PROVIDER PRESS

Summer 2026

- Covered California
- Provider Rate Increases
- Medi-Cal Program Changes
- Provider Profile
- Flex Card Healthy Food Benefit

CalOptima Health

caloptima.org | CalOptima Health, A Public Agency

Open Enrollment for CalOptima Health Covered Launching in November

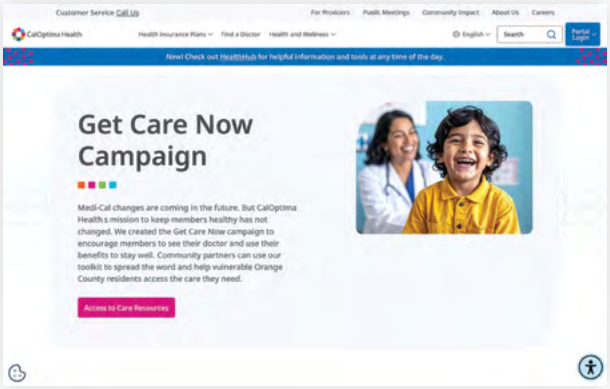
CalOptima Health continues preparations to offer a Covered California product that will go live on January 1, 2027. Following focus groups conducted by our contracted marketing agency, we announced the name of our new product — CalOptima Health Covered. The name was overwhelmingly selected by focus group participants from eight presented options.

This fall, look out for announcements on CalOptima Health Covered's brand campaign. Please encourage your patients to connect with a local enroller, contact CalOptima Health's sales team or visit Covered California's enrollment website, **www.coveredca.com**, for more information on plan options and covered benefits. Open enrollment for 2027 will run from November 1, 2026, through January 31, 2027.

Campaign and Toolkit Promote Continued Use of Health Coverage

Changes are coming to Medi-Cal due to new federal and state laws, but CalOptima Health's mission to keep members healthy has not changed. That is why we launched the Get Care Now campaign in Fall 2025 to encourage members to continue seeking care.

Running through May 2026, the multimedia campaign featured ads in print, digital, social media, radio, outdoor transit shelters, bus interiors, mobile billboards and local places frequented by members.



In addition, CalOptima Health created a toolkit for use by providers and community partners. Together, let's spread the message that members have options for care, including virtual doctor visits and medicine home delivery. A flyer, FAQ and social media content can be downloaded at www.caloptima.org/en/community-impact/get-care to share via your communication channels. Join us in encouraging members to stay healthy and well!

2026 Report to the Community Highlights CalOptima Health's Impact and Accomplishments

We invite providers to read our 2026 Report to the Community, which highlights the impacts and accomplishments of the prior year. Partnership is a key theme, as we work with our Board, community stakeholders and providers to achieve results and transform the delivery of care to members. Special sections cover Member Engagement and Support, Community Outreach and Impact, Provider Network and Access, Care Quality and Outcomes, What's Next, and Finances and Leadership.

In celebration of our 30th anniversary, we also highlight our long-term employees and their dedication to our members and mission. Throughout the report, readers can scan QR codes to watch member videos, read special reports, view televised media coverage and visit the Covered California website. The report is featured on our website at https://bit.ly/rtc2026.

CalOptima Health Invests $429.6 Million in Rate Increases for Hospitals and Specialists

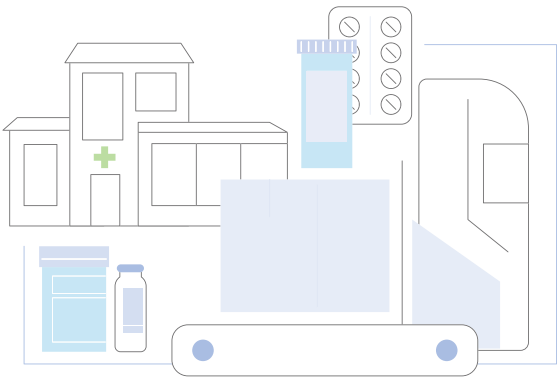
The CalOptima Health Board of Directors has approved using $429.6 million from reserves to increase rates for hospitals and specialists, which will improve access to care for members and support hospitals in the wake of federal and state Medi-Cal changes. With this funding, approved during the Board's June 4, 2026, meeting, the health plan has invested nearly $1 billion in provider rate increases since 2024.

Recent policy changes have led to the loss of Medi-Cal coverage for thousands of Californians, including many Orange County residents. This is predicted to hit hospitals particularly hard, as they will be forced to provide uncompensated care to individuals who are no longer covered, resulting in reduced financial margins and a strain on the local health care safety net. Facilities serving large numbers of former Medi-Cal recipients will see a reduction in funding, which is often used to cover operating costs.

In making this significant move, Board members stated that increasing specialty provider rates keeps CalOptima Health competitive, helps retain existing doctors and entices others in difficult-to-recruit specialties to contract with the health plan. This, in turn, means greater access to care for CalOptima Health members, more geographic coverage by contracted specialists and stronger regulatory compliance. The rates will be in effect from July 1, 2026, through December 31, 2028.

"As a Board, we made a concerted effort to increase our reserves in anticipation of growing pressures on our health care system, knowing we would need the flexibility to support the providers and hospitals who serve CalOptima Health members every day," said Vicente Sarmiento, CalOptima Health Board Chair and Orange County Supervisor. "This investment reflects our commitment to our medical partners and our confidence in their vital role in serving our communities. I know this won't solve all the issues they are facing, but it will offset some of the reductions, impacts and challenges affecting the health care industry right now."

