-02	2025-03	2025-04	2025-05	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
	Perinatal Case Management									**Perinatal Case Management**						**Perinatal Case Management**						**Perinatal Case Management**		
Total Number Of Referrals	257	64	134	137	203	196	157	134		237	223	317	365	319		686	601	474	487	777		2,248	1,461	
Pending	0	0	0	0	0	0	1	21		0	0	0	4	14		0	0	0	22	0		22	18	
Ineligible	9	18	17	13	14	27	17	15		18	15	17	18	22		40	37	44	59	50		180	90	
Total Outreached	248	46	117	124	189	169	139	98		219	208	300	343	283		646	564	430	406	727		2,046	1,353	
Engaged	160	41	103	105	87	71	77	51		113	141	187	224	195		466	346	295	199	441		1,306	860	
Engagement Rate	65%	89%	88%	85%	46%	42%	55%	52%		52%	68%	62%	65%	69%		72%	61%	69%	49%	61%		64%	64%	
Total Cases Managed	619	505	489	422	392	383	368	346		307	311	342	374	387		937	809	670	513	477		1779	634	
Total Cases Closed	153	119	164	102	68	88	58	82		75	60	50	62	74		471	424	334	228	185		1,457	321	
Cases Remained Open	467	388	318	295	306	287	291	247		199	231	277	297	310		442	388	306	247	277		247	310	
	Physical Health Case Management									**Physical Health Case Management**						**Physical Health Case Management**						**Physical Health Case Management**		
Total Number Of Referrals	343	189	224	272	173	313	177	153		185	185	401	544	508		774	800	669	643	771		2,886	1,823	
Pending	0	1	1	0	1	2	1	12		0	0	0	3	31		0	1	2	15	0		18	34	
Ineligible	79	18	4	25	14	12	8	4		4	2	4	28	16		81	134	43	24	10		282	54	
Total Outreached	264	170	219	247	158	299	168	137		181	183	397	513	461		693	665	624	604	761		2,586	1,735	
Engaged	123	77	103	107	67	114	69	82		113	120	180	292	264		339	319	277	265	413		1,200	969	
Engagement Rate	47%	45%	47%	43%	42%	38%	41%	60%		62%	66%	45%	57%	57%		49%	48%	44%	44%	54%		46%	56%	
Total Screened and Refused/Decline	38	15	26	43	27	62	35	16		9	6	72	33	57		108	82	96	113	87		399	177	
Unable to Reach	103	78	90	97	64	123	64	39		59	57	145	188	140		246	264	251	226	261		987	589	
Total Cases Closed	106	94	110	109	85	96	83	88		63	77	100	104	82		312	276	304	267	240		1,159	426	
Cases Remained Open	376	339	331	324	300	323	297	300		277	267	277	253	287		296	339	300	300	277		300	287	
Total Cases Managed	484	441	450	444	402	429	401	398		353	364	388	384	388		622	615	601	582	528		1479	732	
Complex Case	65	65	62	51	46	45	45	40		34	38	35	29	28		99	86	69	60	48		176	58	
Non-Complex Case	419	376	388	393	356	384	356	358		319	326	353	355	360		523	529	532	522	480		1303	674	
	Transitional Care Services									**Transitional Care Services**										**Transitional Care Services**				
Total Number Of Referrals	238	431	493	611	641	827	680	572		577	502	511	514	624		704	797	1745	2079	1590		5,325	2,728	
Pending	0	0	0	0	0	2	8	117		0	0	0	0	3		0	0	0	127	0		127	3	
Ineligible	6	13	3	17	4	22	12	7		7	1	2	3	2		97	26	24	41	10		188	15	
Total Outreached	232	418	490	594	637	803	660	448		570	501	509	511	619		607	771	1721	1911	1580		5,010	2,710	
Engaged	146	232	321	359	402	440	346	246		519	456	462	466	558		375	466	1082	1032	1437		2,955	2,461	
Engagement Rate	63%	56%	66%	60%	63%	55%	52%	55%		91%	91%	91%	91%	90%		62%	60%	63%	54%	91%		59%	91%	
Total Screened and Refused/Decline	6	24	36	33	34	35	34	27		8	3	10	6	6		58	39	103	96	21		296	33	
Unable to Reach	80	162	133	202	201	328	280	175		43	42	37	39	55		174	266	536	783	122		1,759	216	
Total Cases Closed					310	343	354	326		322	232	283	285	253		279	298	795	1023	837		2,395	1,375	
Cases Remained Open	109	233	305	386	423	490	419	383		298	332	324	301	367		107	233	423	383	324		383	367	
Total Cases Managed	245	387	608	735	849	938	932	797		683	617	653	639	679		399	587	1148	1560	1207		2,981	1,801	
	Behavioral Health Care Management									**Behavioral Health Care Management**						**Behavioral Health Care Management**						**Behavioral Health Care Management**		
Total Number Of Referrals	138	81	115	122	83	98	94	88		127	106	154	159	133		245	287	320	280	387		1,132	679	
Pending	0	0	0	0	0	0	0	11		0	0	0	0	7		0	0	0	11	0		11	7	
Ineligible	5	6	2	6	5	3	2	1		6	0	1	6	4		14	13	13	6	7		46	17	
Total Outreached	133	75	113	116	78	95	92	76		121	106	153	153	122		231	274	307	263	380		1,075	655	
Engaged	65	52	73	82	58	78	68	52		81	74	112	115	91		162	152	213	198	267		725	473	
Engagement Rate	49%	69%	65%	71%	74%	82%	74%	68%		67.0%	70.0%	73.0%	75.0%	75.0%		70%	55%	69%	75%	70%		67%	72%	
Total Screened and Refused/Decline	10	1	1	5	0	1	3	1		1	1	0	0	2		5	18	6	5	2		34	4	
Unable to Reach	58	22	39	29	20	16	21	23		39	31	41	38	29		64	104	88	60	111		316	178	
Total Cases Closed	60	36	63	50	60	71	53	52		49	53	57	90	66		93	151	173	176	159		593	315	
Cases Remained Open	127	141	145	160	152	152	157	161		153	142	169	124	101		142	141	152	161	169		161	101	
Total Cases Managed	193	184	217	233	234	243	240	232		216	219	236	232	174		237	297	341	366	338		801	423	
Complex Case	15	13	17	14	19	20	18	16		16	15	17	16	9		19	19	25	23	22		51	23	
Non-Complex Case	178	171	200	219	215	223	222	216		200	204	219	216	165		218	278	316	343	316		750	400	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/01/2025 to 5/31/2025
Report created 6/23/2025

