



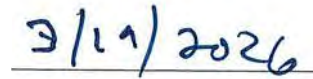
2025 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM EVALUATION

2025 QUALITY IMPROVEMENT AND HEALTH EQUITY
TRANSFORMATION PROGRAM EVALUATION SIGNATURE PAGE

Quality Improvement Health Equity Committee Chair:

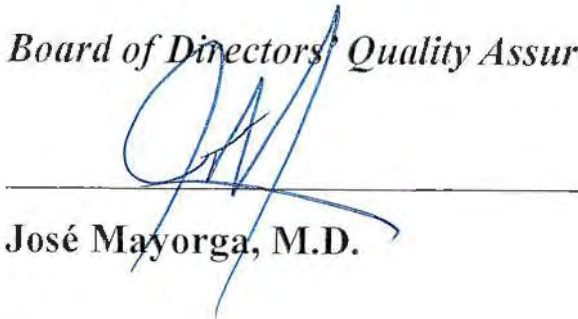


Richard Pitts, D.O., Ph.D.
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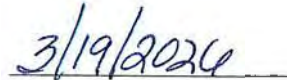


Date

Board of Directors' Quality Assurance Committee Chair:



José Mayorga, M.D.



Date

Board of Directors Chair:



Supervisor Vicente Sarmiento



Date

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Section 1: CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health’s privilege since 1995. CalOptima Health offers health insurance plans for low-income children, adults, seniors and people with disabilities in Orange County. Local leaders launched CalOptima Health in 1995 as a county organized health system to better serve vulnerable residents and provide access to quality health care. CalOptima Health operates independently, under the leadership of a Board of Directors that includes members, providers, business leaders, and local government representatives. Through collaboration with our providers, community partners and local stakeholders, we are working to remove barriers, enhance care coordination and support our members in leading healthier lives. Together, we are building a stronger, more equitable health system.

1.1. Our Strategic Plan

CalOptima Health’s Board of Directors and executive team worked together to develop our 2025–2027 Strategic Plan. After engaging a wide variety of internal and external stakeholders and collecting feedback, the strategic plan, our strategic roadmap for CalOptima Health activities and investments through fiscal year 2027, was approved in February 2025. Our core strategy is the “inter-agency” co-creation of services and programs, in collaboration with our delegated networks, providers, and community partners, to support our mission and vision.

Achieving our Mission, Vision and Values: Through this Strategic Plan, CalOptima Health continues to strive toward our mission: **to serve member health with excellence and dignity, respecting the value and needs of each person.** This continues to be our mission and what drives our strategic priorities. The new Strategic Plan includes a new Vision Statement to better reflect our aspirational vision for CalOptima Health:

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Finally, we have codified our organizational values — CalOptima Health **C-A-R-E-S**: We believe that to best serve the people of Orange County, we will lead with **Collaboration, Accountability, Respect, Excellence and Stewardship.**

The four Strategic Priorities:

- Equity and Population Health
- Quality and Value
- Community Partnerships and Investment
- Operations, Finance and People

CalOptima Health aligns our Strategic Plan with the priorities of our federal and state regulators.

Section 2: Executive Summary

The 2025 Quality Improvement Health Equity Transformation Program (QIHETP) Evaluation analyzes the core clinical service indicators to determine if the QIHETP has achieved key performance goals throughout 2025. This evaluation focuses on quality activities implemented during measurement year (MY) 2025 that impacted performance to improve health care and services available to CalOptima Health members. The look-back period for the 2025 QIHETP Evaluation is Quarter 1 2025 through the end of Quarter4 2025.

The QIHETP for 2025 outlined major program initiatives. Threaded throughout these initiatives were interventions that support both the Department of Health Care Services (DHCS) Comprehensive Quality Strategy and the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy. These strategies aim to deliver care that is equitable, high-quality and value-based, considering the needs of the whole person.

In 2025, QIHETP initiatives aligned with CalOptima Health's strategic priorities, focusing on health equity, social determinants of health, member engagement, improved access to care, and enhanced quality outcomes. CalOptima Health remained focused on advancing Quality Improvement and Health Equity (QIHE) initiatives to achieve 2025 QIHE goals and objectives , ensuring members have access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) and continuous quality improvement (CQI) approaches to developing initiatives in 2025, which has continued into 2026. These initiatives are focused on long-term improvements in selected high-priority measures.

In 2026, based on the 2025 QI Program Evaluation, CalOptima Health will continue to support a strategy, as identified in the 2026 QIHETP, that aligns with CalOptima Health's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes. The 2026 QIHETP Annual Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2026 QIHETP.

2.1 2025 Achievements

January 2025: CalOptima Health receives approval from the Orange County Board of Supervisors to on a revision to our ordinance that will allow participation in Covered California. The launch of a Covered California plan will promote continuity of care for members who transition from Medi-Cal based on eligibility changes.

March 2025: CalOptima Health's Board of Directors approves the expansion of our Street Medicine Program to Santa Ana.

August 2025: CalOptima Health holds our second annual Back-to-School Health and Wellness Event, attracting more than 3,500 attendees to the event, held for the first time in Westminster.

October 2025: In light of new federal and state requirements for Medi-Cal eligibility, CalOptima Health's Board of Directors approves \$19.8 million to expand outreach efforts to ensure Orange County's vulnerable residents understand how to maintain their health coverage.

November 2025: CalOptima Health adds a 10th health network by partnering with Providence, marking a significant step in strengthening access to health care services for Medi-Cal members in Orange County.

December 2025: CalOptima Health achieves Health Equity Accreditation from the National Committee for Quality Assurance.

2.2 Review of 2025 Quality Improvement Health Equity Transformation Program Goals

Goal 1: Maternal Health

- a. Close racial/ethnic disparities in well-child visits and immunizations by 50%.

CalOptima Health focused on a performance improvement project to increase well-child visit appointments for African American members (0–15 months) from 45.05% to 55.78% by December 31, 2025. While the target was set for 2025, the formal DHCS Performance Improvement Project (PIP) timeframe spans from 2023 to 2026. CalOptima Health conducted telephone outreach to remind families of the importance of scheduling well visits and provided care coordination to support African American families in scheduling and completing visits in accordance with the AAP periodicity schedule. The rate for well-child visits (0–15 months) for African American members for MY2024 is 53.06%. While the rate increased from the year before, the goal was not met for this project, and it will remain an area of focus for the next year. The adolescent immunization rates for both the African American and Native Hawaiian and other Pacific Islander decreased from the previous year.

- b. Close maternity care disparity for African American and Native American persons by 50%.

CalOptima Health focused on increasing prenatal and postpartum appointments for African American and Native American members. Planned activities for these initiatives included outreach and promotion of the Bright Steps program, doula services and enhanced care management services. While CalOptima Health met the goal, the denominators for both the African American and Native American populations were very low in 2025, and the rates were not statistically valid. CalOptima Health will continue to monitor rates for both populations and identify opportunities for improvement if a health disparity is identified for this population.

Goal 2: Children's Preventive Care

- a. Exceed the 50th percentile for all children's preventive care measures.

For MY2024, CalOptima Health met or exceeded the 50th percentile for all children's preventive measures.

Goal 3: Behavioral Health Care

- a. Improve maternal and adolescent depression screening by 50%.

For maternal depression screening, the prenatal screening rate decreased from 14.52% in MY2023 to 13.98% in MY2024, with a 0.54 percentage point decrease, and the postpartum screening rate decreased from 17.33% in MY2023 to 9.24% in MY2024, with an 8.09 percentage point decrease. The goal for maternal depression screening was not met. For adolescent and adult depression screening, the rate increased from 6.57% in MY2023 for both adolescents and adults to 8.65% in MY2024. While the rate did not increase by 50%, CalOptima Health did see a 32% increase in adolescent and adult depression screening from the previous year.

b. Improve follow-up care for mental health and substance use disorders by 50%.

For follow-up care of mental health after an emergency room visit, the rate for follow-up within 30 days increased from 35.73% in MY 2023 to 52.33% in MY2024, with a 46.5% increase in follow-up care. For follow-up care of substance use disorders after an emergency room visit, the rate for follow-up within 30 days increased from 21.41% in MY2023 to 28.63% in MY2024, with a 33.7% increase in follow-up care. While CalOptima Health did not see a 50% improvement, there was a significant improvement from the previous year.

Goal 4: Program Goals

a. Medi-Cal: Exceed the minimum performance levels (MPLs) for Medi-Cal Managed Care Accountability Set (MCAS).

All MCAS measures exceeded the MPLs except for Follow-up After ED Visit for Alcohol and Other Drug Dependence within 30 Days (FUA), Follow-up After ED Visit for Mental Illness within 30 Days (FUM), and Asthma Medication Ratio (AMR). The FUM and FUA measures will remain focus areas for CalOptima Health in 2026 and will be included in the 2026 QIHETP work plan.

b. OneCare: Attain a four-star rating for Medicare.

CalOptima Health met a 3.0 overall star rating for MY2024 and did not meet the goal of attaining a four-star rating. Overall focus on stars improvement will be a focus area for 2026 and will be included in the 2026 QIHETP work plan.

2.3 Recommendations for 2026

For 2026, CalOptima Health will develop and implement the Quality Improvement and Health Equity Transformation Program (QIHTP) and QIHETP Work Plan. QIHETP will align with CalOptima Health's strategic goals and objectives as defined by the Board of Directors as well as with the priorities of our federal and state regulators, as identified in the CMS National Quality Strategy and the DHCS Comprehensive Quality Strategy. The QIHETP Work Plan will remain flexible, and staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a dignified and equitable manner.

Based on the 2025 QIHETP Evaluation, CalOptima Health will continue to focus on the following initiatives and projects to drive improvements that impact members.

- A. Incorporate SDOH factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- B. Collaborate with external stakeholders and partners in comprehensive assessments of members.
- C. Develop robust community-based interventions using analytical tools, such as geo-mapping, in collaboration with community partners and entities that have a good understanding of the target population's barriers and behaviors.
- D. Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through the website, direct mailings, email, interactive voice response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.
- E. Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care.
- F. Expand quality initiatives to improve member experience, focused on increasing member access to care.
- G. Monitor, evaluate and take timely action to address necessary improvements in the quality of care delivered by all providers in any setting and take appropriate action to improve upon health equity.
- H. Incorporate feedback provided by members and network providers in the design, planning and implementation of CQI activities, particularly on interpreter services and access to care.
- I. Enhance member and provider data collection to ensure the provider network can meet the cultural and linguistic needs of our members.
- J. Implement a Diversity, Equity and Inclusion Training Program for staff, health networks and network providers that includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.
- K. Leverage technology and automation to streamline quality operations and enhance productivity.

CalOptima Health also recommends the following new initiatives and projects to drive improvements that impact members.

- A. Promote at-home health care and services (e.g., at-home visits and at-home labs).
- B. Expand member and provider demographic data, particularly on disability and veteran/military status, to ensure effective measurement and reduction of health disparities.
- C. Enhance data exchange and sharing to advance the completeness and timeliness of quality data.
- D. Attain operational readiness to launch the Covered California product on January 1, 2027.

Based on the 2025 QIHETP Evaluation, CalOptima Health has extended the following goals into 2026. CalOptima Health added a goal to attain operational readiness to launch the Covered California product on January 1, 2027. These recommended priority areas and goals are aligned with CalOptima Health's 2025–2027 Strategic Goals and DHCS Bold Goals.

Medi-Cal QIHETP Goals

- Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)

- Maintain NCQA Health Plan and Health Equity Accreditation
- Attain a 4.5 NCQA Health Plan Rating
- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance use disorders by 50%

OneCare QIHETP Goal

- Attain a four-star rating for Medicare

Covered California QIHETP Goal

- Attain operational readiness to launch the Covered California product on January 1, 2027.

Section 3. Program Oversight

3.1 2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Program Documents	
Author(s): Marsha Choo, Gloria Garcia	Department(s): Quality Improvement
Responsible Parties: Marsha Choo (Director, Quality Improvement); Gloria Garcia (Program Specialist, Quality Improvement)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☐ No
Workplan Goal/Objective: Obtain Board approval of 2025 QIHETP Description and Work Plan by April 30, 2025	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

CalOptima Health develops the following quality documents each year:

1. 2025 Quality Improvement Health Equity Transformation Program (QIHETP) Description: The QIHETP was designed to systematically monitor, evaluate, and enhance health care delivery through a structured framework of goals, oversight and performance measures. The program description outlines how CalOptima Health integrates behavioral health, clinical care and service quality into a unified improvement strategy. It includes updates to organizational structure, such as the addition of the Chief Administrative Officer and the Senior Director of Equity and Community Health. The work plan itself is an operational blueprint that details activities across various domains, including Population Health Management Strategy, Continuity of Care, Health Equity, and Culturally and Linguistically Appropriate Services. It also incorporates regulatory goals such as DHCS Quality Withhold targets, NCQA standards, and CMS star ratings. The following quality improvement documents are included as part of the overall QIHETP:

- a. 2025 Quality Improvement Health Equity Transformation Work Plan
 - b. 2025 Population Health Strategy
 - c. 2025 Culturally and Linguistically Appropriate Services Program
 - d. 2025 Pay for Value Program
2. 2025 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan: The annual work plan outlines measurable goals and objectives that CalOptima Health will focus on in the subsequent year. This document is used to monitor and evaluate the performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year based on priorities and opportunities.
3. 2024 QIHETP Evaluation: This document conducts a comprehensive evaluation of the 2024 QIHETP Program and Work Plan at the end of the year that assesses the performance on measures and indicators, and the assessment laid the groundwork for the 2025 QIHETP.
4. 2025 Utilization Management (UM)/Case Management (CM) Integrated Program — The UM/CM Integrated Program defines the oversight and delivery of CalOptima Health’s structure, clinical processes and programmatic approach to review health care services, treatment and supplies, and provide quality, coordinated health care services to CalOptima Health members.
5. 2024 UM Evaluation: This document is a comprehensive evaluation of the 2023 UM Program at the end of the year that evaluates the impact of the UM Program.

The development of the documents involved collaboration across departments, with feedback and contributions from staff and participants from the QIHEC and/or subcommittees, as well as CalOptima Health advisory committees, including the Member Advisory Committee (MAC).

II. Data Sources and Methodology

The methodology for the 2025 QIHETP and Annual Work Plan is built on a structured, data-driven framework that integrates both quantitative and qualitative analysis conducted as part of the evaluation of the QIHETP and Work Plan from the previous year. The program relies on a review and assessment of HEDIS measures, MCAS MPL benchmarks, CMS star ratings, NCQA standards, External Quality Review Organization (EQRO) reports, DHCS audits, and NCQA Health Plan Ratings, as well as DHCS Quality Withhold targets, to guide performance evaluation and improvement planning. When appropriate and when data is available, data is stratified to identify disparities and target interventions for lower-performing groups.

III. Program Results

All 2025 Programs and Work Plans and 2024 Evaluation documents were approved in a timely manner by the appropriate committees and approved on April 3, 2025, by CalOptima Health’s Board of Directors.

IV. Actions/Interventions Implemented in 2025:

Quarters	Interventions
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Quarter 1 (January–March)	QIHEC approved the following documents on January 14, 2025: • 2025 Quality Improvement Health Equity Transformation Program (QIHETP) Description and QIHETP Work Plan • Population Health Management Strategy and PHM Work Plan • CalOptima Health Measurement Year 2024 Medi-Cal and OneCare Pay for Value Programs • Culturally and Linguistically Appropriate Services Program Description QIHEC approved the following documents on February 11, 2025. • 2024 QIHETP Evaluation and Work Plan (Q1-Q4) • 2024 Population Health Management Impact Report • 2024 Culturally and Linguistically Appropriate Services (CLAS) Evaluation, 2025 UM/CM Integrated Program, and 2024 UM/CM Integrated Program Evaluation • 2025 QIHETP and Work Plan Revised QAC received the following documents on March 12, 2025: • 2024 CalOptima Health QIHETP Evaluation QAC approved the following documents on March 12, 2025: • 2025 QIHETP and Work Plan
Quarter 2 (April–June)	CalOptima Health’s Board of Directors received the following documents on April 3, 2025: • 2024 CalOptima Health QIHETP Evaluation CalOptima Health’s Board of Directors approved the following documents on April 3, 2025: • 2025 Quality Improvement Health Equity Transformation Program and Work Plan
Quarter 3 (July–September)	HEDIS quality measures released and assessed.
Quarter 4 (October–December)	• Develop draft of the 2026 QIHETP Description, Work Plan and 2025 QIHETP Evaluation in November 2025 to be finalized and approved by the appropriate committees and BOD in Q1, 2026.

V. Qualitative Analysis

The QI Director, the QI Program Specialist and QI Program Assistant conducted a qualitative analysis in Q1 2025 to identify barriers related to the development and approval of quality documents.

Causal/Barrier Analysis:

- Staff focused on operations may not be familiar with quality process improvement.

VI. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority items first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Quality staff will begin drafting the 2026 QIHETP and Work Plan earlier in the year.	• Quality staff will begin drafting the 2026 QIHETP and the Work Plan will be reviewed shortly after the Healthcare Effectiveness Data and Information Set (HEDIS) rates for the year have been finalized and compared with the goals set in Q3 of 2025. This would allow staff to focus on the evaluation documents in Q4.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Staff training on continuous quality improvement (CQI) and process	• Develop an annual process timeline and share with the business owners in Q1 2026 • Develop training on CQI and process and implement training in Q1, 2026.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L

VII. Conclusion:

Overall Assessment: All quality documents were approved in a timely manner, and all documents were approved by CalOptima Health’s Board of Directors on April 3, 2025. The program descriptions and work plans were approved by the QIHEC in January 2025 and were effective for program implementation. For 2026, Quality staff will begin the evaluation process earlier in the year and conduct staff training on the CQI process.

3.2 Quality Improvement Health Equity Committee (QIHEC)	
Author(s): Marsha Choo	Department(s): Quality Improvement
Responsible Party(ies): Marsha Choo (Director, Quality Improvement); Gloria Garcia (Program Specialist, Quality Improvement)	

I. Committee Purpose

The QIHEC is responsible for guiding and overseeing the Quality Improvement Health Equity Transformation Program (QIHETP).

II. Committee Background

The QIHEC was established to advance health equity and quality improvement across CalOptima Health programs in alignment with regulatory requirements and organizational priorities. The committee is chaired by the Chief Medical Officer (CMO) designee and includes QI Medical Director as the designated committee chair representative, and the Chief Health Equity Officer serves as Co-Chair.

QIHEC reports directly to the Quality Assurance Committee (QAC) and ultimately to the Board of Directors, ensuring accountability and alignment with strategic goals.

Meetings are held quarterly, providing a structured forum for oversight of the QIHETP, review of performance metrics, and integration of health equity principles into all quality improvement activities.

III. Committee Meetings in 2025

The QIHEC met on January 14, 2025; February 11, 2025; March 11, 2025; April 8, 2025; May 13, 2025; June 10, 2025; July 8, 2025; August 12, 2025; September 9, 2025; October 7, 2025; November 4, 2025; and December 9, 2025.

IV. Committee Changes in 2025

- QIHEC continued to report to the Quality Assurance Committee (QAC) and the Board of Directors, but the reporting cadence was refined to ensure quarterly updates and integration with subcommittees like PHMC and CPRC.
- Several members ended their term mid-year review, and seats were filled.
- The QIHEC charter was updated in 2025 to clarify member responsibilities, attendance expectations (75% minimum), and confidentiality attestations:
 - Attendance will be monitored; members must agree to a 75% participation rate for 2026.

- External members must report changes in professional status within 30 days.
- Quarterly summaries of QIHEC activities will be sent to the Board and DHCS and made public on the website.
- Enhanced collaboration with compliance committees to improve the quality of care.
- Committee minutes to include all documents presented at meetings.
- Health equity as a core goal, with equity integrated into the Charter and meeting purpose.
- The committee maintained a quarterly meeting schedule, with published dates for the Calendar Year 2025 to review QIHETP progress and compliance metrics

V. Committee Actions in 2025

QIHEC maintained quorums for all meetings in 2025 and ensured participation from practitioners representing a broad range of specialties within CalOptima Health's network. The committee also received expert advice on quality improvement activities, including contributions from behavioral health practitioners. QIHEC approved 27 quality-related policies in 2025 and filed the meeting minutes from the QIHEC subcommittees.

Quarter 1:

- Meetings were held on January 14, 2025; February 11, 2025; and March 11, 2025.
- Approved QIHEC 12/10/24/24 Meeting Minutes.
- Approved 2025 QIHETP description and appendices.
 - A. 2025 QIHETP Work Plan
 - B. 2025 Population Health Management Strategy and PHM Work Plan
 - C. CalOptima Health MY2025 Medi-Cal and OneCare Pay for Value Programs
 - D. 2025 Culturally and Linguistically Appropriate Services Program Description
- Approved 2024 QIHETP Evaluation and Work Plan (Q1-Q4)
- Approved 2024 Population Health Management Impact Report
- Approved 2024 Culturally and Linguistically Appropriate Services (CLAS) Evaluation
- Approved 2025 UM/CM Integrated Program and 2024 UM/CM Integrated Program Evaluation

Quarter 2:

- Meetings were held on April 8, 2025; May 13, 2025; and June 10, 2025.
- Reviewed Q1 updates to the QI Work Plan.
- Obtained progress reports on QI initiatives carried out by subcommittees and staff.

Quarter 3:

- Meetings were held July 8, 2025; August 12, 2025; and September 9, 2025
- Policy GG.1628: Confidentiality of Quality Improvement Activities was revised to de-identify member/provider information, when appropriate, and to expand the scope to all subcommittees.
- Added representatives from Equity and Community Health.

- The County Behavioral Health committee representative ended their term, and the position was filled.
- Reviewed mid-year updates to the QI Work Plan.

Quarter 4:

- Meetings were held October 7, 2025; November 4, 2025; and December 9, 2025.
- Approved and updated the QIHEC charter to align with QIHETP and regulatory requirements. Clarified member responsibilities, attendance expectations (75% minimum) and confidentiality attestations.
- Policy GG.1620: Quality Improvement Health Equity Committee was revised to clarify collaboration with the Compliance Committee and oversight of delegated entities, remove references to the Population Health Management Committee following its dissolution, and incorporate responsibilities for the annual evaluation of QI and UM/CM programs, as well as the establishment of a QI Reporting Calendar.
- Confirmed reporting cadence to the Quality Assurance Committee (QAC) and Board of Directors, integrated QI subcommittee activities for quarterly updates.
- Reviewed Q3 updates to the QI Work Plan.
- Established QIHEC meeting dates for 2026.

VI. Identified Barriers and Opportunities for Improvement

Throughout the year, the chairs of the QIHEC, the Quality Medical Director and the Chief Health Equity Officer, along with the Director of Quality Improvement and the QI Program Specialist, identify barriers.

Identified Barriers	Opportunities for Improvement
• There is not enough time during a meeting for committee members to hold robust conversations on performance and initiatives.	• Explore how to better use consent items in committee • Provide the presenter with more guidance on how to be more concise when presenting • Review and revise the reporting calendar to streamline meetings

VII. Conclusion

The QIHEC successfully provided governance for the QIHETP and Work Plan by conducting quarterly reviews of quality improvement activities throughout the year, providing feedback to ensure that CalOptima Health is in compliance with regulatory requirements, and providing better quality care for our members. For 2026, the Quality staff will continue collaborating with business owners and presenters to streamline committee meetings and foster robust discussion and feedback from committee members.