Few Medi-Cal health plans in the state are in a financial position to boost provider rates in this manner. CalOptima Health has exercised careful fiscal stewardship over the past several years, planning for this unprecedented time when additional resources are needed, according to the organization's executive leaders. Approved in June 2024, a prior large-scale rate increase of $526.2 million boosted funding for health networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers for a 30-month period from July 2024 to December 2026. These two investments combined represent a historic level of nearly $1 billion in funding to promote the financial stability of Orange County's provider community.



"Nearly half of the Orange County hospitals were operating at a financial loss even before recent Medicaid cuts and coverage losses," said Sara May, Regional Vice President of the Hospital Association of Southern California. "We thank CalOptima Health for taking action that supports hospitals and protects access to emergency and specialty care for Orange County residents."

AltaMed Providing Street Medicine in Santa Ana

In March 2026, CalOptima Health's Street Medicine Program launched in Santa Ana, making it the fourth city to partner with the health plan to deploy a mobile team to engage people experiencing homelessness where they are, reducing barriers to health care and social services. According to Santa Ana data, approximately 500 people in the city are experiencing homelessness, many of whom could benefit from the Street Medicine Program.

Following a rigorous evaluation process, we selected AltaMed Health Services as the provider for Santa Ana and approved a two-year agreement with up to a $4.3 million grant. "AltaMed is proud to partner with CalOptima Health for the Street Medicine Program to bring access to vital health services to vulnerable Santa Ana community members," said Esiquio Casillas, M.D., Executive Vice President and Chief Clinical and Operations Officer, AltaMed Health Services. "As a trusted community health center, AltaMed has been committed to reducing health disparities across Southern California for more than five decades."

Since its inception in April 2023, the Street Medicine Program has served more than 1,100 people in Garden Grove, Costa Mesa and Anaheim, providing integrated primary care, social services and housing navigation. Of those, 52 people have been placed in permanent housing.

CalOptima Health is also currently pursuing a regional expansion of the program. Under this model, two or more cities with a certain number of unsheltered individuals can collaborate to host the program across their jurisdictions. The CalOptima Health Board of Directors will consider approval of future regional programs in August 2026.

SANTA ANA
1869

Help Educate Members About Medi-Cal Program Changes

New federal and state laws have changed the rules on who qualifies for Medi-Cal. Affected CalOptima Health members will be told by mail, text or email. Providers can support their Medi-Cal patients by encouraging them to keep their contact information up to date at **BenefitsCal.com** so they don't miss important notices. Members should also know their renewal date so they can take action if they don't receive notices. Your patients can find more information on CalOptima Health's website at **www.caloptima.org/changes**.

Here's what our members need to know:

Older Adults and People With Disabilities	
January 2026 Asset Limits	Effective January 1, 2026, when you apply for or renew your Medi-Cal, the County of Orange Social Services Agency (SSA) will look at what you own. This is called an asset check. Assets are things you own that have value.
Adult Immigrants	
January 2026 Enrollment Freeze	Effective January 1, 2026, some adults are no longer able to sign up for full-scope Medi-Cal coverage based on their immigration status.
July 2027 Dental Coverage	Effective July 1, 2027, some Medi-Cal members cannot get full-scope dental services as part of their Medi-Cal coverage.
October 2026 Immigration Status Changes	Starting October 1, 2026, the federal government will change how it classifies some immigration statuses (your legal standing in the U.S. based on how and why you came here).
July 2027 Monthly Premiums	Starting July 1, 2027, some Medi-Cal members will need to pay a monthly fee (called a premium) to keep their full-scope Medi-Cal.
Adults (Ages 19–64)	
January 2027 Work Rules	Starting January 1, 2027, some adults will need to work, volunteer or go to school to keep their Medi-Cal. If this applies to you, SSA will send you a letter.
January 2027 Six-Month Eligibility Checks	Starting January 1, 2027, some Medi-Cal members will have their eligibility checked twice a year instead of once.
January 2027 Less Time to Get Help Paying Old Medical Bills	Starting January 1, 2027, Medi-Cal will pay for fewer months of past medical bills from before you applied.
October 2028 Copayments	Starting October 1, 2028, some Medi-Cal members will have to pay a small fee (called a copayment) for certain services.

CEO Michael Hunn to Retire at the End of 2026

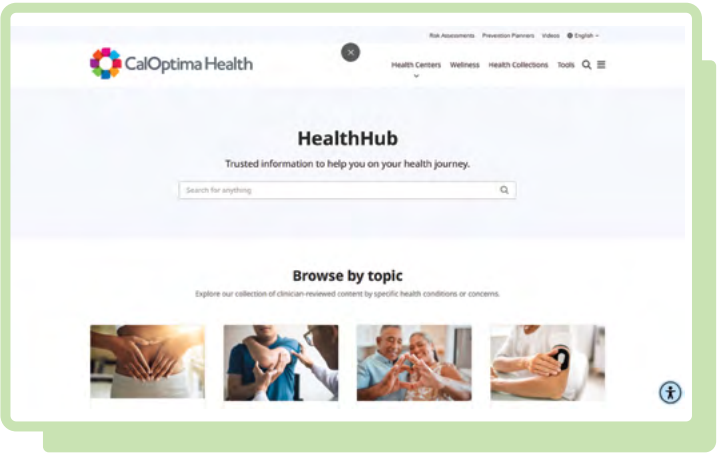
CalOptima Health Chief Executive Officer Michael Hunn has announced that he will retire on December 31, 2026. As the health plan's leader for the past five years, Hunn has been deeply committed to serving low-income and vulnerable populations and supporting the health care safety net. Hunn's focus on putting members at the center of the organization contributed to CalOptima Health's growth, increased employee and provider engagement, and brought positive recognition among public health plans.

Hunn's provider-focused accomplishments include enacting multiple rate increases that benefited safety net providers and hospitals, expanding access to care by adding Providence as a 10th health network, creating Street Medicine programs in four cities across Orange County, and implementing workforce development grants to reduce provider shortages.