ER utilization based on Claims data	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-02	2025-03	2025-04	2025-05	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
	First Year of Life Care Management									First Year of Life Care Management						First Year of Life Care Management						First Year of Life Care Management		
Total Number Of Referrals	29	22	56	34	25	25	24	28		35	38	50	54	41		108	86	115	77	123		386	218	
Pending	0	0	0	0	0	0	0	0		0	0	0	0	0		0	0	0	0	0		0	0	
Ineligible	0	0	0	0	0	0	0	0		0	0	1	0	0		2	1	2	0	1		5	1	
Total Outreached	0	0	0	0	0	25	24	28		35	38	49	54	41		106	85	113	77	122		381	217	
Engaged	0	0	0	0	0	24	24	28		35	38	44	54	41		106	85	103	76	117		370	212	
Engagement Rate	0%	0%	0%	0%	0%	96%	100%	100%		100.0%	100.0%	90.0%	100.0%	100.0%		100.0%	100.0%	91.0%	99.0%	96.0%		97.0%	98.0%	
Total Screened and Refused/Decline	0	0	0	0	0	1	0	0		0	0	0	0	0		0	0	4	1	0		5	0	
Unable to Reach	0	0	0	0	0	0	0	0		0	0	5	0	0		0	0	6	0	5		6	5	
Total Cases Closed	0	0	0	0	0	21	27	23		32	23	23	34	24		20	28	37	71	78		156	136	
Cases Remained Open	0	0	0	0	0	319	317	322		278	296	327	357	375		196	254	319	322	327		322	375	
Total Cases Managed	0	0	0	0	0	342	345	346		350	355	369	393	401		217	282	357	394	424		480	513	

Item #12
Attachment 12.D

Medical Management

Quarterly Summary Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: July 17th, 2025

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 2 2025 (July 2025)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Care Management, and Population Health Management performance, programs and regulatory activities in Quarter 2 of 2025.