3.3 Credentialing Peer Review Committee (CPRC) Oversight

Author: Laura Guest	Department(s): Quality Improvement
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Responsible Parties: Laura Guest (Manager, Quality Improvement); Sharlee LeBleu (Director, Quality Improvement); Rick Quinones (Manager, Quality Improvement); Katy Noyes (Manager, Quality Improvement)
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I. Committee Purpose

The purpose and goal of the CPRC is to maintain a peer review and credentialing program that aligns with regulatory standards (DHCS, DMHC and CMS) and accreditation standards (NCQA). The CPRC is responsible for promoting continuous improvement of the quality of health care and outcomes provided by practitioners and providers in CalOptima Health Direct/CHCN and its delegated health networks, conducting peer-level review and evaluation of practitioner and provider performance and credentialing information based on CalOptima Health requirements and appropriate clinical standards, and investigating patient care outcomes that raise quality and safety concerns for corrective action, as appropriate.

II. Committee Background

The committee is chaired by the Chief Medical Officer (CMO), the Deputy Chief Medical Officer (DCMO) or a physician designated by the CMO.

The CPRC consists of a minimum of five practitioners selected to represent practitioners from the CalOptima Health Community Network (CHCN) and its affiliated health networks. Committee members represent a range of practitioners and specialties from CalOptima Health's network. Members of the CPRC must be licensed practitioners, clinically practicing, credentialed and in good standing with CalOptima Health. CalOptima Health Medical Directors, which includes the CalOptima Health Behavioral Health Medical Director, are voting members.

The CPRC meets at least six times per year. Ad hoc CPRC meetings may be scheduled at the discretion of the CPRC Chair.

III. Committee Meetings in 2025

The CPRC had regular monthly meetings on the following dates: January 23, 2025; February 27, 2025; March 27, 2025; April 24, 2025; May 22, 2025; June 26, 2025; July 24, 2025; August 28, 2025; September 25, 2025; October 23, 2025; November 20, 2025; and December 18, 2025.

Ad Hoc and Closed Session meetings were held on the following dates: March 6, 2025; March 30, 2025; April 24, 2025; July 24, 2025; September 25, 2025; and October 23, 2025.

IV. Committee Changes in 2025

On April 24, 2025, CPRC approved the addition of the Executive Director, Behavioral Health Integration, to the Committee as an Ad Hoc non-voting member.

V. Committee Actions in 2025

Quarter 1:

Informed

- Fair Hearing updates were provided for three physicians in the specialties of Obstetrics and Gynecology, Physical Medicine & Rehabilitation, and Neurological Surgery. CPRC received updates on two physicians, one in Obstetrics and Gynecology and the other in General Practice, who are currently under probation with CalOptima Health.
- PQI trends and statistics for Q3 and Q4 2024
- FSR, MRR and PARS statistics for 2024
- Credentialing statistics for Q4 2024
- Incident reporting for 2024
- Credentialing ongoing monitoring reported on one practitioner.

Approved

- CMO credentialing exception was approved for a Cardiovascular Disease practitioner
- Credentialing and recredentialing clean lists for December 12, 2024; December 31, 2024; January 17, 2025; January 31, 2025; February 7, 2025; February 14, 2025; February 19, 2025; February 21, 2025; February 25, 2025 and February 28, 2025.
- Credentialing and recredentialing closure lists for December 31, 2024; January 31, 2025 and February 28, 2025.
- Three practitioners who did not meet clean file criteria were approved for recredentialing.
- Twenty-six PQIs were reviewed and actions recommended.

Quarter 2:

Informed

- Medical Directors and PQI staff reduced the backlog of PQIs from over 700 to about 400 cases.
- Fair Hearing updates were provided on four physicians in the specialties of Obstetrics and Gynecology, Physical Medicine & Rehabilitation, Neurological Surgery, and Pain Medicine.
- PQI and PPC statistics for Q1 2025
- Credentialing statistics for Q1 2025

Approved

- FSR, MRR and PARS statistics for Q1 2025
- The Executive Director, Behavioral Health Integration, was added as a non-voting, Ad Hoc Committee member.
- Eight credentialing-related policies
- CMO credentialing exception was approved for one Emergency Medicine physician who will participate in the Street Medicine Program.
- 25 Credentialing and Recredentialing clean lists in Q2 2025
- Credentialing and recredentialing closure lists for March 31, 2025; April 30, 2025 and May 30, 2025.

- Three practitioners who did not meet clean file criteria were approved for recredentialing. One physician (Pain Medicine) was declined for recredentialing.
- Three practitioners who did not meet clean file criteria were approved for credentialing.
- Twelve PQIs were reviewed and actions recommended.
- PQI Closed Case Report for March 2025, April 2025 and May 2025.
- As stipulated in APL-22-017, a Family Medicine physician was approved for administrative termination due to non-compliance with the FSR CAP.

Quarter 3:

Informed

- The Advisory Committee on Immunization Practices (ACIP) recommendations are expected in February and will be shared with this and other CalOptima Health committees.
- Delegation Oversight Department presented the credentialing oversight responsibilities and audit findings.
- Fair Hearing updates were provided for four physicians in the specialties of Obstetrics and Gynecology, Physical Medicine & Rehabilitation, Neurological Surgery, and Pain Medicine. The Neurological Surgeon was put on probation.
- FSR, MRR and PARS statistics for Q2 2025
- PQI Trends for January–June 2025 and PQI statistics for Q2 2025.
- Credentialing Statistics for Q2 2025
- Credentialing ongoing monitoring reported six practitioners and one Home Health Agency
- Practitioner Grievance Rate Report January to June 2025
- As stipulated in APL-22-017, a Family Medicine physician was administratively terminated due to non-compliance with the FSR CAP.

Approved

- Two credentialing-related policies
- 14 credentialing and recredentialing clean lists for Q3 2025
- Credentialing closure lists for June 30, 2025; July 31, 2025 and August 29, 2025.
- Five practitioners and one ABA group who did not meet clean file criteria were approved for recredentialing. One of the physicians is an Obstetrics and Gynecology practitioner who is currently on probation and will continue to be monitored.
- Four practitioners who did not meet clean file criteria were approved for credentialing. Two practitioners who did not meet clean file criteria were declined for credentialing.
- PQI Closed Case Report for June, July and August
- Nine PQIs were reviewed and actions recommended.

Quarter 4: (October Only)

Informed

- Fair Hearing updates were provided for a Pain Medicine practitioner.

- Credentialing ongoing monitoring reported one practitioner.
- PQI statistics for Q3 2025

Approved

- Two credentialing-related policies
- CMO credentialing exception was approved for one practitioner.
- The credentialing clean list for September 5, 2025; September 12, 2025; September 18, 2025; September 19, 2025; September 29, 2025 and September 30, 2025.
- Credentialing closure list for September 30, 2025.
- One practitioner who did not meet clean file criteria was approved for credentialing. One practitioner who did not meet the clean file requirements was deferred for decision pending a request for additional information.
- PQI Closed Case Report for September
- Two PQIs were reviewed and actions recommended.

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
• CPRC does not have an Obstetrics and Gynecology practitioner whose expertise would be beneficial for credentialing and peer review.	• CPRC continues to explore opportunities for an Obstetrics and Gynecology physician from the community to add this area of expertise to the Committee.

VII. Conclusion

CPRC successfully conducted credentialing and peer review in 2025. The committee participants remained engaged and active.

Activities/Interventions to continue/add next year:

- Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHC and CMS) and accreditation (NCQA) standards.
- Promote continuous improvement of the quality of health care and outcomes provided by practitioners and providers in CalOptima Health Direct/CHCN and its delegated health networks.
- Conduct peer-level review and evaluation of practitioner and provider performance and credentialing information based on CalOptima Health requirements and appropriate clinical standards.
- Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.
- Continue efforts to recruit an Obstetrics and Gynecology practitioner to participate in CPRC.

3.4 Grievance and Appeals Resolution Services (GARS) Committee

Author: Heather Sedillo	Department(s): Grievance & Appeals Resolution Services (GARS)
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Responsible Parties: Heather Sedillo (Director, Grievance & Appeals); Ismael Bustamante (Manager, Grievance & Appeals)
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I. Committee Purpose

The purpose of the GARS committee is to provide information on the overall complaints received, trending and monitoring of issues and remediation activities consistent with CalOptima Health's policy and procedures, and in compliance with regulatory requirements

II. Committee Background

The committee is chaired by the Director of GARS. Committee members include Medical Directors and internal stakeholders of CalOptima Health. The committee meets quarterly and reports to the QIHEC.

III. Committee Meetings in 2025

In 2025, meetings were held on May 23, August 12 and November 13.

IV. Committee Changes in 2025

In 2025, there were no changes to the committee.

V. Committee Actions in 2025

Quarter 1:

- Recommended more detail on transportation and discrimination grievances. Requested to include types of services the complaints are against and the remediations in place, as well as outcomes.
- Recommended the continuation of CM/GARS collaboration for members identified as "high grievors."

Quarter 2:

- Made reporting enhancements to identify the place of service and treating providers for grievances for better tracking and trending of provider complaints.
- Recommended the continuation of CS/GARS collaboration.
- Appeal trends are being included in UM Quarterly Delegation meetings.

Quarter 3:

- Recommended the continuation of the CM/GARS collaboration and focus on outcomes.
- Assess dialysis transportation grievances and identify if there are trends (increase or decrease).

Quarter 4:

- Committee meeting scheduled for February 10, 2026.

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
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• Appointment delays due to network availability. • Transportation grievances increased.	• Collaboration with internal and external stakeholders to remediate identified issues. • GARS leadership to continue participating in multiple internal work groups and committees to address trends identified.
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VII. Conclusion

Overall, the committee was successful and has contributed to implementing process improvements that result in more positive outcomes for our members and providers. The committee also provides a forum for open dialogue and discussion of recommendations among multiple departments involved in the grievance and appeals process.

3.5 Member Experience (MEMX) Committee Oversight	
Author: Carol Matthews	Department(s): Quality Analytics
Responsible Parties: Kelli Glynn (Director, Quality Initiatives); Carol Matthews (Project Manager, Quality Analytics); Helen Syn (Manager, Quality Analytics)	

I. Committee Purpose

The purpose of the Member Experience Subcommittee is to improve member experience and drive initiatives that achieve the member experience goals established in the corporate strategic plan or quality improvement work plan. The Subcommittee also ensures members have access to quality health care services for all product lines and programs.

II. Committee Background

The committee meets quarterly and reports to the QIHEC. The committee is co-chaired by the Executive Director, Operations and the Executive Director, Quality Improvement. Committee members include Executive Directors, Directors, Medical Directors, and internal stakeholders of CalOptima Health who are involved in improving the member experience.

III. Committee Meetings in 2025

In 2025, meetings were held on January 28, April 15, July 15 and October 7.

IV. Committee Changes in 2025

Additional voting members were added to the committee, including the Executive Director of Medicare Programs, an additional Director of Customer Service, an additional Director of Provider Relations, and a title change for one member from Director of Operations Management to Director of Provider Data Operations Management.

A quorum for decisions and recommendations was changed from seven to nine.

V. Committee Actions in 2025

The following recommendations were made by the committee in 2025.

Quarter 1:

- Reviewed strategic priority recommendations: improve access, customer service and provider office efficiency.

Quarter 2:

- Customer Service: identify ways to gather satisfaction and specific member input post inbound call via survey.
- Grievances and Appeals: update on actions for identified grievance trends and remediation efforts.

Quarter 3:

- Explore PCP expansion to improve access.

Quarter 4:

- Provide updates for specialist types that were out of compliance for urgent and non-urgent appointments.

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
• Voting member attendance tends to decline without proactive engagement from the Project Manager. • Although barriers are routinely identified during the committee meetings, establishing clear cross-functional ownership remains a persistent challenge.	• Proactive outreach by the committee Project Manager prior to meetings to ensure voting attendees are going to be present. • The shift of shared organizational responsibility in strong CAHPS performance is in process.

VII. Conclusion

The committee effectively reported on all components critical to member experience and transitioned from a passive reporting approach to proactively identifying and recommending interventions for improvement. Throughout this process, participants remained consistently engaged and actively contributed to the committee's success.

3.6 Population Health Management Committee (PHMC) Oversight

Author: Katie Balderas	Department(s): Case Management
Responsible Parties: Katie Balderas (Director, Case Management); Stefanie Johnson (Program Manager, Case Management)	

I. Committee Purpose

To provide overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

II. Committee Background

The PHMC was chaired by the Medical Director for Population Health Management. Committee members included internal stakeholders from CalOptima Health and external partners with relevant expertise and experience. The PHMC met quarterly and reported to the QIHEC.

III. Committee Meetings in 2025

In 2025, the PHMC met on February 20, May 15 and August 21.

IV. Committee Changes in 2025

The PHMC originally functioned as a standalone advisory body but was officially terminated in October 2025, with its oversight responsibilities transitioned to the Quality Improvement Health Equity Committee (QIHEC) and other relevant subcommittees, including the Utilization Management Committee (UMC). This structural change was implemented to enhance alignment with organizational priorities, eliminate duplicative reporting structures, and maintain visibility and accountability for population health performance measures.

V. Committee Actions in 2025

Quarter 1:

- Reviewed and Discussed: 2025 PHM Strategy and Work Plan, Risk Stratification and Segmentation (RSS), and Initial Health Appointment (IHA)
- Approved: November 21, 2024, Meeting Minutes; February 20, 2025, Consent Calendar; Updated PHM Committee charter to include Chief Medical Officer (or designee) as voting member

Quarter 2:

- Reviewed and Discussed: Care Management, Complex Case Management, Health Education Program, Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Approved: PHMC February 20, 2025, Meeting Minutes; 2025 Population Needs Assessment; May 15, 2025, Consent Calendar

Quarter 3:

- Reviewed and Discussed: Member Population Health Needs Assessment (MPHNA), Disease Management Program, Controlling High Blood Pressure, Diabetes Quality Measures, Osteoporosis Management, Follow-Up after ED Visit
- Approved: PHMC May 15, 2025; Meeting Minutes; August 21, 2025, Consent Calendar

Quarter 4:

- Committee terminated effective October 2025; oversight requirements transitioned to QIHEC or UMC.

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
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• Survey response limitations and inconsistent tools • Low in-person engagement in health education • IHA compliance variability • Data gaps in population assessments	• Standardize satisfaction survey tools across programs and implement multi-modal distribution (e.g., text, email, phone) to improve response rates and data quality. • Expand partnerships with schools, PCP offices, and community centers to host classes. Offer hybrid models and increase incentives (e.g., car seats, health kits). • Enhance provider training and accountability through dashboards and quarterly performance reviews. Consider implementing incentive programs to encourage timely IHA completion. • Integrate proxy indicators (e.g., language preference, age) and advocate for enhanced data collection (e.g., immigration status) to better inform equity strategies.
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VII. Conclusion

While the PHMC demonstrated strong engagement, alignment with member and community needs, and responsiveness throughout 2025, CalOptima Health determined that streamlining the committee structure would better support organizational goals moving forward. Effective October 2025, the PHMC was terminated to reduce duplication in reporting and to realign population health initiatives directly within Clinical Operations. This strategic shift aims to promote greater synergy, operational efficiency and the integration of population health strategies into core clinical workflows. Despite its short tenure, the committee's contributions laid a strong foundation for continued progress under the new structure.

3.7 Utilization Management Committee (UMC) Oversight

Author: Stacie Oakley	Department(s): Utilization Management
Responsible Parties: Kelly Giardina (Executive Director, Clinical Operations); Jennifer Harlow (Director, Case Management); Katherine Nguyen (Data Analyst, Utilization Management); Stacie Oakley, RN (Director, Utilization Management)	

I. Committee Purpose

The UMC promotes optimum health care services for our members while ensuring responsible resource utilization and protecting member rights. The UMC provides support to the UM Program by monitoring utilization data for health care services to identify areas of under- or overutilization that may impact member care. UMC's goals, expectations and commitment are aligned with CalOptima Health's strategic goals and priorities.

II. Committee Background

The UMC is chaired by the CalOptima Health Medical Director, who oversees Utilization Management (UM). This senior-level physician is involved in UM activities, including but not limited to implementation, supervision, oversight and evaluation of the UM Program.

Representatives of the UMC include but are not limited to Medical Directors, Leadership from Clinical Operations, CalAIM, Behavioral Health, Delegation Oversight, Health Equity, and participation from Health Network practitioners.

The UMC meets at least quarterly. UMC documents are reviewed and approved by the QIHEC, QAC, and ultimately the Board of Directors. UMC meeting minutes and recommendations for UM program improvement activities are included in the Board of Directors updates as appropriate. The UMC routinely submits meeting minutes and written reports to the QIHEC that analyze the above-mentioned tracking and monitoring processes and the status of corrective action plans. Oversight and operating authority of UM activities is delegated to the UMC, which is overseen by the CMO and Deputy CMO. UMC reports to QIHEC and, ultimately, to QAC and the Board of Directors.

III. Committee Meetings in 2025

In 2025, the UMC met on January 23, February 20, May 22, August 21, November 20 and December 18.

IV. Committee Changes in 2025

UMC Charter changes included, but were not limited to the following:

Added:

1. Purpose Statement
2. Chief Health Equity Officer as a voting member
3. UM Senior Manager as a supporting role
4. Conflict of Interest (COI) section
5. Clarification in UMC scope and responsibilities to revise and update CalOptima Health's authorization rules
6. Attachment section to list external physicians and their specialties

Revised:

1. Clarification of roles for voting members
2. Minor formatting and structural improvements throughout for clarity and consistency

V. Committee Actions in 2025

Quarter 1: Ad Hoc: January 23, 2025

- Added the Chief Health Equity Officer and Sr. UM Manager to the UMC.
- Reviewed Confidentiality and Conflict of Interest Forms in alignment with P&Ps GG.1628 and GG.1656.
- Reviewed and approved 2025 UMC Charter
- Reviewed and approved 2025 UM Criteria and Hierarchy
- Approved 2025 board-certified consultants

- Approved 2024 UM Program Evaluation
- Approved 2025 UM/CM Integrated Program Description
- Approved 2024 Behavioral Health Integration Inter-Rater Reliability Assessment results
- Approved 2025 UM Policies and Procedures
- Approved November 21, 2024, UMC meeting minutes

Quarter 1: February 20, 2025

- Approved January 23, 2025, UM Meeting minutes
- Approved revisions to the 2024 UM Program Evaluation, including consolidation of TANF 18+ and Medi-Cal Expansion populations for goals due to shared interventions
- Discussed High Risk Workgroup review of data and trends to identify causes and interventions for readmission rates, post-discharge clinics, and interventions to decrease ALOS and readmission rates. In addition, discussed the implementation of post-discharge text messages
- Review of over-/under-utilization data to include acute inpatient, hospital facility, and ED utilization
- Review of operational performance data to include inpatient data, prior authorization data, and turnaround time data
- Discussed appeal rates based on health equity analysis
- ED program expanded to OneCare
- Reviewed APLs 24-003 and 24-018
- Reviewed BMSC meeting outcomes, including 19 codes identified for PA required, 24 codes removed from PA requirements, and the decision to defer 16 codes overseen by CalAIM
- Gender Affirming Care Workgroup created a roster for electrolysis
- Approved four P&Ps

Quarter 2: May 22, 2025

- Approved February 20, 2025, UMC meeting minutes
- Introduced a new voting member, UM Medical Director for Optum
- Approved review and approval of Clinical Practice Guidelines
- Review of over/underutilization data to include acute inpatient, hospital facility, ED utilization, NEMT, and pharmacy.
- Review of operational performance data to include inpatient data, prior authorization data, and turnaround time data.
- Implemented ED Diversion Program with staff embedded at the facility
- Over/Under Utilization workgroup removed Prior Auth for Medi-Cal preventive screenings
- Gender Affirming Care Workgroup - UM staff completed Transgender, Gender Affirming and Intersex (TGI) Cultural Competency training

- Reviewed BMSC meeting outcomes, including 46 codes identified for PA requirements and 97 codes removed from PA requirements
- Approved six P&Ps
- Investigated drivers of increased Medi-Cal BHT utilization
- Addressed CalAIM Turnaround Time performance below goal and discussed remediation efforts such as cross-training staff, bringing in temporary employees, and holding daily meetings to review inventory.

Quarter 3: August 21, 2025

- Approved May 22, 2025, UMC meeting minutes
- Review of over/underutilization data to include acute inpatient, hospital facility, ED utilization, NEMT and pharmacy
- Review of operational performance data to include inpatient data, prior authorization data and turnaround time data
- ED Diversion Workgroup established, including BH participation, addressing SNF placement from the ED
- Gender Affirming Care Workgroup established the GAC webpage on the CalOptima Health website
- EPSDT Workgroup identified the need for Home Health Agencies that offer PDN services, collaborating with Provider Relations
- High Risk Management Workgroup enhanced resources for urgent care in the provider portal.
- SNF Workgroup was formed in July 2025 to review the SNF Concurrent review process and appeals process
- Reviewed BMSC meeting outcomes, including 37 codes identified for PA requirements and five codes removed from PA requirements
- Approved 14 P&Ps revised in Q2
- Reviewed pharmacy utilization metrics and discussed tracking of adherence through the Medication Therapy Management Program and running an internal analysis to understand gaps
- Community Supports discussed a global CAP for room and board and transitional rent support effective January 2026

Quarter 4: November 20, 2025

- Approved May 22, 2025, UMC meeting minutes
- Review of over/under utilization data to include acute inpatient, ED utilization, NEMT and pharmacy.
- Review of operational performance data to include inpatient data, prior authorization data and turnaround time data.
- Approved Utilization goals for Bed Day and ED utilization

- Established ER High Utilizer Clinical Workgroup
- Reviewed TCS, CM, ECM and Community Supports referral process
- Gender Affirming Care Workgroup developed GAC provider roster, started monthly Interdisciplinary Care Team meeting with UCSD clinical team to expedite care coordination and access for members needing GAC services
- Launched preventive screening text campaign and promoted member portal access
- Reviewed BMSC meeting outcomes, including 33 codes requiring PA and 18 codes removed from PA requirements. In addition, three codes require PA for Medi-Cal only, and two codes have been moved to auto-approval. One code carved out to the County for Medi-Cal and for OneCare, no PA required.
- Approved 16 P&Ps
- Integrated PHM Committee into UMC
- CM held training for Complex Case Management

Quarter 4: December 18, 2025

- Approved November 20, 2025, UMC meeting minutes
- Approved 2026 UM Policy and Procedures

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
• Utilization reporting • Outgoing provider fax notifications • Delegated Health Network oversight and monitoring	• Utilization reporting • Enhancement of existing reports, development of reports identified as gaps, collaboration with CalOptima Health IT Services Department, ZeOmega, and outside consultants to develop an action plan related to additional report enhancement, report development, and Jiva workflow enhancements. • Refinement of UM bed day and ED utilization goals • Enhanced prior authorization and referral intelligence rules • Outgoing provider fax notifications • Monitoring report development, fax server upgrade • Transition to a print fulfilment vendor • Delegated Health Network Oversight and monitoring • Enhanced KPI Dashboard reporting • Enhanced collaboration with delegated Health Networks to review metrics not meeting the goal • Continued quarterly Health Network meetings • Enhanced Provider Portal • Established ED Program Workgroup and SNF Workgroup

	• Inclusion of Chief Health Equity Officer and Sr. UM Manager to the UMC structure • Collaboration with CalOptima Health’s Delegation Oversight department to enhance Health Network oversight and monitoring
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VII. Conclusion

The UM Program continues to refine programs, workgroups and oversight to address member needs and clinical outcomes under the oversight of the UM Committee (UMC). Internal and external committee members representing diverse specialties and backgrounds actively participated in discussions that led to clinical decisions and program improvements. The UMC effectively implemented improvement actions, including the launch of the ED program, the SNF workgroup, and the Over/Underutilization workgroup, based on data analysis that identified key opportunities. Activities and interventions planned for continuation or introduction in 2026 include, but are not limited to, the following:

Enhance reporting

- Contract with a vendor to manage print fulfillment
- Continue monitoring over-/underutilization data and patterns
- Continue Health Network oversight and monitoring
- Continue monitoring compliance with key performance indicators

3.8 Whole Child Model Clinical Advisory Committee (WCM CAC)	
Author(s): Thanh-Tam Nguyen, MD, FAAP, Medical Director, Whole-Child Model	Department(s): Quality Improvement
Responsible Parties: Thanh-Tam Nguyen, MD, FAAP, (Medical Director, Whole-Child Model); Hannah Kim (Director III, Case Management); Gloria Garcia (Program Specialist, Quality Improvement)	

I. Committee Purpose

The Whole-Child Model Clinical Advisory Committee (WCM CAC) was established to serve as a clinical advisory body for CalOptima Health’s Whole Child Model (WCM) program. Its primary purpose is to:

- Advise on clinical and behavioral health issues related to California Children’s Services (CCS) conditions
- Review and recommend treatment authorization guidelines and other clinical protocols
- Support quality improvement initiatives by ensuring care is safe, effective, timely, efficient and equitable for WCM members
- Ensure integration of clinical services into the design, implementation and evaluation of the WCM program
- Identify service gaps and recommend clinical program enhancements to the QIHEC

The committee’s desired outcome is to ensure that WCM members receive quality and timely care and services that improve whole-child and family outcomes and quality of life.