"I am proud of everything we have achieved at CalOptima Health over the past five years, and I will remain fully committed and focused through the end of the year," Hunn said. "We have reinvigorated CalOptima Health and reestablished our plan as a trusted community partner that serves members with dignity and respect."

Member HealthHub Goes Live on CalOptima Health Website

In March, we debuted HealthHub on our website, which features a comprehensive library of trusted health information to help members make informed health choices. Topics include diabetes, heart health, nutrition and much more. HeathHub also includes:



- Easy-to-read content and videos on common health topics
- Health and wellness information reviewed by doctors and experts
- Tools to check health risks or make a care plan
- Tips to stay healthy

We are promoting the HealthHub to our members through text campaigns, social media and in member newsletters. To access the HealthHub, visit **healthhub.caloptima.org**.

Review CalOptima Health's Vaccine Guidance Following Updated CDC Recommendations

On January 5, 2026, the Centers for Disease Control and Prevention (CDC) released a revised childhood and adolescent immunization schedule that changes recommendations for several vaccines. Key changes include:

- Hepatitis A and B, rotavirus, influenza, meningococcal disease and COVID-19 vaccines are no longer routinely recommended.
- DTaP, Hib, Pneumococcal, Polio, MMR, varicella and HPV (now one dose instead of two) vaccines are still recommended routinely for all children.
- Rotavirus, hepatitis A and B, and meningococcal ACWY and B vaccines are recommended for high-risk children.
- Rotavirus, COVID-19 and influenza vaccines are recommended for shared decision-making.

The American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) have not endorsed the revised CDC recommendations and have issued their own immunization guidelines that differ from the CDC's. The California Department of Public Health (CDPH) will not adopt the new CDC childhood vaccine recommendations but will maintain its comprehensive immunization schedule, aligning with the AAP and AAFP.

We remain committed to evidence-based practices. We will continue to follow evidence-based immunization guidelines from AAP and AAFP, in alignment with CDPH guidance, to ensure the highest standard of care for children, young adults and families.

Please note that all vaccines, regardless of category, will remain covered at no cost under private and public insurance, including Affordable Care Act plans, Medicaid, the Children's Health Insurance Program (CHIP) and the Vaccines for Children program. California Assembly Bill 144 ensures that vaccines recommended by the CDPH as of January 1, 2025, will continue to be covered by insurance in California, despite federal changes.

What does this mean for you?

- Continue to recommend and administer childhood and adolescent vaccines per AAP guidance and for young adults 19 years or older per AAFP guidance.
- Communicate clearly with families about benefit coverage and safety.
- Performance accountability for the HEDIS immunization measures, including Childhood Immunization Status and Immunizations for Adolescents, remains unchanged.
- Providers who follow immunization guidelines in accordance with CDPH guidelines based on AAP and AAFP vaccination guidelines are provided liability protection.

Frequently Asked Questions: CDC Immunization Changes and CalOptima Health Recommendations

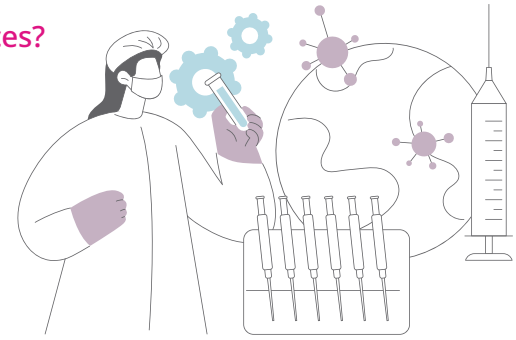
CalOptima Health has developed this FAQ to clarify recent CDC immunization changes and outline our recommendations to ensure the highest standard of care for members.

1 What changed in the CDC immunization recommendations?

The CDC revised the immunization schedule, reducing the number of routine vaccines for children and shifting some to high-risk groups or to shared clinical decision-making. These changes do not align with recommendations from the AAP and AAFP.

2 Should providers change their current immunization practices?

Providers should continue to follow AAP and AAFP immunization standards, ensure timely and accurate documentation in medical records, and report to the California Immunization Registry (CAIR). Proper documentation supports continuity of care and performance reporting.



3 Is CalOptima Health adopting recent CDC changes?

CalOptima Health follows the most protective evidence-based guidelines, including AAP and AAFP recommendations aligned with the CDPH to ensure member safety and health outcomes. This approach supports disease prevention and health equity outcomes.

4 Is there any liability for following immunization guidance that differs from the CDC?

No. California AB 144 protects providers from liability when they follow CDPH guidelines based on AAP and AAFP standards, even if those guidelines differ from CDC guidance.

5 Will providers be held accountable for HEDIS-related immunization measures?

Yes. Providers will continue to be held accountable for performance on HEDIS immunization measures. These measures reflect evidence-based practices for optimal preventive care.

6 Does the CDC change impact vaccine coverage or reimbursement?

No. All vaccines remain included in the Vaccines for Children program and will continue to be covered benefits at no cost to eligible members. Providers should continue to follow established billing requirements.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The most up-to-date AAP immunization schedule can be found at **AAP.org/ImmunizationSchedule**.

For questions, providers may contact their Provider Relations representative.

CalOptima Health's 2026 Medi-Cal and OneCare Member Health Rewards Programs Are Now Digital

Eligible CalOptima Health members can earn health rewards by completing important screenings and tests. Providers play a key role in both ensuring their patients complete these screenings and helping them receive their rewards.

For 2026, both Medi-Cal and OneCare Member Health Rewards have gone digital. Members can now submit health reward forms directly online at **www.caloptima.org/healthrewards**. No more paper forms, signatures/stamps or mailing/faxing. This streamlined digital process helps members receive their rewards faster.