I. Meetings

One QI/UM meeting was held in Quarter 2, on May 15th, 2025. The following **guiding documents** were approved at the May meeting:

1. 2024 Health Equity End of Year Evaluation
2. 2025 Health Equity Program Description
3. 2025 Health Equity Work Plan
4. 2024 Health Equity Language Assistance Program Report
5. 2025 Population Segmentation Report
6. 2025 Long Term Care: Quality Assurance & Performance Improvement Plan

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

1. Medical Policies
2. Clinical Practice Guidelines
3. Appeals & Grievances Policies & Procedures Annual Review

II. QI Reports -

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

1. The **Appeal and Grievance Dashboard & Quarterly A & G Reports** through March 2025 were presented with a general overview. An explanation was provided of how Members and providers submit grievances via phone, fax, email, or online, and each of these is categorized and reported on the dashboard and in other narrative reports. Standardized criteria as outlined in our policies and procedures are used to classify each case in order to include them in the appropriate area on the monthly dashboard.
   Each monthly Excel file includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. These data logs are included on tabs such as Formal Resolved, CCC Exempt Grievances, and BH Exempt. The Outlier tab provides an analysis of the data trends.

The Root Cause Analysis Member Satisfaction report for Quarter 1 was presented to highlight member satisfaction based on the resolved appeal and grievance cases and to identify potential areas for improvement.

Trends included:

a. **Grievances:** There was an increase in all the Top 5 Classifications compared to Q1 2024:
   i. Access to Care
   ii. Eligibility Issues
   iii. Administrative Issues
   iv. Balance Billing
   v. Transportation
b. **Appeals:** There was an increase in appeals volume for all 3 counties compared to Q1 2024. Increases were seen in four (4) out of five (5) appeal categories and there was the addition of a new category, medically tailored Meals from Community Supports.
   The Top 5 Appeal Classifications are:
   i. Self-Injectable Medications
   ii. Genetic Testing
   iii. CAT Scans
   iv. Outpatient Procedures
   v. Medically Tailored Meals

2. The **Potential Quality Issues (PQI) Report** provides a summary of issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.
PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q1 was reviewed for all case types including Behavioral Health and the follow up actions taken when indicated. The number of cases reviewed in Quarter 1 2025 was lower than recent quarters. Follow-up occurs when indicated.

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

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

1. **The Key Indicator Report (KIR)** provided data through March 31st, 2025. Membership has remained consistent. Quarterly comparisons were reviewed with the following results:
   a. Utilization for most risk types decreased in February, but increased again in March 2025, except for SPDs which remained lower.
   b. Bed Days and length of stay for SPDs have remained lower than last year and ER visits remained consistent.
   c. Two (2) Deferral cases did not meet turnaround times.
   d. Care Management results also dipped in February but rebounded in March. Transitional Care Services had a high referral volume and a high engagement rate in March.

2. **NCQA System Controls Appeals & Denials Oversight Report 2024** demonstrates CalViva's oversight of information management and security standard compliance by HealthNet. Per NCQA standards, the report describes how UM Appeals & Denials information is received, stored, reviewed, tracked, and dated.
   The UM System Controls Policy includes the following:
   a. Defines the date of receipt consistent with NCQA requirements.
   b. Defines the date of written notification consistent with NCQA requirements.
   c. Describes the process for recording dates in systems.

d. Specifies titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
e. Specifies how the system tracks modified dates.
f. Describes system security controls in place to protect data from unauthorized modification.
g. Describes how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable.

All cases audited met compliance standards for both Appeals and Denials. No actions at this time.

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

IV. Access Related Reporting for Q2 included the

1. **Access Work Group Quarterly Report.**
2. **Provider Office Wait Time Q1**

V. Pharmacy Quarterly Reports include Pharmacy Executive Summary, Operations Metrics, Top 25 Medication Prior Authorization (PA) Requests, and the Quality Assurance Reliability Results (IRR) which were all reviewed for Quarter 1. All metrics are expected to be within 5% of the standard or goal.

- **All metrics were within 5% of the goal** this quarter with an average turnaround time rate of 99.7%. Prior authorization volumes were higher in Q1 compared to Q4 2024 with no outliers identified.

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

- Overall, the ninety percent (90%) threshold was met, but not the goal of 95%.
- No (0) sample cases missed turnaround time.
- Three (3) sample cases had potential criteria application or documentation issues.
- Three (3) sample cases had letter language that could have been clearer and more concise.
- One (1) sample was determined to have a questionable denial or approval after review.