The committee also plays a role in regulatory compliance, accreditation standards and quality improvement projects, ensuring that CalOptima Health's WCM program aligns with state mandates and best practices.

II. Committee Background

The WCM CAC was formed in 2019 in response to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 18-023, which has since been updated (most recently to APL 24-015 as of December 2, 2024). The committee was created to fulfill regulatory requirements and to provide structured clinical oversight for the WCM program.

III. Committee Meetings in 2025

- February 18, 2025
- May 20, 2025
- August 19, 2025
- November 18, 2025

IV. Committee Changes in 2025

- WCM CAC Charter was updated with minor changes and approved on November 18, 2025
- With the sunset of PHMC, EPSDT (QI Work Plan TOC #15) was moved to be reported through WCM CAC in Q4 2025, as well as UMC.

V. Committee Actions in 2025

Quarter 1:

- Met in February and approved November 12, 2024, meeting minutes
- Reviewed data and analysis of Quality Network Adequacy, Utilization (criteria for 30-day readmission data), Appeals and Grievances, Case Management, Behavioral Health, and Customer Service discussion on Newborn Gateway: Starting in November 2024, DHCS has a new registration process for newborn births aimed at timely immunization data for newborns. Staff meeting with health networks to explain the process
- Reviewed Access and Readmission Rates
 - Discussed timely access, ED readmission rates and authorization turnover time
 - Focused on 30-day readmission rates but will also examine seven-day readmissions
 - Concerns raised about discharge planning and care coordination

Quarter 2:

- Met in May and approved the February 18, 2025, meeting minutes
- The committee discussed health network provider availability, and the Timely Access Survey showed gaps in specialties. The WCM CAC requested that staff address Health Network (HN) Adequacy for specialists serving aging-out WCM members, as well as Timely Access issues. As a result, staff will focus on initiatives to improve access to identified key specialties

- The committee raised concerns about care coordination, Enhanced Care Management paperwork and pediatric formulary changes
- The committee discussed specialist shortages and long wait times for the Autism Comprehensive Program at two Health Networks (UCI and CHOC). Remediation opportunities are to explore partnerships (e.g., Miller Children's) and improve care coordination. CalOptima Health is collaborating with health networks to address specialist shortages and enhance access, with updates anticipated at future meetings

Quarter 3:

- Met in August and approved WMC CAC May 20, 2025, meeting minutes
- Deputy Chief Medical Officer update: CalOptima Health shared updated American Academy of Pediatrics (AAP) immunization guidance for young children
- The Committee reviewed the CHOC Thompson Autism Center and the Student Behavioral Health Incentive Program (SBHIP) Autism Comprehensive Care Pilot. The SBHIP Autism Pilot for teens
 - The SBHIP Autism Pilot for teens was limited to five or six members, with a fall cohort planned. Referral process materials were in development
- The committee discussed expanding specialist access and improving enhanced case management for pediatric CalAIM
- No issues were reported with pediatric prescription prior authorizations, though insulin pump supply limits will be addressed in the following Medical RX meeting
- Perinatal Mental Health & Childcare – The Committee reviewed 2024 data, identifying performance gaps and opportunities for improvement
- WCM pediatric quality measures continue to outperform non-WCM, though improvement is needed in flu and dental care
- CalOptima Health was recognized with first place in screening rates by DHCS
- The EPSDT workgroup has been actively working to meet APL requirements

Quarter 4:

- Met in November and approved the August 19, 2025, meeting minutes
- Reviewed and approved charter updates with minor revisions completed
 - Shared updates on AB 1064 (2021): Pharmacists authorized to administer FDA/CDC-approved vaccines to individuals 3+ years old
- Shared updates on AB 144 (2025): Expanded pharmacist authority to initiate/administer CDPH-recommended vaccines
- Received staff presentations on SBHIP Autism Comprehensive Care Pilot Program follow-up, WCM Provider Network Specialist network, pediatric new contract exploration in progress, and shared ECM Data
- Confirmed no major issues in Pediatric Rx authorization requirements: noted supply limits were under review

- Reviewed Pediatric Quality Metrics year-to-date data. Identified concern for children vaccinated outside primary care may skip well-child visits. Recommended CalOptima Health to explore offering flu vaccines in subspecialty clinics
- Depression Screening (DSF-E): Noted slight decline (-0.8%) in adolescent screening rates, identified issue with providers not submitting screening data, agreed to coordinate follow-up meetings to improve integration and data capture
- Adverse Childhood Experiences (ACEs): Confirmed members flagged with CPT code G9919 (ACE score ≥ 4) should be referred for interventions, and requested outcome analysis for high-risk members over time
- Utilization Management (UM): Acknowledged positive trends: referral turnaround reduced to three days; 60-day lookback supported and requested UM performance data across all Health Networks
- Risk Stratification: Recognized improvements in timely outreach and assessments and requested focused analysis on pediatric foster care populations
- Reviewed QI Work Plan and provided activities for 2026 goals
- Created 2026 WCM CAC Reporting Calendar
- Approved EPSDT reporting changes: Starting 2026, EPSDT will no longer report to WCM CAC to eliminate redundancy

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement
Q1: Understanding Newborn Gateway criteria	Clarify with DHCS and implement appropriate action
Q2: 1) The lack of certain specialist providers in health networks 2) Whole-Child Model case-managed members and Enhanced Care Management overlap 3) Identify challenges related to the reinstatement of prior authorization for Pediatrics	1) Pediatric new contract exploration 2) Examine ECM population criteria and Care Coordination; explore ECM data; follow WCM regulatory requirements 3) No major issues; review supply limits
Q3: The SBHIP Autism Pilot for teens has limited Pilot slot availability	CalOptima Health's Behavioral Health continues to collaborate and support the SBHIP Autism Pilot
Q4: • Changes to the California pharmacy scope of practice for pediatric vaccine administration • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) was being reported to UMC and WCM CAC	• Research implications of AB 144 on pediatric vaccine administration and report back • Improve pediatric immunization and Well Child Care (WCC) rate • In 2026, EPSDT will no longer report to WCM CAC

VII. Conclusion

WCM CAC actively collaborates with WCM CAC members, Orange County CCS, the Regional Center of Orange County (RCOC), and the County of Orange Social Services Agency (SSA). In 2026, WCM CAC will continue meeting quarterly, fulfilling regulatory requirements and the committee's purpose.

3.9 Assessment of QI Staff and Resources

Author(s): Marsha Choo

Department(s): Quality Improvement

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QIHETP. CalOptima Health's Chief Medical Officer, with support from the Deputy Chief Medical Officer, continues to oversee the QIHETP and its work plan. There are 14 medical directors who support various aspects of member care and collaborate with departments to improve the quality of member care.

The QI Program also received support from the following key departments within the organization, including but not limited to the following:

- Quality Improvement
- Quality Analytics
- Equity and Community Health
- Behavioral Health Integration
- Case Management
- Utilization Management
- Customer Service (including outreach and engagement)
- Human Resources
- Medi-Cal and CalAIM
- Medicare Product
- Compliance
- Provider Relations and Contracting

At the beginning of 2025, there were many vacant positions supporting quality and the QIHEC. However, throughout the year, CalOptima Health's Human Resources department collaborated with the business areas to fill necessary positions that supported the QIHETP.

In 2025, CalOptima Health added the following:

- Manager of Quality Improvement (NCQA)
- Director of Provider Network Strategy
- Director of Quality Improvement (Credentialing)
- Director of Medical Management

In 2025, CalOptima Health filled the following vacant positions:

- Director, Grievance and Appeals Resolution Services (GARS)
- Director of Stars and Quality Initiatives

While CalOptima Health has sufficient resources to support the QIHETP, additional resources may be needed to achieve significant improvements.. As a result, CalOptima Health will continue to focus on leveraging vendors and technology to support the QIHETP.

3.10 Review of System Resources

Author(s): Marsha Choo

Department(s): Quality Improvement

CalOptima Health dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate the performance of QIHETP on an ongoing basis. CalOptima Health utilizes three enterprise data systems for utilization and care management (Jiva), provider/member data management and claims payment (Facets) and credentialing data management (Cactus by Symplr). Data from these systems is stored in a data warehouse and integrated through data workflows to identify improvement opportunities. Business and IT resources are allocated to create robust tools using Tableau to analyze and generate high-quality reports, including gaps-in-care reports and other relevant reports to support the QIHETP.

In 2024, CalOptima Health transitioned to a new care management platform, Jiva Healthcare Enterprise Platform. Jiva represents a comprehensive set of AI-powered solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways. Jiva also developed a module to support potential quality issues (PQIs). Although the transition was successful, CalOptima Health continues to collaborate with Jiva and the IT department to improve reporting capabilities within the Jiva system.

While CalOptima Health continues to use Cactus by Symplr as the credentialing data management system, the credentialing providers is conducted by our contracted NCQA-certified credential vendor organization (CVO), Verisys. Verisys conducts the primary source verification to ensure our providers are qualified to provide appropriate care, and credentialing data is then transferred and stored in Cactus. In 2025, as part of the implementation, staff identified the following barriers: CVO did not send out applications via email and used a paper mailing process, verifications were inconsistent and, at times, missing, and data was difficult to access and enter into the Cactus system. Throughout 2025, CalOptima Health worked closely with Verisys to ensure that the credentialing of providers was conducted appropriately, meeting regulatory standards, and that the data was entered into the Cactus system.

CalOptima Health utilizes a HEDIS software engine, CitiusTech, to optimize HEDIS data processing. With this technology, CalOptima Health can conduct quality reporting, such as running monthly prospective rates, to share with providers.

CalOptima Health is also contracted with Decision Point Analytics to run predictive analytics of the CAHPS data to predict patient experiences as measured by CAHPS, allowing CalOptima Health to identify individuals most likely to provide negative feedback and proactively address potential issues to improve overall patient satisfaction scores.

In addition, CalOptima Health continues to utilize the FACETS system to store member and provider demographic and claims information and uses FACETS to monitor its network.

3.11 Review of Program Structure

Author(s): Marsha Choo

Department(s): Quality Improvement

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer, and in collaboration, develops and oversees the QIHETP, QIHETP Work Plan, and QIHETP Evaluation activities. The QIHEC ensures that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated health networks and their contracted provider and practitioner partners.

In 2025, there were five subcommittees: The Utilization Management Committee (UMC), the Credentialing and Peer Review Committee (CPRC), the Member Experience Committee (MEMx), the Grievance and Appeals Resolution Services (GARS) Committee, and the Population Health Management Committee (PHMC). The Pharmacy & Therapeutics Committee and the Benefit Management Subcommittee report to the UMC. Staff successfully reported findings, recommendations and quality activities on all items in the work plan to QIHEC or a subcommittee throughout the year. Items reported directly to the subcommittee are summarized and then presented to QIHEC.

In 2025, CalOptima Health determined that streamlining the committee structure would better support organizational goals moving forward. Effective October 2025, the PHMC was sunset to reduce duplication in reporting and to realign population health initiatives directly within Clinical Operations. This strategic shift aims to promote greater synergy, operational efficiency, and the integration of population health strategies into core clinical workflows. Despite its short tenure, the committee's contributions laid a strong foundation for continued progress under the new structure. Items reported to PHMC in 2025 will be reported either to UMC or to QIHEC directly in 2026.

The organization receives adequate feedback from its community practitioners about the development and implementation of the QIHE initiatives and programs. There are physicians participating in the QIHEC, representatives from the SSA, HCA, CalOptima Health delegated health networks and community-based organizations. In addition, network providers participate in the subcommittees that report to the QIHEC.

Staff present QIHETP activities to the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC). CalOptima Health engages members through the MAC to seek input, advice and guidance related to QIHETP goals. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs, needs assessment, member survey results, access to health care, and preventive services to ensure that the QIHETP meets the needs of the population. The PAC provides advice and recommendations to the Board on CalOptima Health

programs and services as a liaison on items of interest to the provider community. The PAC meets with the MAC on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC/PAC meetings are open to the public.

CalOptima Health continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. CalOptima Health's Quality Medical Director chairs the QIHEC, along with the Chief Health Equity Officer. There are 14 medical directors supporting QIHETP, and they actively participate in the review and analysis of quality performance measures and the development of quality initiatives. All medical directors are invited to attend and participate in QIHEC meetings. Four of the six subcommittees are also chaired by a CalOptima Health medical director.

3.12 Overall Review of the QIHETP

Author(s): Marsha Choo	Department(s): Quality Improvement
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CalOptima Health had adequate staffing and resources in 2025 to meet the QIHETP requirements. CalOptima Health will continue to evaluate the needs of the program on a quarterly basis through the Work Plan, and add staffing and resources, as needed, to supplement the departments supporting the QI Program.

In 2025, CalOptima Health's three enterprise data systems for utilization and care management (Jiva), provider/member data management and claims payment (Facets), and credentialing data management (Cactus by Symplr) were sufficient to support the QIHETP. In 2026, CalOptima Health will continue to work with Jiva to streamline system utilization, particularly in reporting. For provider/member data management and credentialing, CalOptima Health will explore opportunities to enhance technology and API data transfer in 2026.

Currently, QIHETP activities are reported quarterly to either the QIHEC or the subcommittee. All the subcommittees report committee findings, actions and recommendations to the QIHEC to ensure that the QIHEC has oversight of the entire QIHETP and work plan. Since CalOptima Health sunset the PHMC at the end of 2025, there is no need to make any changes or restructure the program.

3.13 Care Management (CM) Program

Author(s): Megan Dankmyer, Hannah Kim, and Sherry Hickman	Department(s): Medical Management
Responsible Party(ies): Megan Dankmyer (Director, Medical Management); Hannah Kim (Director, Case Management); Sherry Hickman (QI Nurse Specialist, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Report on key activities of the CM program, analyze CM data compared to the goal, and improvement efforts.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

- A. Basic Population Health Management (PHM)/Case Management (CM): CalOptima Health works to understand a member’s risk. Based on the results of the risk stratification algorithm and the analysis of the identified high-risk population, members are outreached to complete a Health Risk Assessment (HRA) survey. When obtained, the HRA results are shared with the Health Network. Health Networks are required to share the HRA with the Primary Care Provider (PCP).
- B. Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Case Management facilitates workgroup efforts to address potential gaps in the delivery of EPSDT services.

II. Data Sources and Methodology

- A. Basic PHM/CM: Completed HRAs are stored in the Jiva Medical Management platform and shared with the Health Networks through the sFTP file sharing process. Health Networks are then required to share with the provider.
- B. EPSDT/CM: Coordination and facilitation of identified needs from EPSDT workgroup meetings
 - a. Quality Analytic evaluation of performance for preventive and screening services seen in link D.
 - b. Methodology for data on dental, vision, and hearing reflects members who are overdue for all three screening services; have been enrolled for at least 12 months; and are under 21 years of age. Claims data for the prior 12 months is used in conjunction with the required screening based on age according to the American Academy of Pediatrics (AAP) periodicity schedule. Members are identified as either having qualified or being overdue for services.

III. Program Results and Quantitative Analysis:

Medi-Cal Members

Graph A

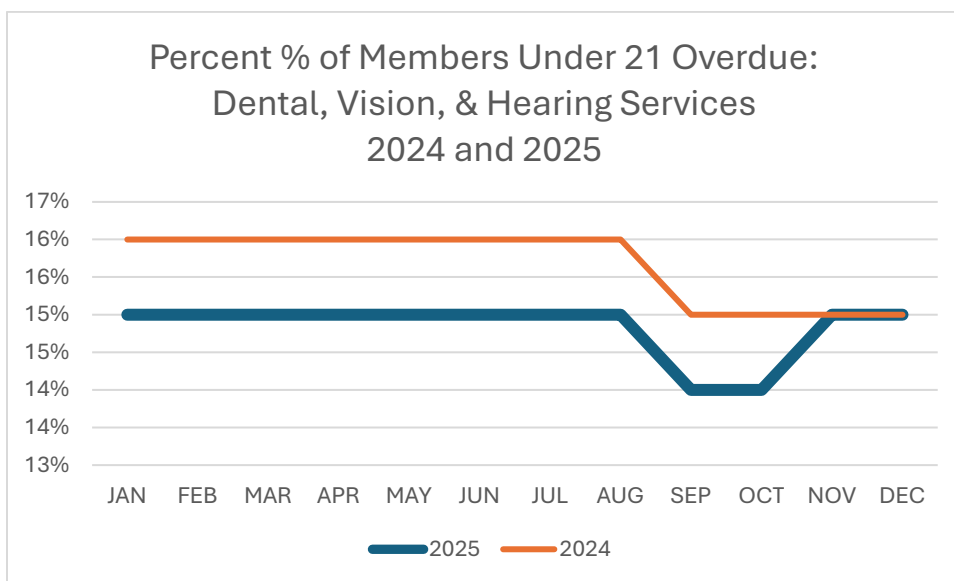


Chart caption: Percent % of Members Under 21 Overdue: Dental, Vision and Hearing services 2024 and 2025

Indicator/Goal: The goal is to decrease the percentage of members who are overdue for screening exams. A rate that is trending down or lower provides evidence that more members are receiving screening services.

There was level shift in September 2024 from 16% to 15% of members overdue for all three screening exams. This was sustained throughout 2025 with an additional dip to 14% observed in September and October 2025. 2025 exhibited lower rates and reduced variability in contrast to 2024.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Basic PHM/CM: Health Risk Assessment (HRA), when collected, is shared with the Primary Care Physician.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Continued meeting in workgroup and review of collected data to address potential gaps in delivery of EPSDT services, including vision, dental and Behavioral Health screenings.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Review and analysis of claims for dental, hearing and vision according to the American Academy of Pediatrics (AAP) periodicity schedule standards.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Medical Director re-reviewed EPSDT requirements in the CalOptima Health Clinical Ops meeting with delegated Health Networks 3/6/2025.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Medical Director met with CHOC (3/31/2025) and Optum (3/17/2025) for EPSDT review.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Preparation for texting campaign to members overdue for vision, dental and hearing screening.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Ongoing monitoring with Utilization Management and each Health Network to review EPSDT.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Behavioral Health Integration review of depression and developmental screening codes for oversight needs.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Texting Campaign members overdue for vision, dental and hearing screening and advising members on services.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Creation of the EPSDT dashboard that identifies vision, dental and hearing compliance.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

V. Effectiveness of Interventions:

- A. Basic/PHM: Interventions by Case Management effectively provided informational support through HRA data collected and transmitted to the PCP, who coordinates Basic PHM services.
- B. EPSDT: Facilitation and coordination of workgroup efforts improved oversight of EPSDT services, evidenced by continued collaboration to identify and address gaps in EPSDT service delivery, including vision, dental and behavioral health screenings. A review of dental, hearing and vision claims was conducted according to AAP periodicity standards. EPSDT requirements were re-reviewed by the Medical Director with Health Networks to reinforce compliance and quality (meetings held on 3/6, 3/17 and 3/31). Preparation and launch of a single texting campaign targeting members overdue for key screenings (vision, dental, hearing). There was a review of depression and developmental screening codes to begin support of appropriate oversight and integration by the behavioral team.

VI. Qualitative Analysis

- A. Basic/PHM: Members are risk-stratified, receive outreach, and when HRAs are collected, these are effectively shared with Health Networks, who are then required to share with the PCP.
- B. EPSDT: There is improved oversight of EPSDT delivery of services. Medical Director and Utilization Management collaborated with Health Networks (Optum and CHOC) to review a sample of prior authorization denials and ensure that EPSDT criteria had been reviewed. There was the creation of a dashboard by Enterprise Analytics (EA), and data used to support a targeted texting campaign for members who were missing vision, dental and hearing screenings. A targeted texting campaign occurred for members who missed their vision, dental, and hearing screeners according to AAP periodicity schedule standards. Enterprise Analytics and Behavioral Health are collaborating to develop an oversight dashboard, which is currently in process. Quality Analytics continues to monitor the performance of HEDIS data and initiatives. A dashboard was created that was not previously available and used to support the targeted texting campaign mentioned earlier for members who were missing vision, dental and hearing screenings. The dashboard supported the identification of members missing dental, vision and hearing screening supported by Enterprise Analytics.

Causal/Barrier Analysis:

- Lack of existing reporting for non-quality measures explored during work group meetings.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Develop a process for tracking and monitoring the rate for vision, dental and hearing compliance over time.	Work with Enterprise Analytics and the existing dashboard to establish trend rates.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

- A. Basic/PHM: Risk stratification of members will continue for the identification of members in need of HRA outreach. When collected, HRAs will be shared with Health Networks, who are then required to share with the member's PCP.
- B. EPSDT: Case Management will continue to facilitate and coordinate the ongoing interdepartmental EPSDT workgroup for improvement of oversight efforts to identify and address gaps in EPSDT services.

3.14 Complex Case Management Program	
Author(s): Hannah Kim and Diana Tep	Department(s): Case Management
Responsible Party(ies): Hannah Kim (Director, Case Management); Diana Tep (QI Nurse Specialist, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of five files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2025-December 31, 2025, will report that the case management process helped them meet their care plan goals.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Complex Case Management is the coordination of care and services provided to a member with serious, chronic, or high-risk conditions and/or who has experienced a critical event that requires the extensive use of resources. The CCM program supports CalOptima Health members by facilitating the appropriate delivery of care and services to improve health outcomes and quality of life.

II. Data Sources and Methodology

Goal 1: The population of focus includes members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups (including, but not limited to): Spinal injuries, transplants, cancer (with additional complex condition), serious trauma, AIDS, multiple chronic

illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.

CalOptima Health Case Management reviews five or 5% of members for each Health Networks that have complex case management cases enrolled for 60 days or longer. These files are identified from the monthly CM logs and CCM Universe (CC0251) for the reporting month.

Numerator: Total score achieved for PHM5 D (Initial Assessment) and E (Ongoing Case Management) by each health network with files to audit.

Denominator: Overall possible score achievable for PHM5 Elements D and E for each health network with files to audit.

Goal 2: Member Satisfaction Survey results are stored in Jiva.