2026 Medi-Cal Member Health Rewards Program

Medi-Cal Health Reward	Who's Eligible
Annual Wellness Visit* **$50**	Members age 45 and older who complete an Annual Wellness Visit in 2026
Breast Cancer Screening **$25**	Members ages 40–74 who complete a breast cancer screening mammogram in 2026
Blood Lead Test at 12 Months of Age* **$25**	Members between 12 and 23 months of age who complete a blood lead test in 2026
Blood Lead Test at 24 Months of Age* **$25**	Members between 24 and 35 months of age who complete a blood lead test in 2026
Cervical Cancer Screening **$25**	Members ages 21–64 who complete a cervical cancer screening in 2026
Colorectal Cancer Screening — Other Types • Fecal occult blood test (FOBT) **$15** • Fecal immunochemical test (FIT) **$15** • Flexible sigmoidoscopy **$25** • CT colonography **$25**	Members ages 45–75 who complete either a FOBT, FIT, flexible sigmoidoscopy or CT colonography test. Members are eligible for one of these colorectal cancer screening rewards each calendar year
Colorectal Cancer Screening — Colonoscopy **$50**	Members ages 45–75 who complete a colonoscopy in 2026
Diabetes A1c Test **$25**	Members ages 18–75 with a diagnosis of diabetes who complete an A1c test in 2026
Diabetes Eye Exam **$25**	Members ages 18–75 with a diagnosis of diabetes who are due for and complete a dilated or retinal eye exam in 2026
Postpartum Checkup **$25**	Members who have a postpartum checkup between one and 12 weeks after delivery

*No health reward form needed

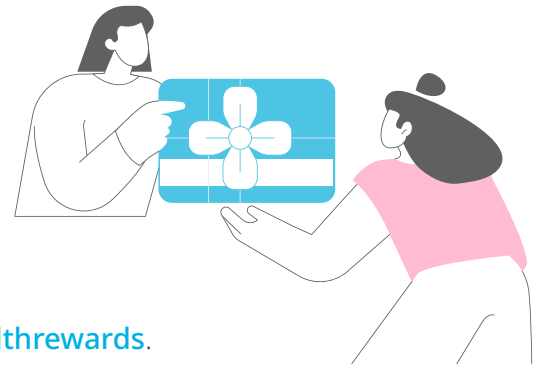
Important Notes About Medi-Cal Member Health Rewards:

- Each health reward may be earned once per calendar year, while funds last.
- Rewards are processed after visit confirmation. Please allow up to 90 days for delivery. Rewards will be mailed to the address provided in the digital form.
- If a provider recommends a screening outside the listed age range, members may still qualify by submitting a form.

2026 OneCare Member Health Rewards Program

OneCare Health Reward	Who's Eligible
Annual Wellness Visit* **$50**	Members who complete an Annual Wellness Visit in 2026
Breast Cancer Screening **$25**	Members who complete a breast cancer screening mammogram in 2026
Colorectal Cancer Screening — Other Types • FOBT **$15** • FIT **$15** • Flexible sigmoidoscopy **$25** • CT colonography **$25**	Members who complete either an FOBT, FIT, flexible sigmoidoscopy or CT colonography test. Members are eligible for one of these colorectal cancer screening rewards each calendar year
Colorectal Cancer Screening — Colonoscopy **$50**	Members who complete a colonoscopy in 2026
Diabetes A1c Test **$25**	Members with a diagnosis of diabetes who complete an A1c test in 2026
Diabetes Eye Exam **$25**	Members with a diagnosis of diabetes who complete a dilated or retinal eye exam in 2026
Health Risk Assessment* **$25**	Members who are due for and complete a Health Risk Assessment in 2026
Osteoporosis Management **$25**	Members who get a bone mineral density test or fill a prescription to treat osteoporosis in 2026

*No health reward form needed



Important Notes About OneCare Member Health Rewards:

- Each health reward may be earned once per calendar year, while funds last.
- Rewards are processed within five business days and loaded to the member's flex card.
- Members can submit forms online at www.caloptima.org/healthrewards.
- Members can get help with submitting the form by calling OneCare Customer Service at **1-877-412-2734** (TTY **711**).

Review CalOptima Health's Timely Access Standards

CalOptima Health adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). DHCS conducts an annual, timely access survey of all managed care plans (MCPs) to ensure compliance with provider availability and wait-time standards for urgent and non-urgent appointments across network provider types.

The survey consists of calling a randomized sample of network providers in each MCP's local reporting unit. In addition, DHCS provides CalOptima Health with a plan-specific Quarterly Monitoring Response Template and Medi-Cal Managed Care Quarterly Monitoring Performance Report as part of this ongoing performance monitoring.

CalOptima Health continuously monitors and evaluates our members' ability to obtain prompt health care services, as required by DHCS. Please refer to CalOptima Health's Medi-Cal Policy GG.1600: Access and Availability Standards for more information related to the monitoring process.

Thank you for ensuring our members have access to timely health care. To assist you with this effort, CalOptima Health is providing the following list of Medi-Cal timely access standards. If you have questions or would like to speak with a Provider Relations representative, please call **714-246-8600** or email providerservicesinbox@caloptima.org.