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

VI. HEDIS® Activity

In Q2, HEDIS® related activities were focused on finalizing and preparing **Measurement Year** (**MY)2024 full HEDIS® Data for submission** to HSAG & DHCS for the Managed Care Accountability Set (MCAS) measures. Final Attestations and IDSS submission were completed on June 12th. Medi-Cal Managed Care (MCMC) health plans currently have 18 quality measures (MCAS) on which we will be evaluated this year. The Minimum Performance Level (MPL) remains at the 50th percentile.

Quality Improvement Activities

A. Two Performance Improvement Projects (PIPs):

1. **Clinical Disparity PIP** - Improve Infant Well-Child Visits (WCV) in the Black/African American(B/AA) Population in Fresno County.
    - Continuing **Intervention #1** to refer all B/AA pregnant or newly delivered members to Black Infant Health (BIH); added member incentives for attending.
    - **Continue 2nd intervention** to utilize **CDC Milestones Tracker app** via BIH to support timely completion of WCV.
    - Next **Submission due 08/07/2025**

2. **Non-Clinical PIP** - Improve Provider Notifications following ED Visit for Substance Use Disorder or Mental Health Issue.
    - Implementing **three (3) interventions** at Saint Agnes Medical Center:
        1. Staff Training on appropriate Coding to document services provided. Modifying to focus on "**Smart Phrases**" used in EPIC EMR.
        2. **Cultural Competency** focusing on the Hispanic Population to increase Follow up.
        3. Facilitate referrals to local CBO (**Resiliency Center**) for follow-up services.
    - Next **Submission due 08/07/2025**

B. DHCS Collaboratives

1. ***Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative*** Completed 5 Interventions in Phase 1 (March 2025); – Phase 2 begins in August 2025.
2. ***Institute for Healthcare Improvement (IHI) Behavioral Health Collaborative*** Phase 1 concluded June 2025. Phase 2 begins in August 2025.

C. ***DHCS County Projects****- All projects in progress with submissions due in June/July 2025*

a. ***Fresno County – Transformational Equity Improvement Projects for 3 Domains***
    1. *Behavioral Health Domain*
    2. *Children's Domain*
    3. *Chronic Conditions Domain (Asthma)*

b. ***Kings County – Comprehensive Equity Improvement Projects for 2 Domains***
    1. Children's Domain (Submitted 06/13/25)
    2. Chronic Conditions Domain

c. ***Madera County - Lean Equity Improvement Project for 1 Domain***
    1. Behavioral Health Domain

VI. Findings/Outcomes

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of the quality and safety of care provided to CalViva members. No significant compliance issues have been identified. Oversight and monitoring processes will continue.

Item #12
Attachment 12.E

Medical Management

Credentialing Sub-Committee Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: July 17th, 2025

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 2 2025

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the 2nd Quarter 2025 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on May 15th, 2025. At the May meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the fourth quarter for 2024 were reviewed for delegated entities and first quarter 2025 for Health Net and Behavioral Health (BH). A summary of the fourth quarter 2024 data is included in the table below.

III. Table 1. Quarter 4 2024 Credentialing/Recredentialing

	Sante	ChildNet	BH	HN	LaSalle	ASH	Envolve	IMG	CVMP	AHP	Grow HC	Mind path	Teledoc	CSV	UPN	**Totals**
Initial credentialing	36	7	19	8	51	0	1	6	28	37	50	23	7	8	59	**340**
Recredentialing	39	22	57	6	32	0	11	0	34	14	0	25	43	7	86	**376**
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	**75**	**29**	**76**	**14**	**83**	**0**	**12**	**6**	**62**	**51**	**50**	**48**	**50**	**15**	**145**	**716**

Note: Grow Healthcare Group, Mindpath, Teledoc, and Clinica Sierra Vista (CSV) are new for 2024.

IV. **Credentialing Adverse Actions** report for Q1 for CalViva from Health Net Credentialing Committee was presented. There were no (0) CalViva cases presented for discussion in Quarter 1.

V. The **Adverse Events Q1 2025** report was reviewed. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period.

- Credentialing submitted zero (0) cases to the Credentialing Committee in the first quarter of 2025.
- There were no (0) reconsiderations or fair hearings during the first quarter of 2025.
- There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the first quarter of 2025.
- There were zero (0) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in the first quarter of 2025.