The survey tool utilizes a rating scale with four options across six questions. For five of the questions, responses include Very Helpful, Helpful, Somewhat Helpful, Not Helpful, Very Beneficial, Beneficial, Somewhat Beneficial and Not Beneficial. Satisfaction is defined by selecting either Very Helpful, Helpful, Very Beneficial or Beneficial. The sixth question uses a Yes or No format, where a Yes response indicates satisfaction. Numerator: Members enrolled for 60 days or longer, complete satisfaction survey, and whose results show satisfaction* with the program.

Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year.

Goal 3: Member Satisfaction Survey results for meeting care plan goals are stored in Jiva.

The survey tool utilizes a rating scale with four options for questions related to developing and assisting with care plan goals: Very Helpful, Helpful, Somewhat Helpful and Not Helpful. Satisfaction is defined by selecting either Very Helpful or Helpful.

Numerator: Members enrolled for 60 days or longer, completed question 13 (How helpful was the case management process in helping you to meet your care plan goals?) in the satisfaction survey, and whose results show satisfaction* with the program.

Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually or upon case closure during the measurement year.

III. Program Results and Quantitative Analysis:

Results:

Table A: Complex Case Management Scores for Each Health Network in 2025

Health Networks	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV
AltaMed	97%	100%	99%	100%	99%	99%	100%	98%	97%	99%	95%
AMVI	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CCN	82%	80%	88%	88%	79%	88%	82%	86%	88%	87%	89%
CHOC	98%	95%	98%	100%	99%	99%	100%	99%	100%	100%	100%
Family Choice	N/A	N/A	N/A	N/A	N/A	N/A	100%	97%	82%	100%	94%
Noble	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	100%	96%	94%
Optum	N/A	94%	100%	94%	100%	99%	100%	100%	100%	100%	100%
Prospect	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Regal	100%	100%	N/A	N/A	82%	94%	100%	97%	100%	N/A	N/A
UCMG	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	94%
Benchmark of 90% and above is met – shown in bold ; below 90% is not met – shown <u>underlined</u>											

Table A displays the score for each Health Network for each month. N/A indicates the Health Network did not have files available for review. Results for November and December are pending. Benchmark is 90%.

Audit results include extensive feedback and areas for improvement.

Q1 2025: CCM files reviewed are members who have been enrolled for 60 days or longer. Minimum goal of 90% or higher. Eight out of 10 Health Networks had files available for review. FCMG and Noble did not participate, as they did not identify any CCM cases. Of the eight participating Health Networks, all but CHCN scored 90% or above in Q1. CHCN had an average score of 84% in Q1. Q1 2025 reflects an improvement compared to Q1 2024, when only two Health Networks met the minimum score of 90%. This indicates progress in both quality and consistency across participating networks.

Q2 2025: Nine out of 10 Health Networks had files available for review. FCMG did not participate because no CCM cases were identified. CHCN and Regal did not meet the 90% benchmark, while Optum improved by identifying cases during this quarter and meeting the benchmark. Additional training and support continued to be provided to CHCN. Training was offered to Regal.

Q3 2025: All 10 Health Networks had files available for review, indicating increased member engagement in the CCM program. Performance remained consistent across most networks during the quarter. CHCN showed a slight improvement of 1 percentage point compared with the previous quarter. Family Choice showed improvement by identifying new CCM cases; however, it had a decline month over month in this quarter. In-person training provided to CHCN to review and re-educate on Elements D and E. Monitor Family Choice through the next quarter.

Q4 2025: For Q4, only October data was available. Of the 10 Health Networks, nine had files for review. CHCN scored 87%, which is 3 percent below the 90% benchmark, while all other participating Health Networks met or exceeded the benchmark with scores above 90%.

Table B: Members referred to Complex Case Management (CCM) in 2025

Health Networks	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV
AltaMed	45	26	20	18	17	16	16	27	39	56	52
AMVI	9	6	7	7	6	5	6	3	2	1	1
CCN	202	188	156	167	174	172	172	230	233	160	203
CHOC	7	7	8	7	6	8	8	10	11	8	9
Family Choice	1	0	0	0	0	0	4	4	8	12	21
Noble	6	2	3	3	2	0	15	4	5	7	8
Optum	2	7	10	11	14	15	15	14	14	13	13
Prospect	49	44	42	35	27	25	25	11	9	8	4
Providence											2
Regal	1	3	4	3	4	5	5	2	1	0	0
UCMG	26	23	18	14	9	8	8	5	4	3	3

Table B: Members referred to Complex Case Management (CCM) month over month in 2025 based on Health Network CM log submission and CCM Universe (CC0251). CCM enrollment is reported to DHCS monthly.

Table C: Member Satisfaction Survey Results January – December 2025

Survey Questions - Benchmark 85% or higher	Q1. Case Management was Beneficial	Q2. Educational Materials were Helpful	Q3. CM was helpful with Medical Questions	Q4. Community Resources were Helpful	Q5. Questions were answered to Satisfaction	Q6. Overall Satisfaction with CM	Q7. Care Plans
Numerator	182	178	176	176	184	178	182
Denominator	186	186	186	186	186	186	186
Score	98%	96%	95%	95%	99%	96%	98%

Table C:

Compared with 2024, member engagement has increased, and a greater number of surveys have been completed. All survey questions met or exceeded the benchmark threshold of 85%, indicating consistent performance across all measured areas.

In Q2 2025, we continued to see improvement. For Question 3, “Was the Care Manager helpful with medical questions,” scores increased from 88% in Q1 to 98% in Q2.

In Q3 2025, we continued to see consistent performance. All scores remained above the 85% benchmark, with most responses in the higher range, reflecting ongoing positive engagement and support.

In Q4 2025, all scores remained above the 85% benchmark, ranging from 92% to 100%.

Goal 1: Based on current results, the goal is projected not to be met, as not all Health Networks have achieved the 90% benchmark. CCN remains consistently below 90%, although it shows gradual improvement with targeted support.

Despite this, there has been notable progress across most Health Networks, with nearly all — except CHCN — scoring above 90% for the majority of the year. Minor dips were observed with Regal in May and Family Choice in September; however, overall trends indicate improvement compared with previous performance.

Goal 1: Current data indicates that this goal is unlikely to be met, as not all Health Networks have reached the benchmark. CHCN continues to perform below benchmark despite receiving targeted support. Some barriers are due to new case managers working on CCM cases and issues with the current complex case management assessment in Jiva. Training is being provided to all case managers on an ongoing basis. Revisions to the assessment are pending.

There has been notable progress across most Health Networks, with nearly all except CHCN.

Isolated dips were observed with Regal in May and Family Choice in September, but these were brief and did not significantly impact the overall upward trend. Possible reasons for the dips are that CCM cases are not consistently opened. Will continue to monitor and offer support as needed.

Goal 2: In 2024, Question 3 (“Care Manager was helpful with medical questions”) received the lowest score at 89%, though it still met the 85% benchmark.

In 2025, all questions met the benchmark in Q1, with Question 3 again scoring the lowest at 88%. However, performance improved significantly in Q2, with Question 3 rising to 98%, and that score was maintained in Q3. All other questions consistently exceeded the 85% benchmark throughout the year. These results reflect a clear upward trend in member satisfaction, demonstrating the program’s continued success in meeting member needs and expectations.

Goal 2: This goal is met, with data showing a clear and consistent upward trend in member satisfaction. All questions met or exceeded the benchmark in Q1, with Question 3 scoring lowest but still meeting the

benchmark. However, by Q2, Question 3's score surged and surpassed the benchmark and was maintained through Q3. In Q4, performance remained stable, with all questions asked receiving a score exceeding the 85% benchmark. The consistency of high scores across all questions further reinforces the program's success in addressing member needs and expectations.

Goal 3: In 2024, 91% of the 89 members who completed the survey reported that Case Management helped them achieve their care plan goals. In 2025, we consistently exceeded the 85% benchmark each quarter. Q1 results showed 95%, followed by 98% in both Q2 and Q3.

These results demonstrate a steady improvement in how effectively case managers engage and support members in reaching their health goals, ultimately contributing to better health outcomes and a higher quality of life.

Goal 3: Based on the data, this goal is met. In 2025, we consistently exceeded the benchmark each quarter.

These results demonstrate a steady improvement in how effectively case managers engage and support members in reaching their health goals, ultimately contributing to better health outcomes and a higher quality of life.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
- Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/situations. (Goal 1) - Element D/E training for all Health Networks on 2/27/2025 and 3/4/2025.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Member Satisfaction Survey (MSS) scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) - MSS score will be shared during the Clinical Ops meeting and CCN Department meeting.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Ongoing training and support for new and existing staff. (Goal 2)	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Continue to gather feedback from MSS to improve outcomes. (Goal 2) - Meeting will be held with QI Nurse and leadership in Quarter 2 to discuss results	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Training and education on member-centric care plans. (Goal 3) - Develop training for CCN team to be provided in Quarter 2.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

- Continue training and educational opportunities to staff on the 2025 PHM Element D/E and complex conditions/situations. (Goal 1) a. Element D/E training for WCM CCN on 5/12/2025, 5/14/2025, and 5/20/2025	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- MSS scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) a. Q1 MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Ongoing training and support for new and existing staff. (Goal 2)	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Continue to gather feedback from MSS to improve outcomes. (Goal 2) a. Meeting held with QI Nurse and leadership on 5/5/2025 to discuss Q1 MSS results. An additional meeting was held on 5/19/2025 with the QI Nurse, Data Analyst, MA, and Leadership to discuss ways to improve the survey and engage the members in completing the MSS.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Training and education on member-centric care plans. (Goal 3) a. Care plan training for CCN conducted on 4/18/2025, 6/25/2025, and 6/27/2025.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/situations. (Goal 1) - o Developed new training materials on Element D/E. Trainings for CCN on 8/19/2025 and 9/16/2025. - o Mock audits planned in Q4	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- MSS scores shared with CHCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) - o Q2 MSS score shared during the Clinical Ops meeting with the Health Networks on 9/4/2025 and in the CCN CM department meeting on 9/17/2025. Q3 will be shared in Q4	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Ongoing training and support for new and existing staff. (Goal 2)	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Continue to gather feedback from MSS to improve outcomes. (Goal 2) - o Meeting held with QI Nurse and leadership on 7/15/2025 to discuss Q2 MSS results	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Training and education on member-centric care plans. (Goal 3)	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

○ Motivational Interviewing Training provided on 9/3/2025 and 9/9/2025 to better engage and empower members to achieve their goals. ○ Planned training for Health Networks on SMART goals in October 2025				
• 1) Continue training and educational opportunities for all CCM staff on 2025 PHM Element D/E and complex conditions/situations. (Goal 1) • a. Mock audits with consultants conducted for all health networks in November 2025. • b. Individual meetings were conducted with CHCN staff on the following dates: • i. 11/18/2025 • ii. 11/24/2025 • iii. 12/30/2025 – 2 meetings • iv. 12/31/2025 – 2 meetings	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• 2) MSS scores shared with CHCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) • a. MSS score shared during the Clinical Ops meeting with the Health Networks on 11/13/2025 and in the CHCN CM department meeting on 12/17/2025.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Ongoing training and support for new and existing staff. (Goal 2)	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Continue to gather feedback from MSS to improve outcomes. (Goal 2) • a. Meeting held with QI Nurse and leadership on 10/20/2025 to discuss Q3 MSS results	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• a. Care plan training for Health Networks • i. 10.22.2025 Care Planning: Building a SMART Goal (AltaMed/FCMG & Regal) • ii. 10.28.2025 Care Planning: Building a SMART Goal (CHOC & Noble) • iii. 10.30.2025 Care Planning: Building a SMART Goal (AMVI/Prospect/UCMG)	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Goal 1: The interventions implemented in 2025, based on 2024 findings, have led to some improvement with the Health Networks. Nine of the 10 Health Networks achieved a score of 90% with a setback with Regal in May and Family Choice in September scored less than 90%. While CHCN remains below the 90% benchmark throughout the year. Significant training is provided in person for CHCN.

Goal 2: Sharing survey results with all Health Networks helped them identify gaps and make changes to improve member care. This information sharing, combined with training, contributed to exceeding the 85% benchmark.

Goal 3: Care plan and motivational interviewing trainings strengthened the case managers' ability to more effectively engage members and support them in achieving their health goals. As a result, scores consistently remained in the high 90s each quarter.

VI. Qualitative Analysis

The QI Nurse conducted the review and identified a key barrier: the need for additional training across all Health Networks.

Causal/Barrier Analysis:

Goal 1 Barriers

- CCM assessment in Jiva have been a barrier for CHCN
- Ongoing training needed for Elements D and E

Goal 2 and 3 no barriers identified

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Enhance training materials on Elements D and E	Develop new training materials based on mock audit recommendations Continue training and education on member centric care plans for all health networks as needs arise.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
Training provided in groups and individualized settings to reinforce learning.	Provide 1:1 and group training as needed	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Strengthen performance tracking for all Health Networks.	Intervene immediately and meet to discuss audit outcomes.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
Strengthen our member experience with CCM program.	Share MSS scores with all health networks on a quarterly basis Conduct quarterly leadership meetings to review MSS scores and member feedback to collaborate on strategies to improve outcomes.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data shows that we are making overall improvements. Goal 1 was not fully met, but most Health Networks made strong progress, with only one falling slightly short.

Goals 2 and 3 were successfully met, showing strong performance across all Health Networks and a positive experience for members in the CCM program.

In summary, the program is showing clear signs of success and continuous improvement. With continued adjustments and support for Goal 1, along with some additional support and adjustments, we will be on track to meet all goals for 2026.

3.15 Population Health Management (PHM) Strategy and Program	
Author(s): Katie Balderas	Department(s): Medical Management/Case Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Megan Dankmyer (Director, Medical Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement initiatives for the 2025 PHM program starting January 1, 2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health conducts an annual Population Needs Assessment to better understand the health characteristics and needs of its Medi-Cal members in Orange County. This assessment draws on a wide range of data sources to inform planning, guide resource allocation, and support quality improvement initiatives.

As part of this effort, Risk Stratification and Segmentation (RSS) is used to analyze diverse data inputs to identify member health needs and preferences. This process supports the Population Health Management (PHM) Program by enabling more targeted and meaningful member engagement.

Screening and Assessment activities are conducted for newly enrolled Medi-Cal members within 90 days of enrollment. Outreach includes three attempts: mailing the Health Information Form/Member Evaluation Tool (HIF/MET) followed by two reminders. Members identified as high-risk receive further outreach for a Health Risk Assessment (HRA), which includes three phone calls and a follow-up letter if contact is unsuccessful.

The PHM Strategy is a foundational component of CalOptima Health's QIHETP Work Plan. It is implemented through a detailed PHM Work Plan that outlines annual goals, priority populations, interventions and performance measures. Each quarter, designated business owners update their assigned PHM activities, documenting progress, challenges, and next steps. These updates are compiled into quarterly reports and presented to the QIHEC or its subcommittees, ensuring continuous oversight, accountability, and alignment with organizational priorities.

Wellness and prevention services are integrated throughout the PHM strategy to promote whole-person care and improve health outcomes. These services include:

- Health education to empower members with knowledge and tools to manage their health.

- Disease management programs that provide targeted support for members with chronic conditions.
- Screenings and assessments that identify risk early and connect members to appropriate care.
- Care coordination and referrals that ensure members receive timely access to behavioral health, specialty care and community-based resources.

Together, these components form a comprehensive, proactive approach to population health that supports member well-being.

II. Data Sources and Methodology

To comprehensively understand the needs of CalOptima Health’s Medi-Cal members, the Population Needs Assessment draws from a wide array of internal and external data sources. These sources inform strategic planning, guide interventions and support the integration of wellness and prevention services throughout the PHM strategy.

Internal Data Sources

- Member demographic data
- Medical and behavioral health claims and encounters
- Pharmacy claims
- Laboratory results
- Health appraisal outcomes
- Participation in CalOptima Health programs
- Advanced analytics tools

These internal sources provide a foundational understanding of member health status, service utilization and engagement with wellness and prevention programs, including health education, disease management and care coordination.

Quality Performance Benchmarks

- Healthcare Effectiveness Data and Information Set (HEDIS®) (Reporting Years 2020–2024; Measurement Years 2019–2023): A standardized set of performance measures developed by the National Committee for Quality Assurance (NCQA) to evaluate health plan effectiveness.
- Medi-Cal Managed Care Accountability Set (MCAS) (RY 2024; MY 2023): A set of performance indicators selected by DHCS for annual reporting by Medi-Cal managed care plans.

These benchmarks help assess the impact of PHM interventions, including those focused on preventive care and member experience.

Supplemental External Data Sources

- 2024 Point-in-Time Homeless Count (Everyone Counts)
- California Healthy Places Index (2022) from the Public Health Alliance of Southern California
- U.S. Census and American Community Survey (Orange County)

These external sources provide critical context on social determinants of health and community-level disparities, helping to tailor wellness and prevention strategies to local needs.

Risk Stratification and Screening

Risk stratification is supported by the Chronic Illness and Disability Payment System (CDPS), a data-driven tool that uses diagnostic codes and pharmacy data to group members by health status and expected costs. This enables tiered care planning aligned with the CalAIM PHM Policy, to identify members who require high, medium-rising, or low levels of care.

Screening and assessment activities are tracked through the Jiva Medical Management platform, which monitors completion rates and supports timely outreach. These assessments help identify members who may benefit from wellness services such as health coaching, disease management, or referrals to behavioral health and social support programs.

PHM Work Plan and Performance Monitoring

The PHM Work Plan includes a diverse set of measures that reflect both clinical quality outcomes and member experience. These include:

- HEDIS performance metrics
- Health equity indicators
- Member satisfaction survey result

The integration of wellness and prevention services, such as health education, chronic disease self-management, and connections to appropriate care, is a key component of these efforts.

III. Program Results and Quantitative Analysis:

PHM Strategy Overall Assessment

The outcomes of the PHM goals are outlined below.

PHM Strategy Domain	Program	2025 PHM Goal Met / Not Met
Keeping Members Healthy	Blood Lead Screening	☒ Yes ☐ No ☐ Partially Met
Keeping Members Healthy	Prenatal/Postpartum Depression Screening	☒ Yes ☐ No ☐ Partially Met
Keeping Members Healthy	Healthy Heart Program	☐ Yes ☒ No ☐ Partially Met
Emerging Risk	Chronic Condition Care and Self-Management Program	☒ Yes ☐ No ☐ Partially Met
Patient Safety	CalAIM Community Supports	☐ Yes ☒ No ☐ Partially Met
Patient Safety	Street Medicine Program	☐ Yes ☐ No ☒ Partially Met
Patient Safety	Behavioral Health Services	☐ Yes ☒ No ☐ Partially Met

Managing Multiple Chronic Conditions	Complex Case Management	☐ Yes ☐ No ☒ Partially Met
Advanced Care Support	Enhanced Care Management	☒ Yes ☐ No ☐ Partially Met

Of the nine programs in the PHM Strategy, four met the goal. Blood Head Screening and Prenatal/Postpartum Depression Screening in the Keeping Members Healthy Domain, Chronic Condition Care and Self-Management Program in Emerging Risk, and Enhanced Care Management in Advance Care Support met goals. The following three programs did not meet the goal: Heart Healthy Program, CalAIM Community Supports, and Behavioral Health Services.

Further information and detailed assessments of the nine PHM Strategy programs can be found throughout the 2025 QIHETP Program Evaluation.

HIF-Met Return Rates January through June 2024 and 2025

Chart A

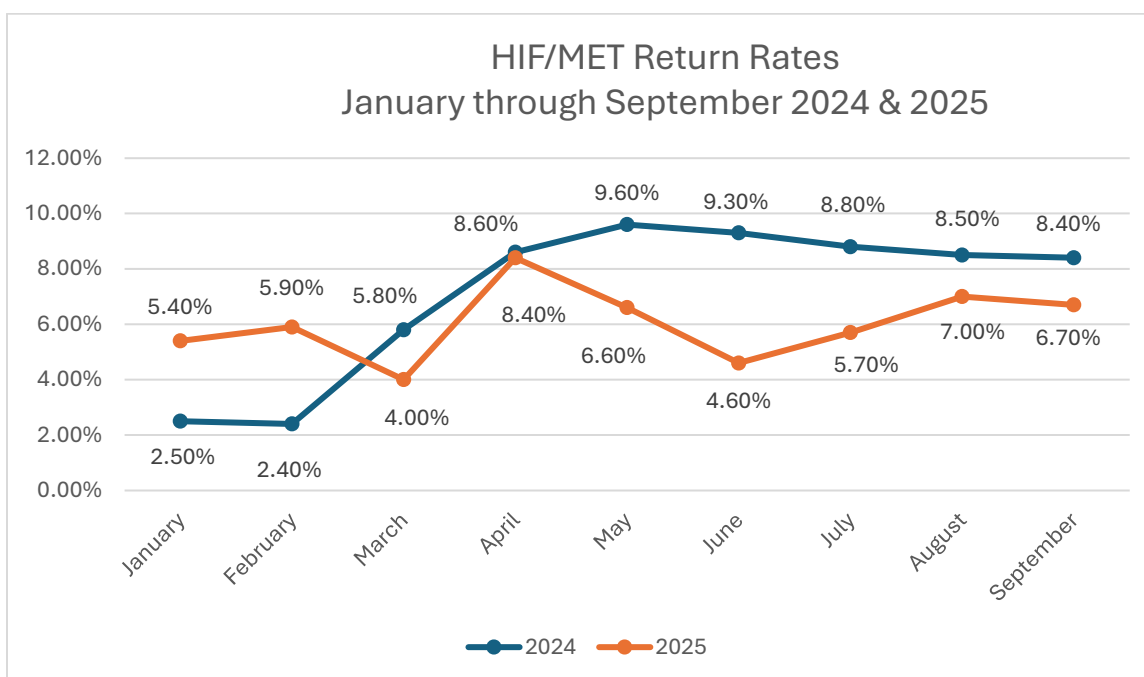


Chart caption: HIF/MET Return Rates January Through September 2024 & 2025

Indicator/Goal(s): A higher return rate is preferred.

From January to September, the average rate declined from 7.10% in 2024 to 6.03% in 2025. Rates in 2025 started stronger in January (5.4%) and February (5.9%) then declined for the remaining seven (7) months to rates below 2024 for same point in time.