Appointment Standards:

Type of Care	Standard
Emergency Services	24/7
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request
Urgent Appointments that DO Require Prior Authorization	Within 96 hours of request
Initial Health Appointment (first visit after becoming a CalOptima Health member)	Within 120 calendar days of enrollment or for members less than 18 months of age within recommended timelines established by AAP Bright Futures
Non-Urgent Appointments for Primary Care	Within 10 business days of request
Non-Urgent Appointments With Specialist Physicians	Within 15 business days of request
Non-Urgent Follow-Up Appointments for Physician Behavioral Health Care Providers	Within 30 calendar days of request
Non-Urgent Appointments for Ancillary (Support) Services	Within 15 business days of request
Non-Urgent Appointment With a Non-Physician Mental Health Provider	Within 10 business days of request
Non-Urgent Follow-Up Appointment With a Non-Physician Mental Health Provider	Within 10 business days of request

Telephone Access Standards:

Description	Standard
Telephone Triage or Screening Services	Telephone triage or screening will be available 24/7. Telephone triage or screening waiting time will not exceed 30 minutes
Telephone Access After and During Business Hours for Emergencies	The phone message or live person must instruct members on: • The length of wait time for a return call from the provider • How the caller may obtain urgent or emergency care
After-Hours Access	A primary care provider (PCP) or designee will be available 24/7 to respond to after-hours member calls or to a hospital emergency room practitioner

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation, including but not limited to American Sign Language, will be made available to members at key points of contact through an interpreter, either in person (upon request) or by telephone, 24/7
Written Translation	All written materials to members will be available in all threshold languages as determined by CalOptima Health in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services
Alternative Forms of Communication	Informational and educational information for members in alternative formats will be available upon request or standing request at no cost in all threshold languages in at least 20-point font, audio format or braille, or as needed within 21 business days of request or within a timely manner for the format requested
Telecommunications Device for the Deaf	Teletypewriter (TTY) and auxiliary aids will be available to members with hearing, speech or sight impairments at no cost, 24/7. The TTY line is **711**
Cultural Sensitivity	Providers and staff will encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs, and integrate these beliefs into treatment plans where appropriate
Moral Objection	In the event a provider has a religious, moral or ethical objection to perform or otherwise support the provision of covered services, CalOptima Health or the health network must, on a timely basis, arrange, coordinate and ensure the member receives covered services through referrals to a provider that has no religious or ethical objection to performing the requested service or procedure at no additional expense to DHCS or the member

Provider Profile: Sabrina Cooley, M.D.

Dr. Cooley attended Cornell University for her bachelor's degree before earning her medical degree from Ohio State University and completing her residency at Kaiser Permanente Family Medicine. Dr. Cooley has practiced in diverse settings, including serving four years in the United States Navy as a medical officer, one year at the County of San Diego Psychiatric Hospital and four years at an urgent care center with MemorialCare Medical Group before working as Site Medical Director at ShareOurselves Community Health Center.

In 2021, she became Chief Medical Officer of Celebrating Life Community Health Center, where she pursues her passion for providing whole-person care to underserved communities. Dr. Cooley is a member of the AAFP and is board-certified in family medicine. She enjoys the arts, Zumba, paddleboarding, and spending her free time with her loved ones and pets.

1 Why did you go into medicine and family practice in particular?

Growing up, I was drawn to science, nature and service. With encouragement from mentors, I explored medicine and, after shadowing a physician, I knew it was the right path for me.

I initially considered pediatrics, but during medical school, I was inspired by a family physician who showed me the impact of caring for patients across all stages of life. I value the family unit and believe in caring for the whole person, which made family medicine a natural fit.

2 How does your role connect to delivering whole-person care to Celebrating Life's patients?

As Chief Medical Officer, I focus on improving the quality of care and developing systems that support better outcomes. For me, that means looking beyond a diagnosis — understanding each patient's barriers, mental health and overall well-being.

I'm grateful to work alongside teams who share this vision, allowing us to create a more compassionate, whole-person approach to care.

3 As someone with a passion for caring for underserved communities, what needs do you see in Orange County?

I see ongoing disparities in access to care, resources and opportunity. Many patients face challenges that go far beyond their medical conditions.

I believe everyone deserves high-quality care and the chance to live a healthy life, regardless of their background. That belief continues to drive my commitment to reaching underserved communities and helping close those gaps.

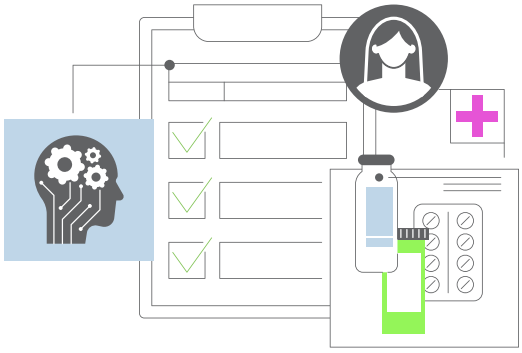
4 What does it mean to you to serve the Medi-Cal population in particular?

Serving the Medi-Cal population is especially meaningful because it allows me to care for those who often face the greatest barriers to health care.

It aligns closely with my personal mission and our clinic's mission, and it's what motivates our team and me to remain deeply committed to providing compassionate, equitable care.

Review These Tips for Working With LEP Patients

State and federal regulations require CalOptima Health and our contracted health networks, medical groups and providers to make interpreter and translation services available for limited English proficient (LEP) members.



Interpreters must be professionally trained and versed in medical terminology and health care benefits. Because it is important that providers know how to identify, offer and access interpreter services for LEP members, please review the following information about requesting either telephonic or face-to-face interpreter services for your CalOptima Health LEP patients:

1 **Verify the member's eligibility and identify if the member is enrolled in a health network or CalOptima Health Direct.**

2 **Determine whether telephonic or face-to-face interpreter service is needed.**

a. Telephonic interpreter service is recommended for urgent situations or short and simple conversations. This service is available 24/7.

b. Face-to-face interpreter service, including American Sign Language, is recommended when a complicated or extensive explanation of treatment or symptoms is required. This service is available for scheduled medical appointments in an ambulatory setting and requires at least five working days' advance notice.