VI. The **Access & Availability Substantial Harm Report Q1 2025** was presented and reviewed. The purpose of this report is to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issue (PQI) cases related to identified appointment availability complaints. Each case is assigned a severity outcome score and cases requiring follow up are tracked to conclusion. This report now includes behavioral health cases in addition to physical health.

After a thorough review of all first quarter 2025 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).

VII. The **NCQA System Controls CR Oversight Report 2025**

The purpose of this report is to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policies describe:

a. How primary source verification information is received, dated, and stored.
b. How modified information is tracked and dated from its initial verification.
c. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.
d. Security controls that are in place to protect the information from unauthorized modification.
e. How the organization monitors its compliance with the policies and procedures in factors a-d at least annually and takes appropriate action when applicable.

Quarterly audits were performed of all CalViva credentialing files processed with two (2) modifications to CalViva provider records identified in 2024. These two (2) cases were audited against the information management criteria included in the policy and were found to be fully (100%) compliant. Modifications were made by individuals authorized to do so; when and why the modification was made was documented and consistent with policy; what was modified and who made the modification was also documented. Quarterly monitoring will continue with annual auditing and reporting. Appropriate actions will be taken when indicated.

VIII. **The Credentialing Sub-Committee Charter for 2025** was reviewed and approved by the committee. There were no changes to the Charter this year.

Item #12

Attachment 12.F

Medical Management

Peer Review Sub-Committee Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Chief Medical Officer Amy R. Schneider, RN Senior Director Medical Management
COMMITTEE DATE:	July 17th, 2025
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 2 2025

Purpose of Activity:

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

I. The Peer Review Sub-Committee met on **May 15th, 2025**. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 1 2025 were reviewed for approval. There were no significant cases to report.

II. The Q1 2025 **Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period.

- There were nine new (9) cases identified in Q1 that met the criteria and were reported to the Peer Review Committee.
  - Three (3) cases involved a practitioner, and six (6) cases involved organizational providers (facilities).
  - Of the nine (9) cases, three (3) were tabled, one (1) was tabled with a letter of concern, zero (0) were deferred, one (1) was closed to track and trend with a letter of concern, zero (0) were closed to track and trend with a letter of education, and four (4) were closed to track and trend.
  - Seven (7) cases were quality of care grievances, two (2) were potential quality issues, zero (0) were lower-level cases, and zero (0) were track and trend.
  - Zero (0) cases involved seniors and persons with disabilities (SPDs).
  - Zero (0) cases involved behavioral health.
- There were no incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2025.

- There were zero (0) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4)
- Reviews completed in December, January and February did not identify any providers/practitioners who met the Peer Review trend criteria for escalation.
- There were **thirteen (13) cases** identified that required **further outreach**. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management.

III. **The Access & Availability Substantial Harm Report for Q1 2025** was also presented. The purpose of this report is to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances **Quality of Care (QOC)** and **Potential Quality Issue (PQI)** cases related to identified appointment availability issues. Each case is assigned a tracking number, and all pertinent information is gathered for presentation to the Peer Review Committee. Each case is assigned a severity outcome score, and cases requiring follow-up are tracked to conclusion.

- **Seventeen (17) * new cases** were submitted to the Peer Review Committee in Q1 2025. Three (3) cases were related to appointment availability issues *without significant harm,* and three (3) were related to significant harm *without appointment availability issues*. There were no (0) behavioral health related cases identified this quarter.

*One (1) case appeared twice in the quarter.

IV. The **Q1 2025 Peer Count Report** was presented and discussed with the committee. There was a total of seventeen (17) cases reviewed. There were ten (10) cases closed and cleared. No (0) cases were closed/terminated. There were five (5) cases tabled for further information. There was one (1) case with CAP outstanding/continued monitoring, and one (1) was pending closure for CAP compliance.

V. The **Peer Review Sub-Committee Charter for 2025** was reviewed and approved by the Committee. There were no changes to the Charter this year.