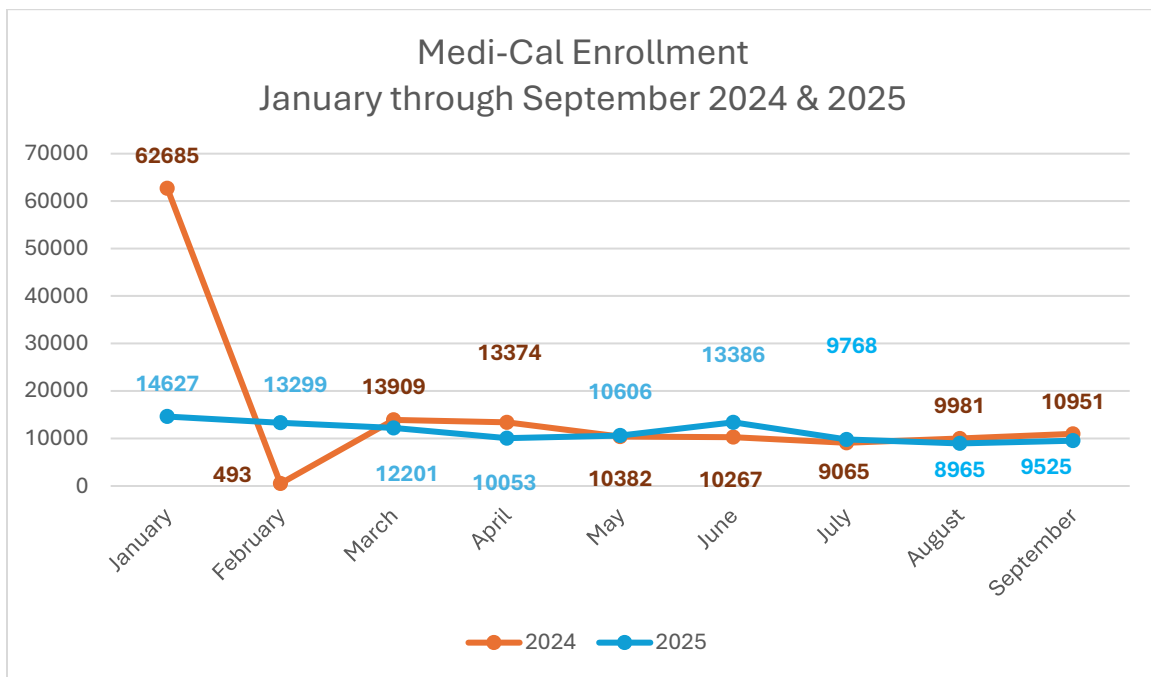


Chart caption: Medi-Cal Enrollment January through September 2024 & 2025

Indicator/Goal(s): Observational for enrollment trend year over year.

Year-to-date newly enrolled members total 102,430 in 2025, down 27.4% from 141,107 in 2024, with the largest gap in Q1 (-48%). The most recent quarter (Jul-Sep) is 5.8% lower than last year, and the 3-month rolling average remains 11.7% below 2024.

Medi-Cal Risk Stratification by Risk Level:

Table A

Reporting Time Frame	High-Risk Members	Medium-High Risk	Medium Risk	Low Risk
Q4 2025	10,382	20,706	202,752	395,462
Q3 2025	10,892	21,221	208,372	410,699
Q2 2025	10,806	21,323	208,350	421,407
Q1 2025	10,230	22,380	212,630	438,876
Q4 2024	10,081	22,289	210,924	439,533

Chart caption: Medi-Cal Risk Stratification by Risk Level

Indicator/Goal(s): Observational and monitoring

High Risk membership shows an upward trend through 2025 rising from 10,230 (Q1) to a peak of 10,892 (Q3), followed by a small pullback in Q4 (10,382), a net increase of 1.5% from Q1 and 3.0% from Q4 2024. High Risk membership as a share of the population increased from 1.48% in Q4 2024 to 1.65% in Q4 2025 (+0.17 percentage points). Low Risk membership declined across 2025, dropping from 438,876 in

Q1 to 395,462 in Q4 (-43,414, or -9.9%), accounting for nearly 80% of total membership attrition and reducing its share from 64.2% to 62.8%.

Medi-Cal Risk Stratification by % Risk Level:

Chart A

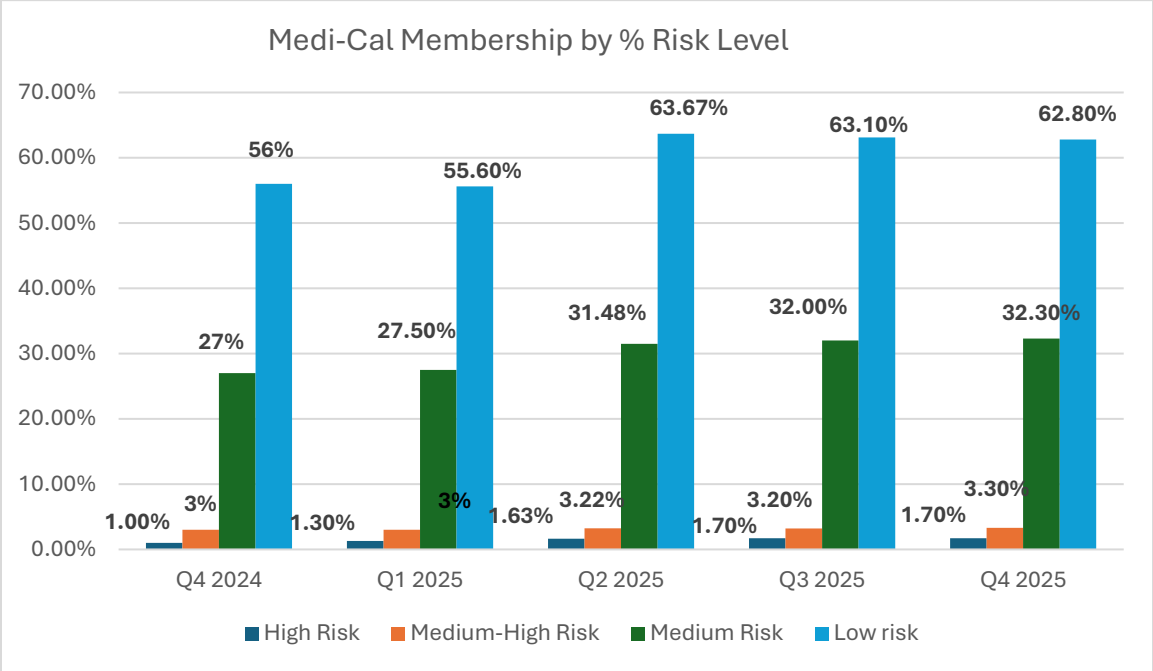


Chart caption: Medi-Cal Risk Stratification by % Risk Level

Indicator/Goal(s): Observational Monitoring.

Members identified as high risk increased from 1% in Q4 2024 to 1.7% through the end of Q4 2025, signifying an upward trend in risk. When contrasting Q4 2024 to Q5 2025, the High Risk category saw the largest relative increase.

Medi-Cal High Risk Members with and without intervention:

Table B

Reporting Time Frame	High-Risk Members	Members with an intervention	% Members with an intervention	Members without an Intervention	% Members without an Intervention
Q4 2025	10382	7,731	76%	2,651	24%
Q3 2025	10,892	8,282	76%	2,610	24%
Q2 2025	10,806	7,302	68%	3,504	32%
Q1 2025	10,230	7295	71%	2,935	29%
Q4 2024	10,081	6239	62%	3,842	38%

Chart caption: Medi-Cal High Risk Members with and without an intervention

Indicator/Goal(s): A higher volume and a higher rate of members receiving an intervention are preferred. Lower volume and a lower rate of members without an intervention are preferred.

The volume of high-risk members with evidence of an intervention increased from 62% in Q4 2024 to 76% by the end of Q3 2025, demonstrating a relative 22.6% growth. The volume of high-risk members without evidence of intervention decreased from 38% in Q4 2024 to 24% through the end of Q3 2025, demonstrating a relative rate reduction.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Population Needs Assessment approved by the Population Health Management Committee on May 15, 2025.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Ongoing Risk Stratification monitoring	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Ongoing tracking of HIF/MET and HRA completion within 90 days of enrollment.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
4. Population Health Management Strategy approved by CalOptima Health Board of Directors on April 3, 2025 and monitored quarterly	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

1. The Population Needs Assessment was completed, approved by the PHMC, and posted on the CalOptima Health website.
2. Risk Stratification: The volume of members identified as high-risk demonstrates an upward trend while simultaneously showing the improvement in high-risk members with evidence of intervention.
3. Screening and Assessment: Goal met for HIF/Met and HRA completion.
4. The PHM Strategy was approved by the CalOptima Health Board of Directors on April 3, 2025 and monitored throughout the year. The outcomes and effectiveness of each intervention in the PHM strategy is documented in the QIHET Program Evaluation.

VI. Qualitative Analysis

1. The PNA focuses on understanding the health of the overall member population and specific groups such as children, individuals with disabilities, those with severe mental illness and members with limited English proficiency. It also examines the social determinants of health, including housing instability, poverty and adverse family events.

Top physical health conditions among CalOptima Health members include:

- Hyperlipidemia (16.04%)
- Hypertension (13.15%)
- Obesity (9.10%)
- Diabetes (8.50%)
- Anemia (5.60%)

Top behavioral health conditions among CalOptima Health members include:

- Anxiety disorders (6.60%)
- Depression and other mood disorders (6.43%)
- Drug use disorders (2.31%)
- ADHD and conduct disorders (1.65%)
- Bipolar disorders (1.33%)

These findings help shape CalOptima Health’s PHM Strategy and Work Plan, including disease management programs, culturally appropriate outreach and targeted interventions to improve health outcomes.

2.a Risk Stratification: Risk stratification efforts have shown improvement with more high-risk members receiving interventions and fewer high-risk members remaining without evidence of intervention. This positive shift highlights the effectiveness of targeted strategies in addressing the needs of the most vulnerable populations.

1. Screening and Assessment: The comparison of HIF/MET return rates between the first half of 2024 and 2025 reveals a performance shift. In 2024, return rates showed improvement month after month, reflecting member response. By contrast, 2025 began with relatively higher early returns but declined in later months.
2. PHM Work Plan Oversight: CalOptima Health’s 2025 PHM Work Plan reflects steady progress in advancing population health goals, improving care coordination, and addressing health disparities across its Medi-Cal membership. Through structured quarterly reporting, the organization has consistently implemented planned activities and aligned with NCQA and DHCS requirements.

Key Achievements:

- The 2025 Population Needs Assessment (PNA) was finalized and submitted for NCQA accreditation.
- The PHM Strategy and Work Plan were approved by all governance bodies and are being actively monitored.
- Most work plan elements across domains are reported as “on target,” with clear documentation of interventions, findings, and next steps.

Program Highlights:

- Care Management (CM): Health Risk Assessments (HRAs) were consistently shared with PCPs. EPSDT oversight was enhanced through interdepartmental collaboration, member outreach and behavioral health screening reviews.
- Complex Case Management (CCM): Member satisfaction benchmarks were met, with 98% of surveyed members reporting that case management helped them meet their care plan goals. Training and audit support were provided to health networks as needed.
- Disease Management: Two-way text campaigns for diabetes and asthma reached more than 18,000 members in Q2, more than doubling engagement rates in health coaching. A new SMS-based satisfaction survey improved response rates, and stratification logic was reviewed to better target outreach to members with the highest needs.
- Health Education: More than 1,500 referrals were received each quarter. Virtual class offerings expanded, and attendance steadily increased. In-person events were paused in Q3 to support operational transitions, while digital outreach continued.
- Initial Health Appointment (IHA): Text and IVR campaigns reached thousands of new members monthly. Collaboration with Delegation Oversight and Provider Relations supported health network compliance and education.

Targeted Interventions:

- Controlling Blood Pressure: Outreach for hypertension included standing orders for BP monitors, culturally tailored education and telephonic coaching. More than 500 BP monitors were distributed to members along with education on how to use them for self-management.
- Maternal and Child Health: Prenatal and postpartum care initiatives for Black members included ECM and doula referrals, community engagement, and a data-sharing partnership with the OCHCA for enrollment into Black Infant Health.
- Behavioral Health: Depression screening and follow-up (DSF-E) and follow-up after ED visits (FUM/FUA) were identified as areas of concern. Interventions included provider education, member text campaigns and collaboration with OCHCA.

Causal/Barrier Analysis:

- Barriers to the PNA include heavy reliance on quantitative data using claims/encounters, with limited qualitative member feedback.
- Barriers to reaching high-risk members include many members who are unable to be contacted for assessments and support.
- Barriers to PHM workplan include difficulty reaching members to engage in needed care, data delays and fragmentation between plan, providers and member engagement systems.
- Barriers to Screening and Assessment regarding the high-volume and fluidity of high-risk determination creating challenges for prioritization.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. The PNA primarily relies on quantitative data; incorporating qualitative input (such as member stories, focus groups, or community feedback) would enhance its ability to fully reflect member needs and lived experiences.	Use provider and member surveys, interviews, and focus groups from the Member and Population Health Needs Assessment to integrate qualitative insights into the PNA and guide the PHM Strategy.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Continue to prioritize high-risk members without a recent intervention for outreach and assessment.	Outreach for assessment of high-risk members.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Some PHM Work Plan measures, including pediatric well-child visits (W30), maternal health disparities, and behavioral health follow-up, remain areas of concern due to data delays, member engagement challenges, and external factors.	Continued refinement of outreach strategies, provider engagement, and data infrastructure will be critical to sustaining progress and closing performance gaps.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The Population Needs Assessment (PNA) serves as the cornerstone of CalOptima Health’s PHM Strategy, providing a robust, data-driven foundation to identify member needs, guide targeted interventions and inform resource allocation. Beginning in 2026, the PNA will be further enhanced by incorporating qualitative insights from the Member and Population Health Needs Assessment, including member and provider surveys, as well as focus groups, to ensure a more comprehensive and person-centered understanding of the populations served.

Risk stratification and screening efforts continue to evolve, with an increasing number of high-risk members being identified for intervention. These efforts underscore the importance of ongoing monitoring and outreach. High-risk members without an identified intervention remain a priority for completing Health Risk Assessments (HRAs) and Health Needs Assessments (HNAs), ensuring that no member falls through the cracks.

The 2025 PHM Work Plan reflects CalOptima Health’s ongoing commitment to advancing population health through data-informed strategies, cross-departmental collaboration and equity-focused initiatives. With most goals on track, the organization has made measurable progress in key areas, including care coordination, chronic disease management, health education and member engagement. Continued refinement of outreach and performance strategies will support sustained improvement and alignment with quality and regulatory standards into 2026 and beyond.

3.16 Disease Management Program

Author(s): Elisa Mora

Department(s): Case Management

Responsible Party(ies): Katie Balderas (Director, Case Management); Elisa Mora (Manager, Case Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025, will report satisfaction	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health's Disease Management (DM) program is a member-centered, evidence-based initiative designed to improve health outcomes and reduce disparities for individuals with chronic conditions such as diabetes, asthma and congestive heart failure. The program aims to reduce emergency visits and inpatient hospitalizations due to disease exacerbations, empower members to manage their own health and ultimately improve their quality of life. The DM Program meets requirements for the DHCS CalAIM PHM Program and NCQA PHM standards for Health Plan Accreditation.

II. Data Sources and Methodology

The program uses claims encounter, medications and lab data to stratify members for the DM Program. Members deemed high risk are offered individualized, telephonic health coaching and care coordination to manage their conditions. Low-risk members receive a condition-specific mailing package that also includes information on how to connect with a health coach. Provider referrals and member self-referrals are another way to join the program.

Additionally, member satisfaction with health coaching interventions is assessed through an interactive, two-way USHUR text message survey. The survey is sent to members immediately following their health coaching follow-up session. Since implementing this new process, the response rate has increased significantly from less than 10% in previous years to 41%.

III. Data Stratification Results and Quantitative Analysis:

Based on the CMS Tableau report and program criteria, the following members may be eligible for the program:

DM Conditions Vol. of high/mod. risk	DM Conditions Vol. of high/mod. risk	Total Outreach by Health Coaches in 2025	Successful Member Outreach YTD* 2025
	27,666	5,824 (21%)	2,068 (7.50%)

Data reflects members reached through 1/1/2025-12/1/2025

The Disease Management team implemented several impactful interventions across Medi-Cal and OneCare populations, with a strong focus on member engagement. A two-way text messaging campaign for stratified asthma and diabetes members is ongoing and has achieved a 40% engagement rate,

outperforming traditional outreach. Real-time satisfaction surveys, deployed via USHUR after follow-ups, have yielded a 41% response rate and a 97% satisfaction score, exceeding the 85% goal. Stratification criteria were refined using clinical, utilization and quality data to better target high-risk members, with full implementation planned for the first quarter of 2026. Completed pilots include shortened assessments for asthma, diabetes and CHF, which cut completion time by over 50% without reducing engagement quality. Additionally, a new text message process and a pre-call dashboard — both currently in the Q4 pilot phase — will enhance outreach efficiency upon full implementation.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Re-launched a two-way text message campaign asking stratified members with asthma and diabetes to opt in to the program	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Implemented real-time satisfaction survey via Ushur and delivered after follow-up sessions- goal is to rate 85% satisfaction	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Stratification criteria were reviewed and refined using utilization, clinical data and quality data to better target high-risk members and identify gaps in care.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
4. Piloted shortened assessments for asthma, diabetes and CHF	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
5. Piloted a new text message process that allows staff to text members to give them a heads up on call outreach with the HC name	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
6. Tested a pre-call dashboard for diabetes members	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

1. Two-Way Text Messaging Campaign for Stratified Members

This intervention aimed to boost member engagement. Members who opted in via text messaging demonstrated a 40% engagement rate, which is significantly higher than the 15%–20% typically seen with cold calls.

2. Real-Time Satisfaction Survey via Ushur

Implementing real-time surveys through Ushur led to a 41% response rate, compared with less than 10% via traditional mail. Notably, the overall satisfaction rate for Disease Management services is 97%.

3. Refined Stratification Criteria

Stratification logic was enhanced using utilization, clinical and quality data to better identify high-

risk members and care gaps. A request for implementation has been submitted and is currently pending IT assignment.

4. Streamlined Assessments

DM assessment tools were shortened and simplified, reducing completion time by more than 50% without compromising the quality of member engagement.

5. Pre-Call Dashboard

A centralized dashboard now provides staff with essential clinical information about members with diabetes, reducing pre-call preparation time from 15 minutes to 5 minutes.

DM Satisfaction Survey

Goal: 85% satisfaction

The Disease Management Satisfaction Survey conducted between March and November 2025 yielded highly positive results. Out of 369 texted surveys, 153 responses were received, reflecting a 41% response rate — substantially higher than the previous mailed survey rate of under 10%.

Quantitatively, satisfaction rates across all measured dimensions were exceptionally high: 98% of respondents agreed that their health coach helped manage health needs, followed doctor recommendations and provided useful resources. Additionally, 96% of participants felt included in care plan decisions, and 97% reported meeting their care plan goals. Overall satisfaction with the CalOptima Health wellness program reached 98%, surpassing the target benchmark of 85%. These results indicate strong member engagement and the effectiveness of the health coaching model.

Questions	Satisfaction Rate
My health coach helped me manage my health needs and concerns	98%
My health coach helped me follow my doctor's recommendation	98%
I was included when making decision about my care plan	96%
The information and resources I received from my health coach have been useful	98%
My health coach helped me meet my care plan goals	97%
My health coach helped me manage my needs and concerns	98%
I am satisfied with the health and wellness program at CalOptima Health	98%

VI. Qualitative Analysis

Casual/Barriers Analysis

The Disease Management team demonstrated a proactive and collaborative approach in addressing health. Their initiatives focused on enhancing member engagement and improving care delivery.

Key Interventions and Strategic Insights:

- Implemented a two-way text messaging campaign for asthma and diabetes members, reflecting a shift from traditional outreach to personalized communication.
- Deployed real-time satisfaction surveys via Ushur after follow-ups, emphasizing continuous feedback and quality improvement.

- Refined stratification criteria using clinical, utilization, and quality data, aiming to better target high-risk members with full implementation planned for Q1 2026.
- Piloted shortened assessments for asthma, diabetes, and CHF, achieving significant efficiency gains while maintaining engagement quality.
- Developed a new text messaging process and a pre-call dashboard to enhance communication workflows.

Barriers:

- Incomplete pilots: Some initiatives are still in pilot or limiting phase, limited scalability and measurable outcomes.
- Limited Provider Involvement: Most interventions are member-focused; lack of provider engagement could limit holistic care coordination.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Expand the use of technology for member engagement	Use multimodal methods of outreach (text, WebMD, mailings) to identify members for Disease Management services and provide evidence-based health education and self-management resources.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L
Ensure all CalOptima Health members have equitable access to a standardized Disease Management (DM) program and consistent Shared Decision-Making (SDM) programs across all health networks by implementing unified protocols, centralized oversight, and continuous quality improvement.	Develop standardized Disease Management playbook inclusive of member identification/stratification, interventions, and Health Network/provider collaboration strategies.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data clearly indicates that the interventions implemented are yielding meaningful improvements in both member engagement and satisfaction. The two-way text messaging campaign significantly outperformed traditional outreach methods, demonstrating a strong preference among members for digital, low-barrier communication. Similarly, the adoption of real-time satisfaction surveys via Ushur not only increased response rates but also revealed exceptionally high satisfaction with DM services.

While the refinement of stratification criteria is still pending implementation, the groundwork laid reflects a proactive, data-driven approach to targeting high-risk populations more effectively. Additionally, the

streamlining of assessments and new workflows to allow staff to reach more members will position the program for even greater impact once operationalized.

Overall, the DM program is meeting its intended goals. The interventions are not only effective but also aligned with broader organizational strategies to enhance care delivery, close gaps and improve health outcomes.

3.17 Health Education	
Author(s): Thanh Mai Dinh, Aulina Bradley	Department(s): Case Management/ Medical Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Aulina Bradley (Director, Medical Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. The 2025 Health Education program focuses on promoting early detection, fostering healthy habits and empowering members to be proactive with preventive care.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health maintains a structured health education system designed to support members in improving health outcomes, achieving behavioral change and managing chronic conditions through evidence-based approaches. Programs emphasize wellness and prevention across the lifespan and align with requirements from DHCS and CMS. The program is delivered using educational strategies, methods and materials that appropriately meet the cultural and linguistic needs of the member population, informed from various population needs assessments.

CalOptima Health continues to offer Shape Your Life (SYL), a weight management program designed for children ages 5–18 years old and their families. Sessions foster healthy living through education about nutrition, physical activity and healthy habits, including sleep and stress management. Classes are provided virtually and in person in English, Spanish and Vietnamese, customized based on location and audience needs.

In January 2025, the Equity and Community Health department piloted a Community Impact Team (CIT) to directly address health disparities, work closely with clinics and providers on targeted HEDIS performance measures, and bring services to members where they live, work and play. Then in July 2025, the CIT transitioned to Clinical Operations.

II. Data Sources and Methodology

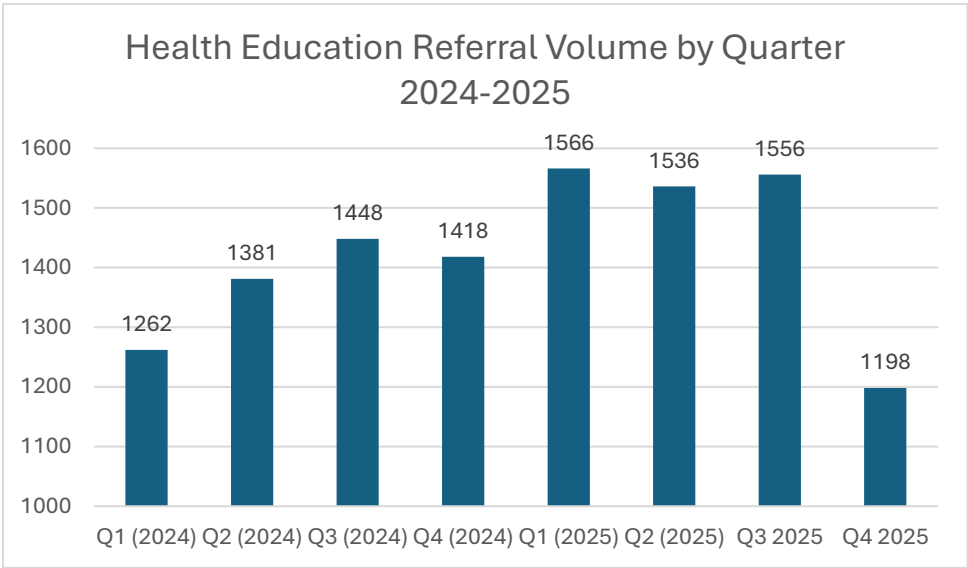
Health education referrals for health education services come primarily from provider and member self-referrals. Additional sources include internal referrals, health networks, claims or encounter data, and member surveys, such as the Health Risk Assessment. Triage of health education referrals provides for the identification, assessment, and implementation of appropriate interventions based on health

conditions, comorbidities age and, when appropriate, body mass index. Program utilization is monitored monthly and reported quarterly to the Quality Improvement & Health Equity Committee.