3 **Please have the following information ready at the time of the request:**

- Member's name
- Member's client index number (CIN)
- Member's gender
- Member's age
- Date of appointment
- Time of appointment
- Language needed
- Approximate duration
- Type of visit
- Name of doctor/facility
- Address of appointment/ location
- Phone number of appointment/location

4 **If the member is in CalOptima Health Direct, call Customer Service at 714-246-8500. Prior authorization is not required.**

5 **If the member is in a health network, please contact the member's health network after verifying eligibility. The health network will work with you and the member to coordinate all interpreter services.**

For additional information, please see sections N7 and N6 of the Provider Manual on the CalOptima Health website: https://bit.ly/chmanualguides.

Follow These Best Practices to Avoid Prescribing Unnecessary Antibiotics

Approximately 80% to 90% of antibiotic prescriptions are written in outpatient settings, and at least 28% of those antibiotics are unnecessary, according to the CDC. Because most causes of upper respiratory tract infections are viral, the CDC advises against prescribing antibiotics for acute bronchitis or bronchiolitis in otherwise healthy individuals.

The HEDIS measure for Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) examines the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis or bronchiolitis that did not result in an antibiotic dispensing event.

Common ICD-10-CM Diagnosis Codes

For inclusion:

- Acute bronchitis — J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9
- Acute bronchiolitis — J21, J21.1, J21.8, J21.9

For exclusion:

- Acute pharyngitis — J02
- Acute tonsillitis — J03
- Suppurative otitis media — H66
- Acute sinusitis — J01
- Pneumonia — J18
- Chronic sinusitis — J32
- Chronic tonsillitis; hypertrophy tonsils — J35
- Disease upper respiratory tract — J39
- Cellulitis/acute lymphangitis — L03
- UTI — N39

Are any members excluded from the AAB measure?

- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.

How can I improve performance?

- Document correct ICD-10-CM diagnosis codes for acute bronchitis and bronchiolitis.
- Avoid the use of antibiotics for routine treatment of uncomplicated acute bronchitis or bronchiolitis.
- If an antibiotic prescription is needed due to the patient having a coexisting bacterial infection (e.g., otitis media, sinusitis, pneumonia) or a comorbid condition (e.g., chronic obstructive pulmonary disorder [COPD], HIV, cancer), make sure to document and code for the bacterial infection and/or comorbid condition on the same claim.

How can I respond to a patient who wants antibiotics?

- Refer to the illness as a chest cold rather than bronchitis, as patients tend to associate the label with a less frequent need for antibiotics.
- Educate the patient that antibiotics do not work against viruses that cause most chest colds or bronchitis.
- Suggest medications for symptom relief, such as guaifenesin/dextromethorphan for an antitussive (covered by Medi-Cal Rx with a prescription).

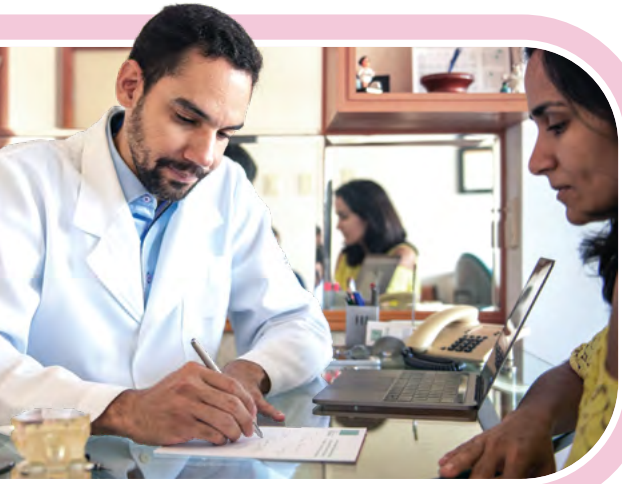
Where can I learn more?

- Free courses are available through the Stewardship Training Course: **www.cdc.gov/antibiotic-use/hcp/training/index.html**
- The AAFP offers resources on Improving Antibiotic Use for Acute Respiratory Infections: **https://bit.ly/antibioticuseuri**

FAQ: CalOptima Health's Utilization Management (UM) Decisions

How are UM decisions made?

Our decisions to authorize, modify or deny health care services are based on medical necessity and Medi-Cal coverage. There is no financial incentive or reward for our staff or providers if they deny services. Decisions to deny or modify requests are based on medical necessity and can only be made by another physician or, in the case of a pharmacy request, by a licensed pharmacist.



What criteria and/or guidelines are used to make decisions?

CalOptima Health uses nationally recognized guidelines, such as MCG, InterQual, the Medi-Cal Manual and various guidelines from recognized professional academies like AAFP and the American Congress of Obstetricians and Gynecologists. Guidelines and criteria sets are based on sound clinical principles and processes. They are reviewed and updated as required annually. To ensure consistency with current standards of care and local practice, we actively involve participating practitioners in the development and approval of criteria.

How can I obtain a copy of the criteria used in making a decision?

As a CalOptima Health provider, you have the right to inquire about our UM decisions. You can contact our medical director in writing or via telephone. The medical director's phone number is included in every Notice of Action letter you receive. CalOptima Health Community Network providers may call **714-246-8600** to request criteria.

What if I have a general question about the UM process?

UM staff are available by phone during CalOptima Health business hours, 8 a.m. to 5:30 p.m. After-hours contact with the UM staff is through the on-call service, which will notify staff to contact you. You can reach the UM staff by calling **714-246-8686**.

Get Familiar With Member Rights and Responsibilities

As a CalOptima Health provider, you should be aware that our members have rights and responsibilities. These are the standards CalOptima Health promises members, as well as their responsibilities as members.