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.G

Executive Dashboard

	2024	2024	2024	2024	2024	2024	2024	2024	2025	2025	2025	2025	2025
Month	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**Feburary**	**March**	**April**	**May**
CVH Members													
Fresno	347,954	347,975	349,399	348,729	347,975	348,113	346,388	344,539	343,331	343,661	344,009	343,946	344,786
Kings	38,563	38,404	38,370	38,254	38,133	38,078	38,137	38,356	38,319	38,416	38,595	38,593	38,656
Madera	48,666	48,888	49,258	49,373	49,507	49,666	49,757	49,814	49,686	49,936	50,015	50,185	50,466
Total	435,183	435,267	437,027	436,356	435,615	435,857	434,282	432,709	431,336	432,013	432,619	432,724	433,908
SPD	46,763	46,841	47,066	47,185	47,411	47,615	48,116	48,373	47,384	47,559	47,614	47,581	47,873
CVH Mrkt Share	66.83%	66.85%	66.90%	66.92%	66.92%	66.91%	66.87%	66.86%	66.70%	66.71%	66.75%	66.77%	66.79%
ABC Members													
Fresno	155,374	155,027	155,215	154,520	154,078	154,265	153,460	152,518	152,847	152,663	152,377	151,970	151,951
Kings	25,234	25,053	24,915	24,819	24,689	24,659	24,681	24,705	24,836	24,916	25,007	24,942	25,042
Madera	28,949	28,785	28,665	28,541	28,385	28,149	27,966	27,944	27,940	27,879	27,723	27,650	27,553
Total	209,557	208,865	208,795	207,880	207,152	207,073	206,107	205,167	205,623	205,458	205,107	204,562	204,546
Kasier													
Fresno	5,467	5,931	6,269	6,645	6,936	7,161	7,601	7,873	8,130	8,479	8,737	9,020	9,356
Kings	98	102	113	121	129	154	153	171	187	199	206	209	206
Madera	918	987	1,054	1,098	1,151	1,202	1,253	1,302	1,372	1,428	1,485	1,565	1,608
Total	6,483	7,020	7,436	7,864	8,216	8,517	9,007	9,346	9,689	10,106	10,428	10,794	11,170
Default													
Fresno	59.38%	64.17%	56.65%	59.99%	55.98%	58.51%	57.19%	60.02%		65.71%	61.18%	62.07%	
Kings	57.36%	57.76%	53.88%	53.85%	54.72%	54.02%	47.49%	56.30%			56.49%	42.30%	
Madera	72.97%	77.26%	61.66%	65.08%	66.39%	72.04%	57.60%	81.46%			63.13%	47.18%	
County Share of Choice as %													
Fresno	62.40%	64.25%	62.86%	62.71%	62.50%	63.30%	63.27%	59.51%		63.95%	64.88%	62.72%	
Kings	67.10%	65.56%	66.07%	58.59%	61.86%	69.74%	62.45%	60.92%		40.29%	61.16%	58.03%	
Madera	58.80%	62.24%	65.38%	68.13%	69.84%	65.30%	64.17%	63.15%		69.36%	64.47%	71.61%	

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Security Risk	**2**	Description: Average security risk for all hosts. 5 = High Severity. 1 = Low Severity
	Business Risk Score	**24**	Description: Business risk is expressed as a value (0 to 100). Generally, the higher the value the higher the potential for business loss since the service returns a higher value when critical assets are vulnerable.
	Average Age of Workstations	**3.8 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	Microsoft will stop providing security updates for Windows 10 as of October 14, 2025. Any machines running Windows 10 that are eligible for the upgrade need to have it installed and those that are not eligible should be replaced. At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems. Only 1 workstation remains in the Plan's environment which is currently running Windows 10 and this device is on schedule to be replaced by October 14, 2025.		

Member Call Center CalViva Health Website		**Year**	**2023**	**2024**	**2024**	**2024**	**2024**	**2025**
		Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	(Main) Member Call Center	**# of Calls Received**	**34,875**	**41,520**	**36,270**	**38,251**	**33,900**	**41,923**
		# of Calls Answered	**34,533**	**41,114**	**36,104**	**37,970**	**33,610**	**41,609**
		Abandonment Level (Goal < 5%)	**1.00%**	**1.00%**	**0.50%**	**0.70%**	**0.90%**	**0.70%**
		Service Level (Goal 80%)	**83%**	**85%**	**98%**	**96%**	**93%**	**92%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,436**	**940**	**864**	**957**	**827**	**1,008**
		# of Calls Answered	**1,426**	**936**	**859**	**950**	**816**	**1,004**
		Abandonment Level (Goal < 5%)	**0.70%**	**0.40%**	**0.60%**	**0.70%**	**1.30%**	**0.40%**
		Service Level (Goal 80%)	**95%**	**97%**	**94%**	**93%**	**88%**	**95%**
	Transportation Call Center	**# of Calls Received**	**8,239**	**9,469**	**13,007**	**14,196**	**14,123**	**14,958**
		# of Calls Answered	**8,181**	**9,384**	**12,942**	**13,940**	**14,010**	**14,868**
		Abandonment Level (Goal < 5%)	**0.50%**	**0.60%**	**0.40%**	**1.50%**	**0.60%**	**0.40%**
		Service Level (Goal 80%)	**86%**	**79%**	**86%**	**63%**	**82%**	**86%**
	CalViva Health Website	**# of Users**	**45,000**	**54,000**	**53,000**	**64,000**	**69,000**	**79,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (67%)**	**Mobile (73%)**	**Mobile (70%)**
		Session Duration	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	Q1 2025 numbers were presented on May 15, 2025. Q2 2025 numbers are not yet available. At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website activities. Lastly, approximately 1,100 members have registered and created a member portal account.							