III. Program Results and Quantitative Analysis:

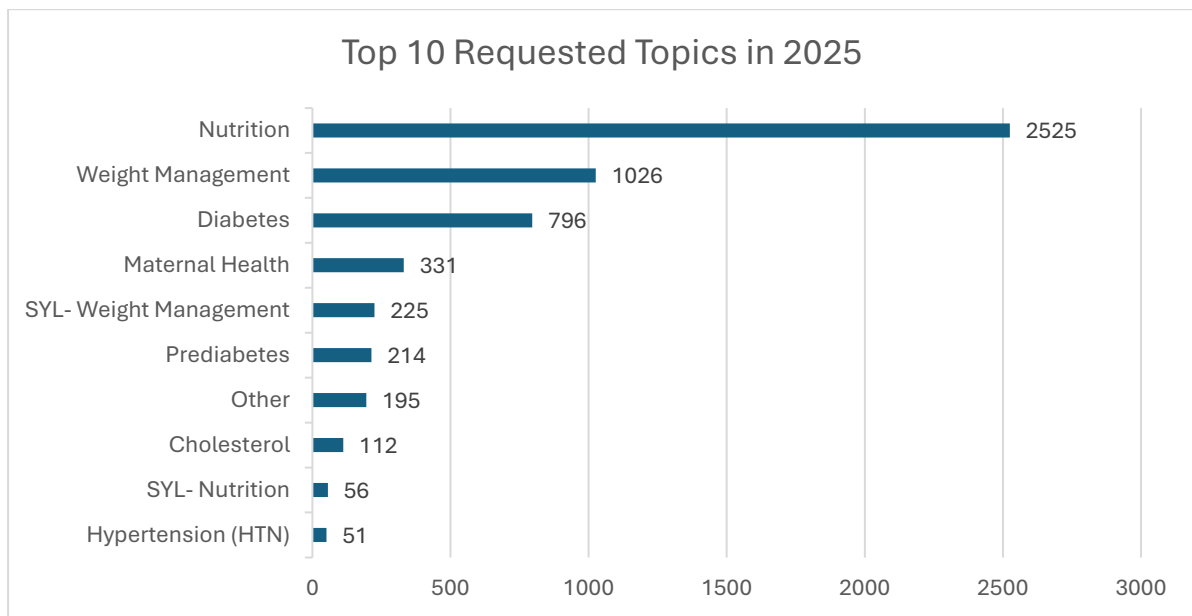
Health education referrals in 2025 were consistently higher than all referrals per quarter in CY 2024, as seen below in Chart 1. From Q4 2024 to Q1 2025, there was a 10% growth in referral requests. In 2025 there were 5,856 referrals for health education compared with 5,509 for CY 2024.

Chart 1



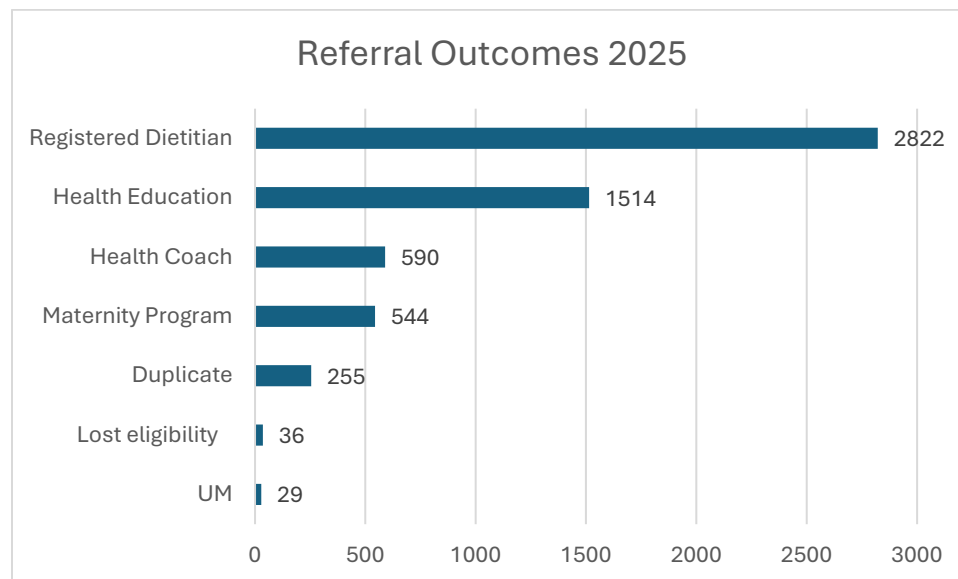
The top 10 requested topics for CY 2025 in descending order were nutrition, weight management, diabetes, maternal health, prediabetes, weight management pediatric, cholesterol, nutrition pediatric and lastly hypertension.

Chart 2



As such, referrals were triaged to the appropriate intervention outcomes noted below in Chart 3. With nutrition and weight management being the most requested topics, registered dietitians received 2,822 referrals, followed by health education with 1,514 referrals, disease management with 590 referrals, and the maternity program with 544 referrals.

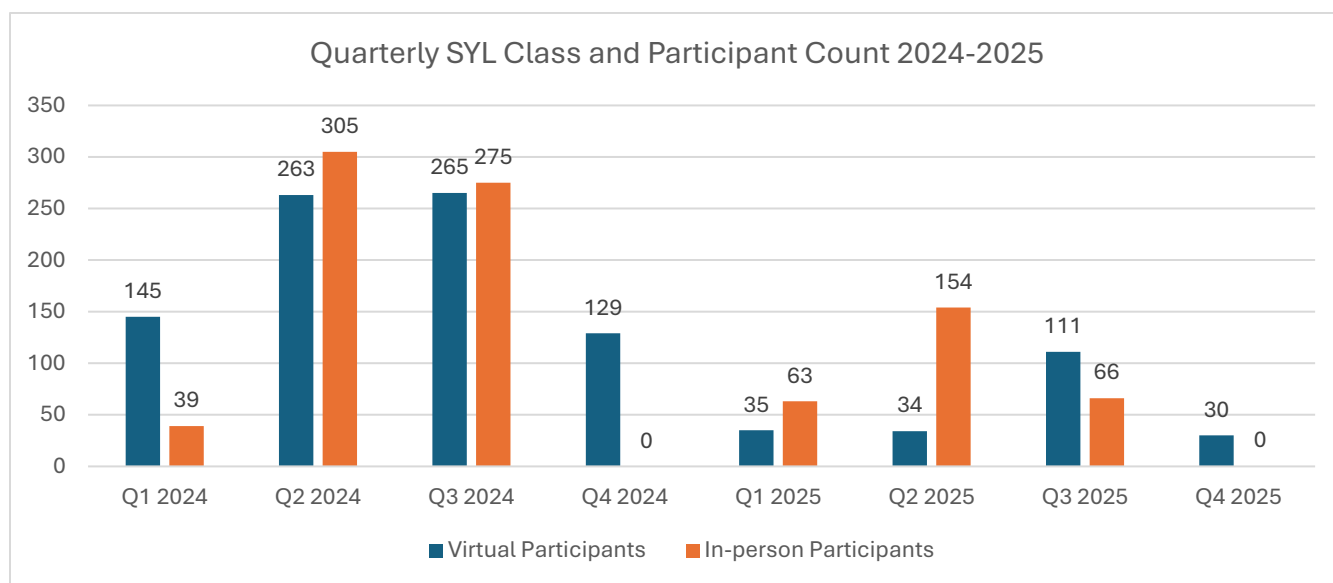
Chart 3



Referrals handled specifically by the health education team offered mailings, individual in-person, telephonic and virtual coaching, as well as group classes, which were open to the community. Newly added for CY 2025 were adult virtual health education classes in English and Spanish on healthy living habits, cholesterol and healthy heart basics. A total of 56 virtual classes were held with 632 participants. Additionally, four awareness presentations were provided at three locations to 166 participants.

CalOptima Health continued offering Shape Your Life (SYL), a pediatric weight management program for members aged 5–18 years and their families who were referred for weight management or nutrition services. This program consists of six consecutive group classes, taught in English, Spanish and Vietnamese, both in-person and virtually. Virtual classes were offered weekly on a rolling basis. In-person classes were held throughout the county at 12 locations, with more than 20 community partners. In CY 2024, there were 1,421 participants who attended 197 in-person or virtual SYL classes. In contrast, for CY 2025, a total of 493 participants attended 109 in-person or virtual SYL classes, as depicted in Chart 4. No in-person classes were again conducted in Q4.

Chart 4



The SYL program goal was: By the end of 2025, at least 40% of SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle strategies. Results for pre- and post-class knowledge change by quarter are provided in Table 1 below, with CY 2024 numbers provided for reference.

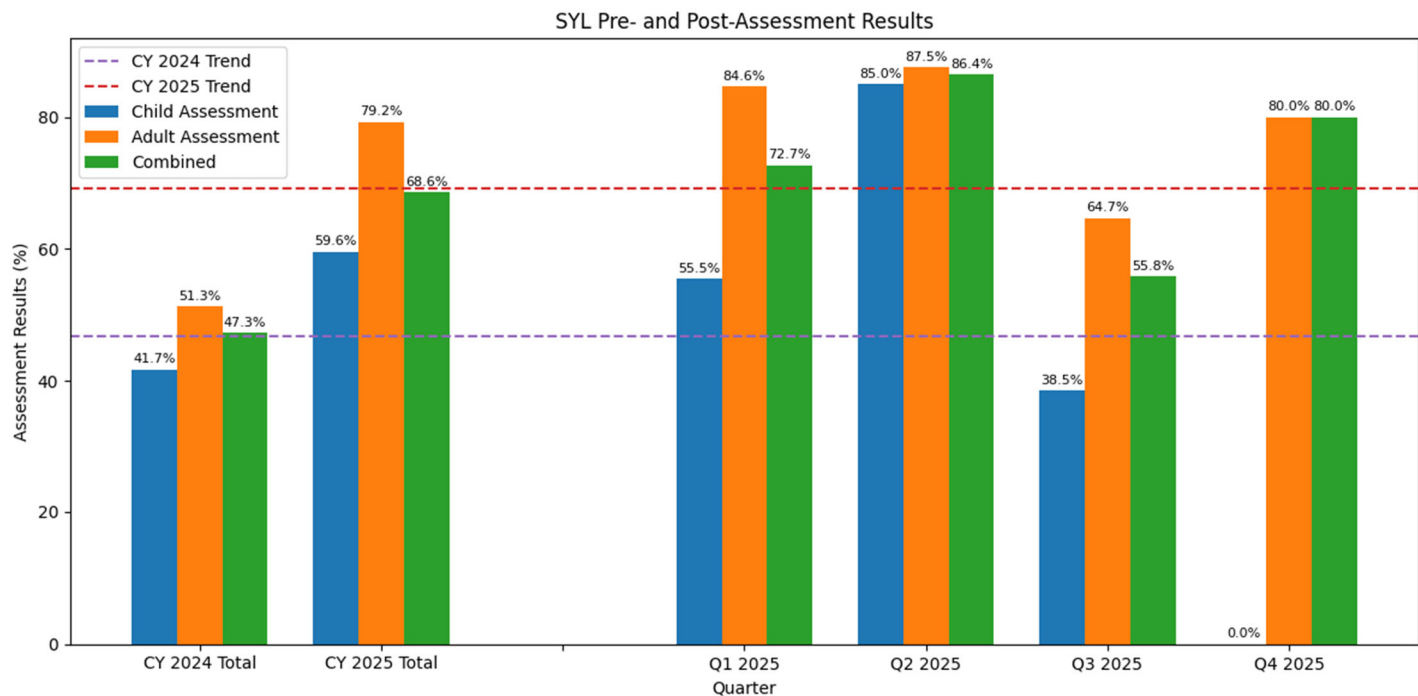
Table 1

	Child Assessment	Adult Assessment	Combined
Total CY 2024	41.7%	51.3%	47.3%
Q1 2025	55.5%	84.6%	72.7%
Q2 2025	85%	87.5%	86.4%
Q3 2025	38.5%	64.7%	55.8%
Q4 2025	0%	80%	80%
Total CY 2025	59.6%	79.2%	68.6%

The CY 2025 SYL program goal was met and exceeded at 68.6%, which was 21.3% higher than CY 2024. Despite significantly fewer SYL class participants in 2025 compared with 2024, knowledge gains were

higher for both children and adults. As visually depicted in Chart 5 below, child assessments peaked in Q2 (85%) and dropped in Q3 (38.5%), but results were only slightly lower than the overall combined child assessment results for CY 2024 (41.7%). Adult assessments, however, consistently showed high results, with a slight drop in Q3 but a rebound in Q4.

Chart 5



IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Provide in-person and virtual health education classes in English, Spanish and Vietnamese	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A
2. Conduct a two-way text campaign announcing the new virtual adult hypertension class for Medi-Cal members with a diagnosis of hypertension.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A
3. Develop adult curriculum and implement classes for hypertension, cholesterol and healthy living in both English and Spanish.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A
4. Coordinate targeted screening events for members with gaps in care and assess health disparities in key community and provider clinic locations.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS CCS PPC

5. Conduct a call campaign to 320 members who were out of compliance for glycemic status and/or blood pressure control.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	GSD CBP
6. Conduct call campaigns to 405 OC members who were missing a documented blood pressure reading in the last year and/or a PCP visit.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	CBP
7. Conduct a text message campaign to 657 members sharing self-care tips, the importance of seeing the PCP and actively tracking blood pressure.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Highlights:

- SYL Program goal: Met and exceeded at 68.6%, which was 21.3% higher than CY 2024.
 - Post assessments for children increased by 18% and adults increased 28% respectively, compared with CY 2024
- SYL Program expansion: Added three new MOU contracts for classes at two family resource centers and one school district, in addition to the 10 locations from 2024.
 - 109 in-person and virtual SYL classes provided to 493 participants
- Implement adult health education classes:
 - 56 in-person and virtual adult classes were provided to 632 participants
 - 4 awareness presentations were provided at three locations for 166 participants.
- Targeted screening events for gaps in care: 12 events were conducted at four FQHCs and one supermarket.
 - 267 members completed mammograms
 - 19 completed cervical cancer screening
 - 11 members completed the postpartum screening
 - 799 members completed a social determinants of health survey
 - 48 members completed a survey on social determinants of health, sexual orientation and gender identity
- Text campaign outcomes:
 - Hypertension class invitation in English and Spanish: Sent to 30,798 MC members with 23,162 users successfully reached and a 1.58% engagement click rate (opened)

- Hypertension tips for self-care in all threshold languages: Sent to 657 OC members with 464 users successfully receiving the campaign message and a 1.94% engagement click rate (opened)

This was the first year that active outreach and events were organized for members who had gaps in care regarding breast and cervical cancer screening, as well as for patients with diabetes in relation to glycemic status and blood pressure management. Since this was the inaugural year, no prior baseline data was available. The effectiveness of the intervention showed mixed results, depending on the type of engagement or screening required. Conducting timely outreach, hosting events at community locations, and coordinating vendor contracts require significant resources. However, ultimately, some members were able to meet several healthcare measures, and providers were notified.

Notably, CBP call outreach was particularly successful due to the implementation of the standing order program, which enabled durable medical equipment orders to be mailed directly to members. Members who had missed blood pressure readings were educated on how to use the machines, track and understand their blood pressure readings and follow up with their providers. The goal of this outreach project was to educate members and motivate them to take an active part in self-managing their condition, in partnership with their provider. Over the course of approximately six months in 2025, 545 blood pressure monitors were successfully ordered.

VI. Qualitative Analysis

Analysis:

- Health education referrals and outcome analysis are conducted by a manager through monthly productivity reports.
- A senior health educator conducted the analysis for SYL and is responsible for identifying barriers to meeting goals. This role held monthly meetings with class facilitators to identify barriers with the curriculum or at the class site and to troubleshoot solutions in a timely manner. By practicing formative evaluation within each series, facilitators were able to anticipate participants' questions and dedicate more time to the most challenging topics.

The expansion of health education offerings in various community classes and events started off strong in Q2 2025 with a pilot effort to launch the CIT. These activities were aligned with planned activities to expand health education offerings in various community classes and events listed in section IV above, as well as tech-based modalities by adding two adult virtual health education classes.

Causal/Barrier Analysis:

- Pilot CIT interventions from January through July 2025 were showing promising outcomes, but were time and resource-intensive. In July 2025, as part of CalOptima Health's broader care continuum realignment, many of the activities and resources on the CIT transitioned into Clinical Operations.

This strategic shift was designed to better integrate member-facing services and streamline clinical and wellness operations. In parallel, feedback from community partners and health care providers about immigration enforcement-related events significantly reduced attendance and participation at their sites, prompting a thoughtful reassessment of outreach and engagement strategies to ensure continued access to health education services in a manner that is responsive to community needs. As a result, in-person health education classes and community events originally scheduled for Q3 and Q4 were paused to support the transition and ensure alignment with the new operational structure.

- Additionally, the high demand for weight management and nutrition education has continued to outpace current coaching capacity, especially with the transition of the CIT.

Unlike requests for emailed health education materials, adult virtual classes and text campaigns have not seen high engagement. Adult virtual classes were introduced to increase accessibility and flexibility for members, as announced widely at community meetings, in social media posts, member newsletters, and through a text message campaign. Reported barriers for participation in virtual outreach from members include limited digital literacy, especially using email, distrust of unsolicited text messages, and limited internet coverage when using a cellphone. Similarly, engagement via email and text is hindered by required PHI verification prior to receiving health education messages.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Accelerate digital offerings of curated and interactive health education content to reduce the manual load of individual coaching and high unable to contact outcomes	Launch a linked webpage from the CalOptima Health domain, with curated and evidence-based health education content in various available in all threshold languages. Develop on-demand videos of virtual class content to be posted on the external website.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Scale up text campaigns for preventive care and behavioral health that move members to take action	Send text messages to members with real-time information on their gaps in care and actionable steps to meet them timely.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☐ M ☒ L
3. Create a feedback loop with members who access health education services immediately after a session with staff	Implement a member satisfaction survey via text message after each individual coaching outreach.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☐ M ☒ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The increase in health education referrals and class participation year after year is an indication that basic health education and self-management of chronic conditions remain a priority for both members and providers. Ongoing health education efforts with provider and community awareness campaigns

continue to yield positive results. Interventions conducted throughout the year to support the member-provider relationship for wellbeing have been impactful in reducing care gaps and ultimately health disparities. By addressing current gaps and investing in scalable solutions for digitally enabled health education, CalOptima Health can improve health literacy, reduce disparities, and support better outcomes for our diverse member population. CalOptima Health remains committed to identifying barriers and continually refining its approach to meet member health education needs even through realignment.

3.18 CalAIM Community Supports and Enhanced Care Management (ECM)	
Author(s): Mia Arias and Andrew Kilgust	Department(s): Medi-Cal and CalAIM
Responsible Party(ies): Mia Arias – Director, Medi-Cal and CalAIM Andrew Kilgust – Director, Medi-Cal and CalAIM	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase the number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing
Status: ☐ Completed ☒ Ongoing	

I. Purpose or Background:

In 2022, DHCS launched the California Advancing and Innovating Medi-Cal (CalAIM) initiative focused on broad transformation of the health care delivery system to create a more coordinated, person-centered, and equitable health system that works for all Californians. A key feature of CalAIM is Enhanced Care Management (ECM) and 14 Community Supports. CalOptima Health implemented both ECM and all 14 Community Supports in 2022 and currently contracts with 150 community-based organizations to provide one or more of these services. These are Medi-Cal benefits and services only.

II. Data Sources and Methodology

There is no data source for the Community Supports service providers being audited other than tracking those who have been. The data source for ECM utilization is the CalAIM Tableau dashboard, which utilizes claims data from Facets and authorization data from Jiva.

III. Program Results and Quantitative Analysis:

Medi-Cal

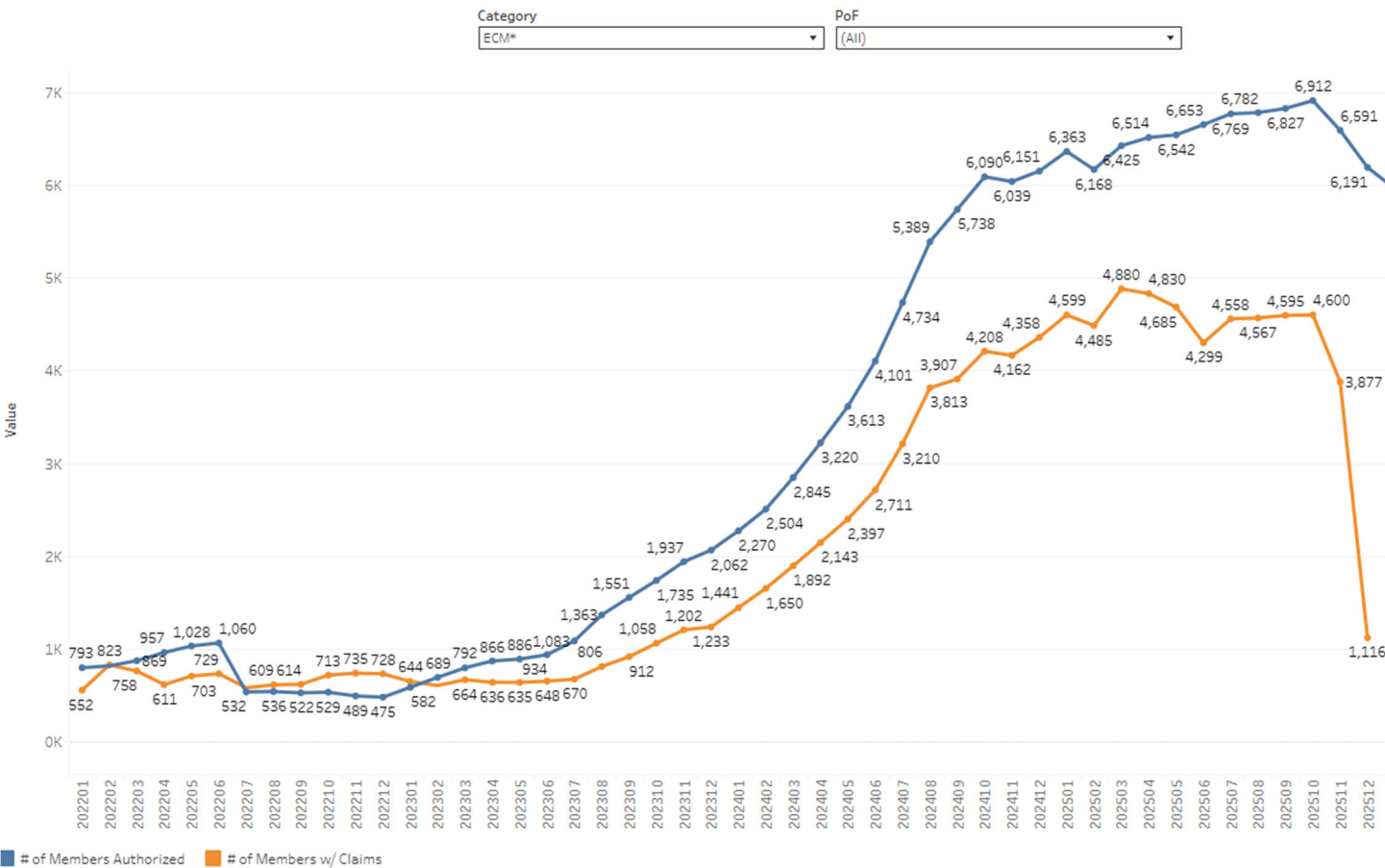
Indicator/Goal(s): By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers.