Members have a right to:

- Be treated with respect and dignity, given due consideration to their right to privacy and the need to maintain confidentiality of their medical information, such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- Privacy and to have their medical information kept confidential
- Be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities
- Get fully translated written information in their preferred language, including all grievance and appeals notices
- Make recommendations about CalOptima Health's member rights and responsibilities policy
- Be able to choose a PCP within CalOptima Health's network
- Have timely access to network providers
- Participate in decision-making with providers regarding their own health care, including the right to refuse treatment
- Voice grievances, either verbally or in writing, about the organization or the care they received
- Know the medical reason for CalOptima Health's decision to deny, delay, terminate or change a request for medical care
- Get care coordination
- Ask for an appeal of decisions to deny, defer, or limit services or benefits
- Get free interpreting and translation services for their language

- Ask for free legal help at their local legal aid office or other groups
- Formulate advance directives
- Ask for a State Hearing if a service or benefit is denied and they have already filed an appeal with CalOptima Health and are still not happy with the decision, or if they did not get a decision on their appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- Disenroll from CalOptima Health and change to another health plan in the county upon request
- Access minor consent services
- Get free written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182(b)(12)

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage
- Have access to and get a copy of their medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Exercise these rights without adversely affecting how they are treated by CalOptima Health, their providers or the State
- Have access to family planning services, freestanding birth centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside CalOptima Health's network pursuant to federal law

Members are responsible for:

- Knowing, understanding and following the Member Handbook
- Understanding their medical needs and working with health care providers to create their treatment plan
- Following the treatment plan they agreed to with their health care providers
- Telling CalOptima Health and their health care providers what they need to know about their medical condition so they can provide care
- Making and keeping medical appointments and telling the office when they must cancel their appointment
- Learning about their medical condition and what keeps them healthy
- Taking part in health care programs that keep them healthy
- Working with and being polite to the people who are partners in their health care

Follow These Best Practices to Improve on the Health Outcomes Survey

The Health Outcomes Survey (HOS) is an annual survey conducted by the Centers for Medicare & Medicaid Services (CMS) between July and November that assesses a patient's physical and mental health over time. The survey helps CMS measure health plan performance based on patient-reported outcomes. These results inform Medicare Advantage Star Ratings and support quality improvement efforts for better patient health outcomes.

Many of the survey questions ask whether patients have had conversations with their doctor or nurse about certain HOS measures, such as mental health, physical health, fall risk, bladder control and physical activity. Providers can help improve HOS results before the upcoming survey by:

- Having discussions during routine appointments about physical activity, mental well-being, incontinence and fall prevention
- Providing education on preventive care, treatment options and ways to manage health concerns
- Educating staff and staying informed about HOS measures

Here are some best practices that providers can incorporate in their offices for each HOS measure:

Fall Risk Prevention

- Complete a fall-risk assessment and medication review to ensure patients are aware of medications that can contribute to the risk of falling
- Encourage a home safety assessment or provide a home safety checklist, such as removal of throw rugs, installation of handrails and availability of flashlights

Physical and Mental Health

- Assess patients' pain and functional status as well as emotional wellness
- Review interventions to improve physical health, such as disease management, as needed
- Provide patients with self-care information and how to get assistance if needed for behavioral health concerns

Bladder Control

- Evaluate for symptoms of urinary incontinence
- Provide education on treatment options such as medication, pelvic muscle exercises and surgery

Physical Activity

- Assess patients' current physical activity level
- Encourage participation in fitness and exercise programs when appropriate

Strengthening Preventive Care: Annual Wellness Visits and Initial Health Appointments

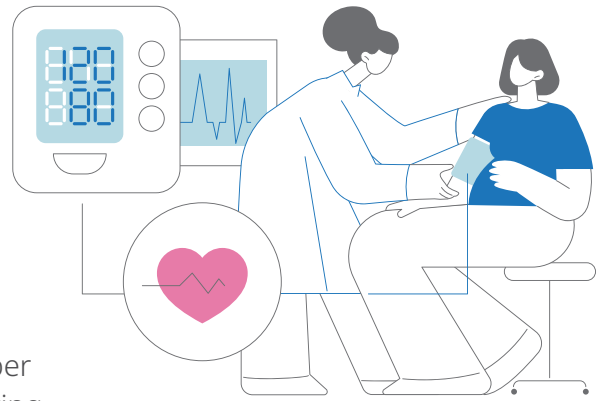
We continue to encourage providers to prioritize two foundational services that support member health and compliance: the Annual Wellness Visit (AWV) for OneCare members and the Initial Health Appointment (IHA) for Medi-Cal members.

AWV

An AWV is a Medicare-covered service designed to help OneCare members stay on top of their health. These visits support early detection, personalized care planning and preventive screenings. Providers should encourage members to complete their AWV within 90 days of enrollment and annually thereafter.

A complete AWV includes:

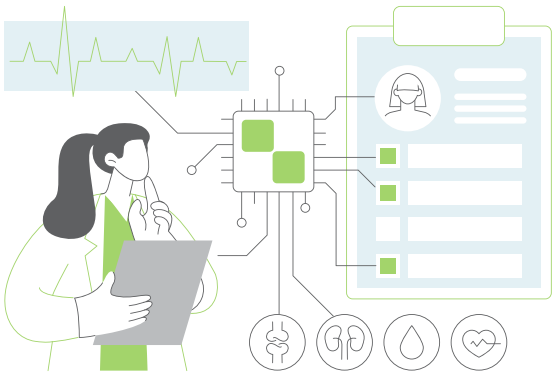
- A review of medical and family history
- Medication reconciliation
- Preventive screenings and referrals
- Capturing Social Determinants of Health (SDOH) using Z codes



Telehealth visits are acceptable if conducted via real-time audio and video platforms. Providers may also earn a $150 incentive per member per year for submitting the attestation form and ensuring proper documentation of chronic conditions, screenings and diagnosis codes.