Provider Network & Engagement Activities	**Year**	**2024**	**2024**	**2025**	**2025**	**2025**	**2025**	**2025**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**160**	**161**	**161**	**161**	**161**	**161**	**161**
	PCP	**434**	**435**	**440**	**438**	**441**	**431**	**433**
	PCP Extender	**447**	**439**	**450**	**463**	**471**	**471**	**473**
	Specialist	**1612**	**1623**	**1635**	**1637**	**1585**	**1589**	**1599**
	Ancillary	**316**	**332**	**333**	**335**	**335**	**336**	**338**
	Year	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**	**2025**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Behavioral Health	**598**	**592**	**353**	**652**	**658**	**558**	**545**
	Vision	**110**	**104**	**108**	**116**	**113**	**114**	**112**
	Urgent Care	**14**	**16**	**16**	**16**	**16**	**17**	**17**
	Acupuncture	**4**	**3**	**3**	**3**	**3**	**2**	**3**
	ECM/CS						**43**	**44**
	Year	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**	**2025**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	% of PCPs Accepting New Patients - Goal (85%)	**98%**	**96%**	**94%**	**94%**	**94%**	**91%**	**89%**
	% Of Specialists Accepting New Patients - Goal (85%)	**98%**	**98%**	**97%**	**98%**	**97%**	**96%**	**96%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**96%**	**93%**	**96%**	**97%**	**98%**	**99%**	**99%**
	Year	**2024**	**2024**	**2025**	**2025**	**2025**	**2025**	**2025**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Providers Interactions by Provider Relations	**450**	**354**	**428**	**415**	**487**	**549**	**408**
	Reported Issues Handled by Provider Relations	**5**	**1**	**14**	**22**	**21**	**17**	**3**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**22**	**1**	**43**	**10**	**74**	**74**	**26**
	Interventions Deployed for PCP Quality Performance Improvement	**22**	**1**	**43**	**10**	**74**	**74**	**26**
Message From the CEO	Q1 2025 numbers are available for % of a particular provider accepting new patients. At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

	Year	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**	**2025**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Claims Processing	**Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure**	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 98% N/A	96% / 98% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	N/A	99% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	87% / 100% NO	76% / 100% NO	1% / 93% NO				
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 98% NO	99% / 99% NO	94% / 97% YES	88% / 99% YES	80% / 100% YES	79% / 95% YES	91% / 100% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	68% / 92% NO	47% / 89% YES	79% / 93% YES	99% / 100% NO	94% / 97% NO	96% / 100% YES	93% / 100% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	98% / 99% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	98% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% YES	99% / 100% YES	98% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	97% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	64% / 100% NO	95% / 100% NO	79% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure		100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q1 2025 numbers are available. Management continues to work with PPG 2 and PPG 3 to improve performance. The Plan is aware informally of some changes which will occur in the near future for PPG 8. The Plan is monitoring this activity. Aside from this, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

Provider Disputes	**Year**	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**	**2025**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	98%	99%	99%	99%	100%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	78%	98%	89%				
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	31%	81%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	66%	65%	70%	93%	99%	96%	99%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	55%	90%	97%	100%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	65%	85%	98%	97%	97%	98%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	63%	97%	100%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	67%	95%	100%	100%	100%	99%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	99%	100%	97%	100%	100%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)		N/A	100%	100%	100%	98%	100%
Message from the CEO	Q1 2025 numbers are available. All areas met goal. At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Dispute activities.							