Goal not met; the Medi-Cal & CalAIM Department moved the start date of the Housing Transition Navigation, Housing Deposits, and Housing Tenancy and Sustaining services audit to 1/1/26 to give providers six months to incorporate standardized templates into their service provision. Medi-Cal and CalAIM Department leadership is confident that audits of more than 10 providers of these services will be completed by the end of Q1 2026.

Indicator/Goal(s): Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.

Goal has been met. The continued increase in ECM utilization can be attributed to the onboarding of new community-based ECM providers via the ECM Academy. CalOptima Health initially launched ECM services in January 2022 with Health Networks as the sole contracted providers. To ensure ECM became integrated into the communities where members live, CalOptima Health has launched three ECM Academy cohorts. On July 1, 2025, DHCS notified CalOptima Health that CalOptima Health had met its 12-month threshold goal of member utilization growth and met the threshold for an adequate provider network by having at least one ECM provider for each Population of Focus. As of December 2025, CalOptima Health had 60 contracted ECM providers and 6,191 members currently authorized.

Enhanced Care Management Summary: January 2022 – December 2025



IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Graduated the third cohort of the ECM Academy, adding 11 additional ECM providers to the contracted network of providers.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Developed the templates and strategy for the launch of the Housing Trio of community supports audit.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Presented the Housing audit templates to contracted Housing Trio providers to solicit feedback and input.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Qualitative Analysis

To date, CalOptima Health has not identified any barriers for CalAIM services. As a result, the CalAIM team has not identified any opportunities for improvement related to these two identified goals. Once the Housing Trio audit is completed, we will compile and share opportunities for improvement and lessons learned.

Causal/Barrier Analysis:

- None identified

VI. Conclusion:

The CalAIM Operations team is looking forward to presenting the results of the Housing Trio audit to the QIHEC upon its completion in mid-2026.

The data for ECM services has demonstrated that the goal for ECM utilization has been met and exceeded. The trend of increased utilization is expected to continue with the addition of new providers and increased provider capacity.

3.19 Street Medicine Program	
Author(s): Nicole Garcia	Department(s): Medi-Cal and CalAIM
Responsible Party(ies): Nicole Garcia (Director, CalAIM Community Outreach)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (2) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP) (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	

Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing
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I. Purpose or Background:

CalOptima Health’s Street Medicine Program was launched on April 1, 2023, as part of a broader commitment to address the health and social needs of individuals experiencing homelessness in Orange County. The program was initially piloted in the city of Garden Grove, where it quickly demonstrated success in engaging unsheltered individuals and delivering consistent, high-quality care directly in the field.

Street Medicine is designed to remove traditional barriers to care by meeting people where they are—literally and figuratively. The model integrates three core components: (1) proactive outreach and engagement, (2) coordinated medical care delivered in the field, and (3) access to Enhanced Care Management (ECM) and Community Supports through CalAIM. Services include primary care, urgent care, lab work, medication management, and referrals to specialists, all delivered with a trauma-informed, person-centered approach.

The program is grounded in values of dignity, trust and harm reduction. Providers prioritize building rapport before delivering care, recognizing that trust is foundational to long-term health engagement. This philosophy — “rapport first, care second” — has been instrumental in the program’s ability to reach and retain members who have historically been disconnected from the health care system.

Following the success of the Garden Grove pilot, CalOptima Health’s Board approved the expansion of the program to additional cities through a competitive Notice of Interest process. Cities were evaluated based on alignment with CalOptima Health’s core values, demonstrated commitment to addressing homelessness, and existing community partnerships. Costa Mesa and Anaheim were selected as the next expansion sites based on the highest evaluation score. Their programs launched in 2024.

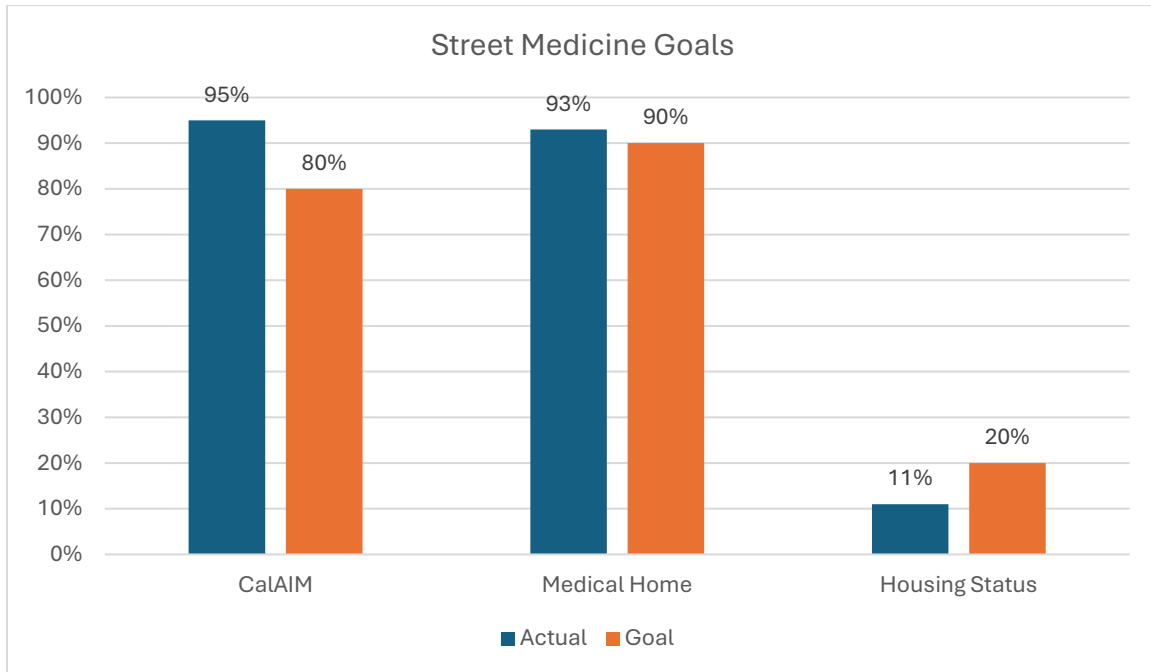
CalOptima Health’s Board of Directors approved a fourth expansion in 2025, and we will launch in the city of Santa Ana in early 2026. This expansion reflects both the program’s effectiveness and CalOptima Health’s ongoing commitment to serving its most vulnerable members with compassion, flexibility and clinical excellence.

II. Data Sources and Methodology

The program utilizes the Care Traffic Control technology platform as its primary data source and operational framework, as mandated by CalOptima Health. Providers are required to engage with this platform by entering all appointment locations directly into the system, a process referred to as “pin dropping.” Additionally, providers must submit automated weekly reports generated from their electronic medical records (EMRs), ensuring a consistent flow of clinical data into the platform. Real-time updates to the referral system are also anticipated, enabling accurate tracking of patient navigation and service coordination. To support ongoing program evaluation, CalOptima Health leadership routinely generates and reviews program monitoring reports through the platform.

III. Program Results and Quantitative Analysis: Medi-Cal

Chart A



Indicator/Goal(s):

(1) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. — This goal has been achieved.

(2) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). — This goal has been achieved.

(3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option. — While this goal was not achieved, progress was made towards housing members of the program. There are many barriers to housing in Orange County, including the lack of affordable housing, and the 11% reflects that. Despite the barriers, CalOptima Health's Street Medicine Program consistently works toward permanently housing all of its enrolled members and always offers temporary shelter to participants. Since program inception, 28 members have been permanently housed.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Outreach to and engage unsheltered individuals, offering them the opportunity to enroll in the program as needed/appropriate	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

2. Provide ECM and/or Housing Navigation to all enrolled members	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. If accepted, help them make the switch with Customer Service.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
4. Care scheduling and delivery, and documentation of all encounters both in their electronic medical record and dropping pins in Care Traffic Control.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
5. Connect all enrolled individuals to local shelters, as requested and appropriate for temporary housing	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
6. Work with members on completing housing documentation. Once completed, add them to the County CES Individual Cue.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The interventions implemented through the Street Medicine program have proven to be highly effective. By offering members the opportunity to enroll and then consistently delivering services directly to them in the field, the program can meet its core goals of engagement, continuity of care and improved health outcomes.

Each enrolled member receives the full spectrum of services offered by the program. These services are carefully documented and tracked, allowing the team to monitor progress over time and ensure accountability. This structured approach not only supports individualized care but also enables data-driven decision-making and program refinement.

The consistency of outreach, the trust built through repeated contact, and the comprehensive nature of the services provided all contribute to the program's success. The model is working, and the outcomes reflect that.

VI. Qualitative Analysis

The program analysis was conducted by Street Medicine leadership in collaboration with Care Traffic Control, which continuously monitors program performance and member engagement.

Responsibility for identifying and addressing barriers lies with the Street Medicine leadership.

Causal/Barrier Analysis:

- While the program meets or exceeds most of its goals, housing remains a persistent unmet need. A deeper review reveals that this is due to systemic and structural factors beyond the program's direct control, such as limited affordable housing inventory and lengthy waitlists for supportive housing placements.

VII. Opportunities for Improvement:

While the Street Medicine program continues to exceed expectations, we remain committed to continuous improvement. We will continue to enroll all members in CalAIM services, ensure they have an active PCP and work towards getting them permanently housed. Currently, we do not identify any urgent operational gaps. The team is performing well, and the program is delivering on its mission to provide compassionate, on-the-ground care to our unhoused members.

We will continue to closely monitor the program through our Care Traffic Control system, utilizing real-time data and feedback to make timely adjustments and ensure quality. Our approach is to stay responsive, agile and always open to refining our practices as needs evolve.

The most significant opportunity ahead lies in expanding our reach. With the planned launch of a fourth team in 2026, we will be able to serve more members across a broader geographic area, bringing care to those who need it most, where they are. Beyond that, we plan to continue working towards the programs goals as outlined above.

VIII. Conclusion:

The data shows that CalOptima Health's Street Medicine program is performing beyond expectations. But numbers only tell part of the story. The heart of this work lies with the dedicated staff who consistently show up — often in difficult conditions — to serve our unhoused members with compassion and dignity. They do work that many would not, because they believe in meeting people where they are.

Our primary goal has always been to bring compassionate care directly to those who need it most, and this program does exactly that. While we continue to make strides in health access and engagement, we recognize that housing remains a critical need — one that is deeply complex and influenced by factors beyond our control. Still, we remain committed.

In 2026, we look forward to launching a fourth team in Santa Ana, expanding our reach and deepening our impact.

3.20 Long-Term Support Services (LTSS)	
Author(s): Scott Robinson	Department(s): Long Term Support Services
Responsible Party(ies): Scott Robinson (Director, Long Term Support Services); Cathy Osborn (Manager, Long Term Support Services)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within five business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within five business days (4) LTC Turnaround Time (TAT): Determination completed within five business days	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☒ Ongoing

I. Purpose or Background:

LTSS benefits have been integrated into CalOptima Health since July 1, 2015, for Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings, ensuring that services are authorized in accordance with DHCS requirements and CalOptima Health policies.

II. Data Sources and Methodology

All data was compiled from utilization reports. The data was analyzed by management and staff and presented to the UM committee on a quarterly basis.

III. Program Results and Quantitative Analysis:

All turnaround times were within goal, except for CalAIM. Due to a change in member eligibility criteria that increased the volume and a staff reduction, the team fell behind in processing authorizations during the fourth quarter of 2024 and the first quarter of 2025 for expedited only. Once CalAIM staffing was corrected, authorizations have met TAT goals. All other LTSS programs ensured that member services were received in a timely manner and steadily improved TATs throughout the year.

CalAIM Turnaround Time Compliance (TAT) Q4 2024–Q3 2025				
Year	Goal	Quarter	Routine	Expedited
2025	95%	Q1	100%	89.5%
	95%	Q2	97%	99%
	95%	Q3	100%	99.0%
	95%	Q4	99.5%	94.0%

LTC Turnaround Time (TAT) Determination Completed within Five Business Days Q4 2024–Q3 2025			
Year	Goal	Quarter	TAT Compliance Rate
2025	95%	Q1	99%
	95%	Q1	99%
	95%	Q2	99%
	95%	Q3	99.6%

CBAS Turnaround Time (TAT) Determination Completed within Five Business Days Q4 2024–Q3 2025			
Year	Goal	Quarter	TAT Compliance Rate
2025	95%	Q1	100%
	95%	Q2	100%
	95%	Q3	100.0%
	95%	Q4	100.0%

CBAS Inquiry to Determination Completed within 30 Business Days Q4 2024–Q3 2025			
Year	Goal	Quarter	TAT Compliance Rate
2025	95%	Q1	99%
	95%	Q2	100%
	95%	Q3	100.0%
	95%	Q4	100.0%

Quantitative Analysis

CalAIM: The Q1 routine TAT improved to 100% and consistently remained above the 95% goal for Q2, Q3 and Q4. The Q1 expedited TAT improved from 89.5% to above the 95% goal remaining 3 quarters.

Long-Term Care (LTC): The LTC TATs remained compliant and exceeded the 95% goal for all of 2025.

Community-Based Adult Services (CBAS):

- The CBAS 5-day TAT remained in compliance and exceeded the 95% goal during all 4 quarters of 2025.
- The CBAS inquiry to determination 30-day goal, which includes completing the CBAS Eligibility Tool (CEDT), exceeded the 95% goal in all four quarters of 2025.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Hired CalAIM MCMs and MAAs to process community supports referrals and authorization and meet 95% TAT compliance.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete	MCM-medical case manager MAA-medical authorization asst.
2. Hired CalAIM MCMs and MAAs to process community supports referrals and authorization and meet 95% TAT compliance.	☐ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete	MCM-medical case manager MAA-medical authorization asst.
3. Cross trained all LTSS MCM and MAA to support all LTSS programs (CBAS, LTC, CalAIM) in times when staffing is low. This strategy has ensured all TATs are within or exceed goal.	☐ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete	MCM, MAA

MC = Medi-Cal; OC= OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The Q4 and Q1 CalAIM interventions of backfilling open positions and cross-training LTSS staff successfully improved the CalAIM authorization TATs to consistently exceed 95% compliance quarter over quarter including CBAS and LTC.

VI. Qualitative Analysis

The LTSS Director and LTSS Manager conducted the analysis and identification of the barriers to successfully meeting TATs. A thorough analysis of staffing ratios to referrals/authorization processing volume was conducted. This resulted in an accurate analysis of staffing ratios to referrals/authorization processing volume to meet CalAIM TATs. The LTSS department is now properly staffed to meet required TATs.

Causal/Barrier Analysis:

- The barriers to achieving the TAT goals were related to not having adequate staffing.
- Based on the staffing ratio analysis a recruitment plan was developed and implemented with human resources. This resulted in hiring the staff needed to process authorizations and meet TATs.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Improved analysis and communication regarding staffing needs.	Continue to monitor referral and authorization volumes to forecast staffing needs so TATs meet goals.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The improvement in the TAT data across all LTSS programs indicates that our staffing and training strategies successfully corrected the CalAIM problem in Q4 2024 and Q1 2025. Additionally, all LTSS TAT goals have been met throughout Q2 and Q3 2025.

3.21 Delegation Oversight	
Author(s): Stacy Baker	Department(s): Delegation Oversight
Responsible Party(ies): Stacy Baker (Director, Delegation Oversight); Zulema Gomez (Manager, Delegation Oversight); John Robertson (Sr. Manager, Delegation Oversight)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health contracts with health care providers who are delegated to perform certain administrative services and functions as part of their agreements with CalOptima Health. CalOptima

Health regularly oversees the delegate’s performance to ensure adherence to regulatory, contractual and operational requirements. Each year, on a regular and periodic basis, CalOptima Health requires delegates to submit reports to substantiate its performance for each administrative service and function delegated. Oversight activities include, but are not limited to, annual audits of the delegate, ad hoc focused audits, and review of monthly and quarterly reports submitted by the delegate. The oversight is designed to evaluate the delegate’s performance against established benchmarks and thresholds, and to verify regulatory and contractual compliance.

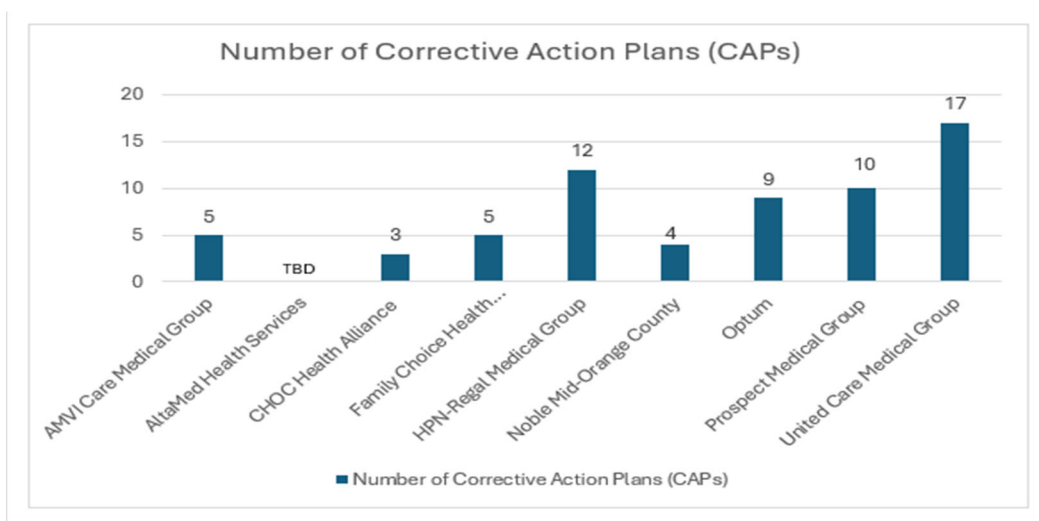
II. Data Sources and Methodology

Delegation Oversight developed an audit preparation guide and audit tools for 2025. The audit tools included File Review Tools (FRTs) and Policy Review Tools (PRTs) to assess delegated activities by functional area. Delegation Oversight auditors utilized the tools to conduct audits for each HN in 2025.

III. Program Results and Quantitative Analysis:

- CalOptima Health conducted an annual audit of all nine HN delegates, a readiness assessment of a new HN, and a readiness assessment of an MSO change for an existing HN in 2025.
- Two delegates were audited in Q1 2025, one was audited in Q2 2025, four were audited in Q3 2025 and three were audited in Q4 2025. The readiness assessments were conducted in Q1 2025.
- All delegates were issued CAPs in 2025, with CHOC receiving the least number of CAPs at three and United Care Medical Group receiving the greatest number at 17 CAPs.
- In 2025, a total of 73 CAPs were issued to the eight HN delegates to ensure that they are meeting their contractual obligations. One HN’s 2025 audit findings are not slated to close until the end of December 2025, and therefore, the CAP counts are not yet available for that HN and are not included in this total count.

Chart A



Number of Delegation Oversight Annual Audit (DOAA) CAPs issued in 2025

Indicator/Goal(s): Complete annual audits according to the timeline specified in the annual audit workplan.

All audits were completed timely.

IV. Qualitative Analysis

CalOptima Health's Director, Delegation Oversight is responsible for identifying barriers to meeting goals.

Causal/Barrier Analysis:

- There were no barriers identified for 2025.

V. Conclusion:

Annual audits were conducted for each contracted delegate, and CAPs were issued to health networks when findings were identified.

3.22 National Committee for Quality Assurance (NCQA) Accreditation	
Author(s): Veronica Gomez	Department(s): Quality Improvement
Responsible Party(ies): Marsha Choo (Director, Quality Improvement); Veronica Gomez (Sr Manager, Quality Improvement)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	
Goal Met (HP): ☐ Yes ☐ No ☒ Partial	Goal Met (HE): ☒ Yes ☐ No ☐ Partial
Status: ☐ Completed ☒ Ongoing	

I. Purpose or Background:

DHCS mandates that all health plans achieve NCQA Accreditation for both Health Plan (HP) and Health Equity (HE) standards by January 1, 2026.

Health Plan Accreditation (HPA): CalOptima Health has maintained NCQA accreditation for its Medicaid line of business since 2012. In July 2024, the organization successfully completed its fourth renewal for the Medicaid-HMO product line, securing accredited status through July 10, 2027. Accreditation scores are determined by annual HEDIS and CAHPS performance, with a full survey conducted every three years.

Health Equity Accreditation (HEA): To meet the initial Health Equity Accreditation requirement, CalOptima Health submitted its application on October 7, 2024. In preparation, the organization established a Health Equity Committee composed of five cross-functional workgroups. The submission covered a six-month look-back period from April 7, 2025, to October 7, 2025. To achieve accreditation, CalOptima Health must demonstrate compliance with at least 80% of applicable NCQA standards.

II. Data Sources and Methodology

Health Plan Accreditation (HPA): CalOptima Health will be evaluated under **the 2026 NCQA Health Plan Accreditation standards**. The assessment focused on six core domains:

- Quality Improvement (QI)
- Population Health Management (PHM)
- Network Management (NET)
- Utilization Management (UM)
- Credentialing (CR)
- Member Experience (ME)

The next formal submission is scheduled for **April 6, 2027**, covering a two-year look-back period from **April 6, 2025, to April 6, 2027**. In addition, CalOptima Health will participate in a **virtual file review audit on May 24–25, 2027**.

Health Equity Accreditation (HEA): CalOptima Health is being assessed under the 2024 NCQA Health Equity Accreditation standards. The evaluation encompasses the following domains:

- **HE1A–B:** Organizational Readiness
- **HE2A–G:** Collection and Use of Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Data
- **HE3A–D:** Access to and Availability of Language Services
- **HE4A–B:** Cultural Responsiveness of the Practitioner Network
- **HE5A–B:** Culturally and Linguistically Appropriate Services (CLAS) Programs
- **HE6A–D:** Strategies to Reduce Health Care Disparities
- **HE7:** Delegation of Health Equity Activities

The submission for HEA includes a six-month look-back period from April 5, 2025, to October 7, 2025.

III. Program Results and Quantitative Analysis:

Health Plan (HP): CalOptima Health’s Health Plan Accreditation encompasses six core domains, evaluated over a 24-month look-back period from April 6, 2025, to April 6, 2027. Year-one document collection began in January 2025 and is on track to be completed by April 2026. Each domain is actively reviewed and documented in alignment with NCQA’s 2026 standards. A detailed status update by domain is maintained internally and will inform the second year of collection and the final submission.

Health Equity (HE): CalOptima Health achieved Health Equity Accreditation from NCQA on December 16, 2025, meeting all required deadlines and demonstrating full compliance with DHCS requirements. This accreditation is effective through December 16, 2028. The accreditation process included an initial survey submission on October 7, 2025, covering a six-month look-back period from April 7, 2025, to October 7, 2025. The organization’s Health Equity Committee, comprising five cross-functional workgroups, coordinated the documentation and evidence collection across all seven NCQA Health Equity domains. CalOptima Health earned 100% of the **allowable points**, reflecting exceptional performance in advancing health equity and reducing disparities.