IHA

IHAs are required for new Medi-Cal members within 120 days of enrollment. These appointments establish a baseline for care and help identify immediate health needs. While not tied to a direct member incentive, completing an IHA may unlock eligibility for other health rewards, such as for diabetes and breast cancer screenings.



A complete IHA includes:

- A comprehensive physical and mental health exam
- A history of present illness, past medical and social history
- Risk assessments, screenings, referrals and health education
- Documentation of member refusals or missed appointments

Providers must use appropriate Current Procedural Terminology (CPT) codes and document all components in the medical record. IHAs are reimbursed and tracked via the Delegation Oversight Committee Dashboard.

Let's work together to ensure that all members receive timely, thorough preventive care. These visits lay the foundation for better outcomes, stronger provider-member relationships and a healthier year ahead.

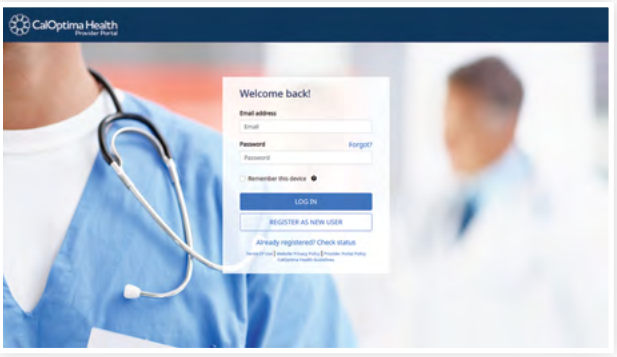
Chronically Ill OneCare Members Can Buy Healthy Foods With Flex Cards

Starting January 1, members with qualifying chronic illnesses such as diabetes, heart disease, cancer, lung disease or dementia can use their flex cards to buy approved healthy food and produce in-store at participating retailers, in addition to over-the-counter (OTC) items. For a full list of qualifying chronic illnesses and other eligibility requirements, please see Chapter 4 of the CalOptima Health OneCare Complete Member Handbook, by going to www.caloptima.org, selecting Health Insurance Plans, then selecting OneCare, and clicking on Documents and Forms.

New members will be screened for qualifying illnesses at the time of enrollment, while current members can have a provider complete a healthy food and produce form, which is then sent to CalOptima Health to approve. This form can be found on the OneCare Benefits and Services page of our website, or members can call OneCare Customer Service at **1-877-412-2734** (TTY **711**) to have it mailed to them.

All OneCare members can still use their flex cards to purchase OTC items online, over the phone or in-store at participating retailers. Each member's flex card is loaded with $167 every quarter, with funds not rolling over each quarter.

Behavioral Health Reports Available for Download From Provider Portal



Providers can download a monthly Behavioral Health Quality Measure Report from the CalOptima Health Provider Portal. This enhancement is part of our ongoing commitment to streamline access to performance data and support behavioral health quality improvement efforts.

Providers can also download a daily Behavioral Health Emergency Department Report from the Provider Portal. This report will include emergency department visits related to mental health and substance use disorders.

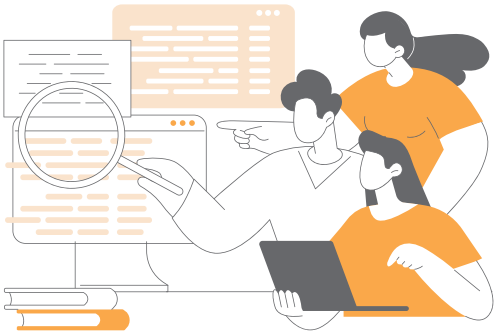
These resources are designed to provide timely, actionable insights that support better care and improved outcomes for members. To access the Provider Portal, visit providers.caloptima.org.

Cozeva Partnership Will Streamline HEDIS Data Collection

We are excited to announce our partnership with Cozeva, a leading digital platform designed to help health plans and provider organizations monitor and improve quality performance. This is part of our commitment to streamlining Healthcare Effectiveness Data and Information Set (HEDIS) data collection and submission, making it easier for providers to close care gaps and enhance member health outcomes.

What Does This Mean for Providers?

- **Cozeva User Interface:** Providers will gain access to Cozeva's user-friendly platform, where they can view quality measure performance details at the member level and upload data directly to close care gaps. CalOptima Health offers comprehensive training and onboarding to ensure smooth adoption.
- **EHR Integration:** CalOptima Health will sponsor the integration of electronic health record (EHR) systems with Cozeva for eligible provider groups. The CozevaConnect solution extracts structured clinical data from EHR systems to automatically close quality care gaps, reducing manual processes and improving efficiency. The provider selection criteria for integration include the number of CalOptima Health members served, EHR compatibility and readiness to engage in onboarding activities.



By leveraging Cozeva, providers will gain actionable insights and improve performance on quality measures. This partnership underscores our shared goals: better care, better outcomes, and a better experience for members and providers alike.

For questions or additional information about our Cozeva partnership, please contact the CalOptima Health Quality Analytics team at QI_Initiatives@caloptima.org.

Remember to Follow Clinical Practice Guidelines

CalOptima Health providers need to follow evidence-based guidance by staying informed about current clinical practice guidelines. For your convenience, the clinical practice guidelines for conditions frequently seen in patients are on our website. All the guidelines have been reviewed and approved by our Quality Improvement Health Equity Committee. We are confident that providers will find these clinical practice guidelines valuable to their daily practice. Find them at https://bit.ly/chclinicalguidelines.

CalOptima Health

CalOptima Health, A Public Agency
P.O. Box 11063
Orange, CA 92856-8163

www.caloptima.org

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PRI-040-161 (06/26)