IV. Actions/Interventions Implemented in 2025

Interventions (HP)	Product	Quarter	Type	Status
1. Conducted internal readiness assessments and gap analysis for NCQA HP Standards. Initiated Year 1 document collection and review for accreditation submission.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Completed second round of mock file review audits covering: UM Appeals, Complex Case Management, Credentialing/Recredentialing, UM BH and non-BH Denials, and UM Pharmacy Denials	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Completed 2026 HP Standards training sessions across all domains: QI, CR, NET, PHM, UM and ME.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Reviewed and disseminated updates and clarifications on 2025 and 2026 HP Standards to impacted stakeholders (March, July, November)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Interventions (HE)	Product	Quarter	Type	Status
1. Established cross-departmental workgroups to address HE standards and coordinate document collection (12/1/2024–4/1/2025).	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Conducted final review of evidence during the look-back period (4/1/2025–10/1/2025).	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Submitted the initial Health Equity Accreditation survey to NCQA by the October 7, 2025 deadline.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Addressed initial feedback and issues raised by NCQA surveyors.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
5. Responded to NCQA's preliminary report.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
6. Procured the 2026 Health Outcomes Standards to support future compliance and planning.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☐ Ongoing ☒ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Health Plan (HP) Accreditation:

The interventions implemented in 2025 have laid a strong foundation for CalOptima Health's 2027 NCQA Health Plan Accreditation renewal. Key accomplishments include:

- **File Review Audits:**
A series of targeted mock audits were conducted to assess readiness and identify documentation gaps across critical domains. Final consultant assessment reports are expected by the end of December 2025.
 - *September 2025:* UM Behavioral Health (BH) Denials
 - *October 2025:* UM Pharmacy Denials and UM Appeals
 - *November–December 2025:* CCN and Delegate Credentialing, UM Medical/Pharmacy Denials, and Complex Case Management
- **2026 HP Standards Training:**
Training sessions were delivered to relevant stakeholders across all six NCQA domains, ensuring alignment with updated standards and expectations.
 - *October 2025:* Member Experience and Utilization Management
 - *November 2025:* Quality Improvement and Credentialing
 - *December 2025:* Network Management and Population Health Management
- **Document Collection Progress:**
Year-one document collection is progressing on schedule, with no past-due deliverables reported. This reflects strong internal coordination and adherence to the accreditation timeline.

Health Equity (HE) Accreditation:

All planned interventions for HE Accreditation were executed on time and contributed directly to the successful submission of CalOptima Health’s initial NCQA Health Equity Survey ahead of the October 7, 2025, deadline.

- The internal gap analysis and cross-functional collaboration across five dedicated workgroups ensured comprehensive evidence collection and alignment with NCQA’s 2024 Health Equity Standards.
- The effectiveness of these efforts is reflected in the final results, for which CalOptima Health was awarded accredited status. CalOptima Health met all standards and received full points- 100%. This recognition takes effect on December 16, 2025, and remains valid through December 16, 2028.

VI. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement (HP)	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Maintain readiness for 2027 HP renewal	Complete Year-One document collection and initiate Year-Two deliverables review to ensure timely submission.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

2. Strengthen file review processes	Continue internal and external file reviews to ensure compliance with NCQA standards across UM Medical, Behavioral, Non-Behavioral, Pharmacy Denials, Appeals, Credentialing, Recredentialing, and Complex Case Management.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Year-Two document collection	Collaborate with stakeholders to collect and review Year-Two documentation for the 2027 HP renewal.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
4. Contracts and delegation agreements	Review and update contracts to ensure delegated activities are clearly defined and appropriately documented.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L
5. Delegate training and support	Continue training for delegated entities on file preparation, documentation standards, and universe submission protocols.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L
Opportunities for Improvement (HE)	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Address gaps from the initial HE submission	Improvements on the domains identified during our initial findings in our Initial submission for accreditation. HE2 Element E (Factors 1 & 2) HE4 Element A (Factors 3 & 6) HE4 Element B (Factors 2 & 4) HE5 Element B (Factors 2 & 3) HE6 Element D (Factors 2, 4 & 6)	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Prepare for revised 2026 Health Outcomes Standards	Train stakeholders on updated standards to ensure alignment and compliance.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L
3. Enhance HE data infrastructure	Develop and implement dashboards to monitor and evaluate Health Equity metrics in alignment with 2026 Health Outcomes Standards.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VII. Conclusion:

In 2025, CalOptima Health made significant progress toward maintaining NCQA Health Plan Accreditation and achieving initial Health Equity Accreditation. Through a structured and collaborative approach, the organization successfully implemented key interventions, including comprehensive file review audits, targeted staff training, and the timely collection of documents. These efforts have ensured alignment with NCQA's evolving standards and positioned CalOptima Health for continued success in accreditation.

The Health Plan Accreditation workstream remains on track, with Year-One deliverables completed on schedule and Year-Two planning already underway. Mock audits and stakeholder engagement have enhanced internal readiness and identified areas for ongoing improvement. For Health Equity Accreditation, all planned activities were completed ahead of schedule, culminating in the successful

submission of the initial survey. The effectiveness of cross-departmental collaboration and data-driven planning was evident throughout the process.

Looking ahead to 2026, CalOptima Health will focus on sustaining momentum by addressing identified opportunities for improvement, refining documentation practices, and preparing for the 2027 Health Plan Accreditation renewal. Continued investment in training, delegation oversight, and health equity data infrastructure will be critical to advancing the organization’s quality improvement goals and ensuring compliance with NCQA standards.

3.23 Quality Performance Improvement: Managed Care Accountability Set (MCAS), OneCare STAR Measures, DHCS Quality Withhold, Health Plan Accreditation (QI3), Health Plan Rating	
Author(s): Paul Jiang	Department(s): Quality Analytics
Responsible Party(ies): Paul Jiang (Director, Quality Analytics/Director of Medicare Stars and Quality Initiatives); Kelli Glynn (Director, Quality Initiatives)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 5.0 Health Plan Rating	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Quality Analytics submits several reports annually to meet the regulatory requirements and monitors the monthly performance. DHCS’s MCAS measures have a minimum performance level (MPL) requirement, which is based on the national 50th percentile from Quality Compass. A set of measures is used by DHCS for the quality withhold program. CMS maintains a Star Rating measure set. NCQA requires HEDIS for accreditation and Health Plan Rating.

II. Data Sources and Methodology

Quality Analytics generates monthly performance reports based on specifications from NCQA HEDIS, CMS Star and DHCS MCAS, utilizing a certified reporting engine. The data collected from membership and enrollment, medical and pharmacy claims, lab results, CAIR registry, and clinical supplemental data, among other sources, monitors performance at the CalOptima Health and HN levels. Audited results are successfully reported to DHCS, CMS and NCQA in June 2025.

III. Program Results and Quantitative Analysis:

MY2024 MCAS MPL measures

- 15 out of 18 MPL measures achieved the 50th percentile or higher.

- Follow-up after ED visit for Alcohol and Other Drug Dependence within 30 days (FUA) didn't meet the MPL. The reported rate was 28.6%, 7.6 percentage points lower than the MPL 36.2%.
- Follow-up after ED visit for Mental Illness within 30 days (FUM) didn't meet the MPL. The reported rate was 52.3%, 1.5 percentage points than the MPL of 53.8%.
- Asthma Medication Ratio (AMR) didn't meet the MPL. The reported rate was 66.1%, 0.1% percentage points lower than the MPL 66.2%.

MY2024 HEDIS Star measures

- Annual Flu Vaccine rate achieved a 4 Star rating.
- 8 measures achieved a 3 Star rating, which include CBP, COL, GSD, EED, OMW, SPC, KED, and Rating of Health Plan.
- 7 measures were at the 2 Star rating levels, which include BCS, COA medication review, PCR, TRC, FMC, Medication reconciliation, and Rating of Health Care.
- 4 CAHPS measures were at the 1 Star rating levels. They were Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, and Care Coordination.

MY2024 DHCS Quality Withhold measures

- We earned 100% of the quality withhold money for MY2024.
- 7 measures received the full 10 points (≥ 66.6 th percentile). (CBP, PPC-prenatal, W30-15months, W30-30months, WCV, CIS, IMA)
- 3 measures received 7.5 points (≥ 50 th percentile).
 - GSD $>9\%$ and Adult CAHPS Getting needed care
 - PPC postpartum care – improved from the previous year.
- Adult CAHPS Getting Care Quickly received 2.5 points (≥ 25 th percentile).
- Child CAHPS Getting Care Quickly received 0 points (< 25 th percentile) but improved.
- Child CAHPS Getting Needed Care received 0 points.

MY2024 Health Plan Rating measures

- Maintained 3.5 rating
 - CAHPS has the same 2.5 rating as last year
 - Getting Needed Care and the Rating of Health Plan measures are rated higher
 - Rating of Personal Doctor, Rating of All Health Care measures are rated lower
 - HEDIS AIS-Tdap, PCE-bronchodilator, FUA, AMM, ADD, APP measures are rated higher
 - HEDIS PPC-prenatal, SPD measures are rated lower because benchmarks increased
 - HEDIS WCC-BMI, AIS-influenza, CBP, BPD, LBP measures are rated lower because of lower performance

IV. Effectiveness of Interventions:

Details of interventions can be found in the individual measures/programs.

V. Qualitative Analysis

Details can be found in the individual measures/programs.

VI. Opportunities for Improvement:

Details can be found in the individual measures/programs.

VII. Conclusion:

The MPL goals are met partially. OneCare goal of a 4-Star rating was not achieved. Medi-Cal Health Plan rating of a 5-Star rating was not achieved. The Quality Withhold program earned 100% of funds back.

3.24 Value-Based Payment Program	
Author(s): Paul Jiang	Department(s): Quality Analytics
Responsible Party(ies): Linda Lee (Executive Director, Quality Improvement); Paul Jiang (Director, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs and CHCN PCPs are eligible to participate in the P4V program.

II. Data Sources and Methodology

Data is gathered through the HEDIS data collection methodology and through the member experience CAHPS survey methodology. CMS Part D data is used for the OneCare P4V program.

III. Program Results and Quantitative Analysis:

MY2024 Medi-Cal P4V Quality Rating by Health Network

Health Network Quality Rating: Overall Rating	Total Measure Count	Total Measure Weight	Total Points Earned	Total Available Points	Overall Rating	P4V Earned Percentage
AltaMed	22	25	88.39	250	3.54	35.4%
AMVI Care	23	26.5	61.84	265	2.33	23.3%
CHCN	23	26.5	79.59	265	3	30.0%
CHOC	21	24.5	117.69	245	4.8	48.0%

Family Choice	23	26.5	73.82	265	2.79	27.9%
Heritage-Regal	18	21.5	31.94	215	1.49	14.9%
Noble	21	23.5	60.37	235	2.57	25.7%
Optum	23	26.5	69.91	265	2.64	26.4%
Prospect	23	26.5	58.87	265	2.22	22.2%
UCMG	23	26.5	71.16	265	2.69	26.9%

MY2024 OneCare P4V Quality Rating by Health Network

Health Network Quality Rating: Overall Rating	Total Measure Count	Total Measure Weight	Total Points Earned	Total Available Points	Overall Rating	P4V Earned Percentage
AltaMed	20	39	55.31	195	1.42	28.36%
AMVI Care	17	34	81.20	170	2.39	47.76%
CHCN	20	39	66.51	195	1.71	34.11%
Family Choice	20	39	65.11	195	1.67	33.39%
Heritage-Regal	18	37	116.74	185	3.16	63.10%
Noble	20	39	125.72	195	3.22	64.47%
Optum	20	39	68.95	195	1.77	35.36%
Prospect	20	39	86.08	195	2.21	44.14%
UCMG	20	39	121.00	195	3.10	62.05%

IV. Qualitative and Quantitative Analysis

Health Networks achieved a lower percentage of available pay for value funds due to adoption of higher benchmarks. The overall earned percentage was about 30%, with 70% of incentive funds unearned. All Health Networks fell below the minimum performance of the 50th percentile for at least one Medi-Cal measure and 3-Stars for at least one OneCare measure.

V. Opportunities for Improvement:

Health Networks have significant room for improvement in pay-for-value measures. Each Health Network that fell below minimum performance levels will be issued corrective action plans in 2026.

VI. Conclusion:

MY2024 P4V programs for both Medi-Cal and OneCare have been completed. Detailed quality rating reports and payment checks have been sent to health networks. Monthly prospective reports will be sent to health networks and providers continuously for monitoring.

Section 4: Quality of Clinical Care

4.1 Facility Site Review (including Medical Record Review and Physical Accessibility Review)

Author(s): Katy Noyes

Department(s): Quality Improvement

Responsible Party(ies): Marsha Choo (Director, Quality Improvement); Katy Noyes (Manager, Quality Improvement)

Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Monitor PCP, high-volume specialists, CBAS, and ancillary service sites utilizing the DHCS audit tools and methodology. Report any findings, barriers and improvement efforts.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. The FSR confirms the PCP site operates in compliance with all applicable local, state and federal laws and regulations. MRRs are conducted to review medical records for format, adherence to legal protocols, and documentation of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records and/or lack of documentation imply the PCP did not provide quality, timely or appropriate medical care.

II. Data Sources and Methodology

To ensure compliance with DHCS contractual requirements, CalOptima Health is required to perform initial and subsequent PCP site reviews, consisting of an FSR and an MRR, using the DHCS FSR and MRR tools and standards.

III. Program Results and Quantitative Analysis

Table A

Type of Reviews	Number of FSRs and MRRs Conducted by Month												
	Totals:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MY 2025													
Number of Initial FSRs Completed	31	3	1	3	7	3	1	2	2	0	6	3	7
Number of Initial MRRs Completed	25	6	2	3	0	2	2	2	2	2	3	1	0
Number of Periodic FSRs Completed	161	15	12	15	24	12	11	20	15	9	19	9	10
Number of Periodic MRRs Completed	168	15	19	20	18	15	9	18	17	12	13	12	11
Number of Annual FSRs Completed	37	1	2	5	6	4	0	3	4	1	7	4	2
Number of Annual MRRs Completed	38	2	2	5	5	6	0	4	4	1	4	5	4

Quantitative Analysis:

- Periodic audits are completed every 36 months and are dependent on the volume of audits conducted three years in the past. These audits currently dominate the workload; 168 Periodic FSRs and 161 Periodic MRRs were completed.

- The number of Initial FSRs and Initial MRRs completed each month varies, and no trend has been identified.
- The number of Annual FSRs and Annual MRRs completed each month ranges from zero to seven.

Table B

	Periodic FSR and Critical Element (CE), FSR, MRR CAP Timeliness											
MY 2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Percentage of Periodic FSRs Completed by Due Dates	93% (N=14)	100% (N=12)	93% (N=14)	92% (N=22)	92% (N=11)	100% (N=11)	95% (N=19)	100% (N=15)	100% (N=9)	95% (N=18)	100% (N=9)	100% (N=10)
Percentage of CE CAPs Closed by Due Dates	100% (N=13)	89% (N=8)	100% (N=11)	100% (N=19)	100% (N=12)	91% (N=10)	100% (N=8)	100% (N=7)	100% (N=4)	100% (N=13)	100% (N=5)	100% (N=11)
Percentage of FSR CAPs Closed by Due Dates	80% (N=12)	90% (N=9)	100% (N=18)	86% (N=25)	91% (N=10)	100% (N=11)	93% (N=13)	100% (N=12)	80% (N=4)	88% (N=14)	75% (N=6)	100% (N=10)
Percentage of MRR CAPs Closed by Due Dates	94% (N=17)	95% (N=18)	100% (N=24)	96% (N=25)	92% (N=11)	100% (N=17)	94% (N=15)	100% (N=14)	100% (N=13)	100% (N=10)	82% (N=9)	88% (N=8)

Quantitative Analysis:

- Average percentage of Periodic FSRs completed by due dates was 96.36%. Monthly percentages range from 92% to 100%.
- Average percentage of CE CAPs closed by due dates was 98.18%. Monthly percentages range from 89% to 100%.
- Average percentage of FSR CAPs closed by due dates was 90.80%. Monthly percentages range from 80% to 100%.
- Average percentage of MRR CAPs closed by due dates was 97.10%. Monthly percentages range from 92% to 100%.

Table C

	Number of PARS Completed, Number of Sites with BASIC/LIMITED Access and Percentage of BASIC/LIMITED Access per Month											
PARS MY 2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Number of PARS	29	17	28	50	56	63	63	67	51	54	44	50
Number of sites with BASIC Access	14	8	16	15	24	28	29	22	21	15	17	20
Number of Sites with LIMITED Access	15	9	12	35	32	35	34	45	30	39	27	30
Percentage of Sites with BASIC Access	48%	47%	57%	30%	43%	44%	46%	33%	41%	28%	39%	40%
Percentage of Sites with LIMITED Access	52%	53%	43%	70%	57%	56%	54%	67%	59%	72%	61%	60%

Quantitative Analysis:

- Total number of PARS completed monthly fluctuates from 17 to 67.
- Sites with BASIC Access peak at 57% in March but drop to 28% in October.
- Sites with LIMITED Access dominate in October (72%) and April (70%).
- Average percentage of sites with BASIC Access: 41%. Average percentage of sites with LIMITED Access: 59%.
- LIMITED Access is more prevalent across sites compared to BASIC Access.

Table D

	Number of Failed FSRs and MRRs, Number of Third Fails, Number of Termed Providers and Reason for Termination											
MY 2025	<i>Jan</i>	<i>Feb</i>	<i>Mar</i>	<i>Apr</i>	<i>May</i>	<i>Jun</i>	<i>Jul</i>	<i>Aug</i>	<i>Sep</i>	<i>Oct</i>	<i>Nov</i>	<i>Dec</i>
Number of Failed FSRs	0	0	0	0	1	1	1	0	0	0	0	0
Number of Failed MRRs	1	1	4	1	3	2	3	2	0	1	3	0
Number of Provider Terminations Due to Third Consecutive Failed FSR and/or MRR	1	0	0	0	0	0	0	0	0	0	0	0
Number of Provider Terminations Due to Noncompliance With CAP timelines	0	0	0	0	0	1	0	1	0	0	0	0

Quantitative Analysis:

- Only three months (May–July) recorded one failed FSR each.
- MRR failures are more frequent and variable than FSRs.
- March had the highest number (four), followed by May, July, and November (three each).
- One provider termination due to three failed audits (January).
- Two provider terminations due to noncompliance with CAP timelines (June and August).

IV. Actions/Interventions Implemented in 2025:

Quarter 1:	• Conducted FSR, MRR and PARS according to DHCS requirements and using DHCS audit tools and methodologies • Conducted subsequent site reviews, consisting of an FSR and MRR, beginning no later than three years after the initial FSR, and at least every three years thereafter • Followed established DHCS timelines for CAP notification and closures • Administratively terminated a provider for their third consecutive failed audit • Completed annual audits for provider sites with previous failed audit scores • Provided extensive training, education and technical assistance for provider sites with failed audit scores
Quarter 2:	• Conducted FSR, MRR and PARS according to DHCS requirements and using DHCS audit tools and methodologies • Conducted subsequent site reviews, consisting of an FSR and MRR, beginning no later than three years after the initial FSR, and at least every three years thereafter • Followed established DHCS timelines for CAP notification and closures • Administratively terminated a provider for noncompliance with CAP timelines • Completed annual audits for provider sites with previous failed audit scores

	• Provided extensive training, education and technical assistance for provider sites with failed audit scores.
Quarter 3:	• Conducted FSR, MRR and PARS according to DHCS requirements and using DHCS audit tools and methodologies • Conducted subsequent site reviews, consisting of an FSR and MRR, beginning no later than three years after the initial FSR, and at least every three years thereafter • Followed established DHCS timelines for CAP notification and closures • Administratively terminated a provider for non-compliance with CAP timelines • Completed annual audits for provider sites with previous failed audit scores • Provided extensive training, education and technical assistance for provider sites with failed audit scores
Quarter 4:	• Conducted FSR, MRR and PARS according to DHCS requirements and using DHCS audit tools and methodologies • Conducted subsequent site reviews, consisting of an FSR and MRR, beginning no later than three years after the initial FSR, and at least every three years thereafter • Followed established DHCS timelines for CAP notification and closures • Completed annual audits for provider sites with previous failed audit scores • Provided extensive training, education and technical assistance for provider sites with failed audit scores

V. Effectiveness of Interventions:

Interventions implemented to meet site review requirements are effective.

VI. Qualitative Analysis

Under the QI manager's direction, the FSR team, consisting of three support staff and six registered nurse certified site reviewers, is meeting compliance requirements for completing PCP site reviews, medical record reviews and timely CAP closures. Support staff work four months in advance to verify FSR nurses have the correct and up-to-date provider data. This process and proper planning resulted in an average of 96.36% of audits being conducted before the assigned due dates. The senior project specialist responsible for CAPs has implemented an effective process for retrieving and closing CAPs. Over 90% of all CAPs issued were closed by the corresponding CAP timelines. The PARS team consists of two outreach specialists who have completed over 500 physical accessibility reviews for PCPs, high-volume specialty sites, ancillary sites and CBAS centers.

Causal/Barrier Analysis:

- There are a greater number of sites with LIMITED versus BASIC Access. This could affect members' access to care.
- Since the updates to the DHCS FSR and MRR Tools and Standards, there has been an increase in failed audits. This increase has led to a greater number of providers being terminated from the network due to three subsequent failed audits or non-compliance with CAP timelines.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Increase the number of sites with BASIC Access. Deficiencies are shared with sites, and additional ways to increase access are offered. The sites that do not own the property are reluctant to make changes/updates to the facilities.	For sites demonstrating LIMITED Access, the PARS outreach specialists will continue to share deficiencies, provide education and offer ways to increase accessibility. This will assist sites in meeting the Basic Access requirements and demonstrate increased facility access for members with disabilities.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
Decrease the number of failed FSR/MRR audits.	The FSR nurses will continue to provide extensive, on-site training, education, and technical assistance for sites with failed audit scores. Complete annual FSR and MRR for sites with nonpassing scores.	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ H ☒ M ☐ L

VIII. Conclusion:

FSR and MRR audits for PCP sites were completed in accordance with DHCS requirements and timelines. PARS for PCP sites, high-volume specialty sites, providers of ancillary services and CBAS centers were completed in accordance with DHCS requirements and timelines. The program is successful.

4.2 Potential Quality Issues Review	
Author(s): Laura Guest	Department(s): Quality Improvement
Responsible Party(ies): Marsha Choo (Director, Quality Improvement); Laura Guest (Manager, Quality Improvement)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Potential Quality Issue (PQI) investigations are clinical investigations of providers to determine if the care provided meets evidence-based and community standards. Investigations include reviewing all provider types in the CalOptima Health provider network, including physicians, mid-level practitioners, hospitals, home health agencies and other relevant entities. Information specific to the case, which may include medical records and a response to the issue, is obtained and summarized by a nurse. A medical director

reviews cases with an identified PQI, levels the case according to the severity of the findings and makes a recommendation for action, which ranges from no action to presenting the case to the CPRC.

Some cases are sent to contracted external specialists for expert review. Cases presented to CPRC may result in a recommendation, such as a best practice letter or an 805 reporting to the appropriate state board.

The nurses also support the review of quality-of-care grievances by determining and intervening in urgent clinical issues and assisting medical directors with a clinical response, which is included in the member grievance letter sent by the GARS team.

II. Data Sources and Methodology

The investigation and associated documents are contained within the care management system called Jiva. Trend data is analyzed every six months by the provider. The rate is calculated by the volume of PQIs (or grievances) divided by the number of encounters. The rate is compared by provider to the specialty, i.e., the rate of the individual family medicine physician to the rate of all family medicine physicians.

III. Program Results and Quantitative Analysis:

Chart A – Number of Newly Opened PQIs by Month 2024 to 2025

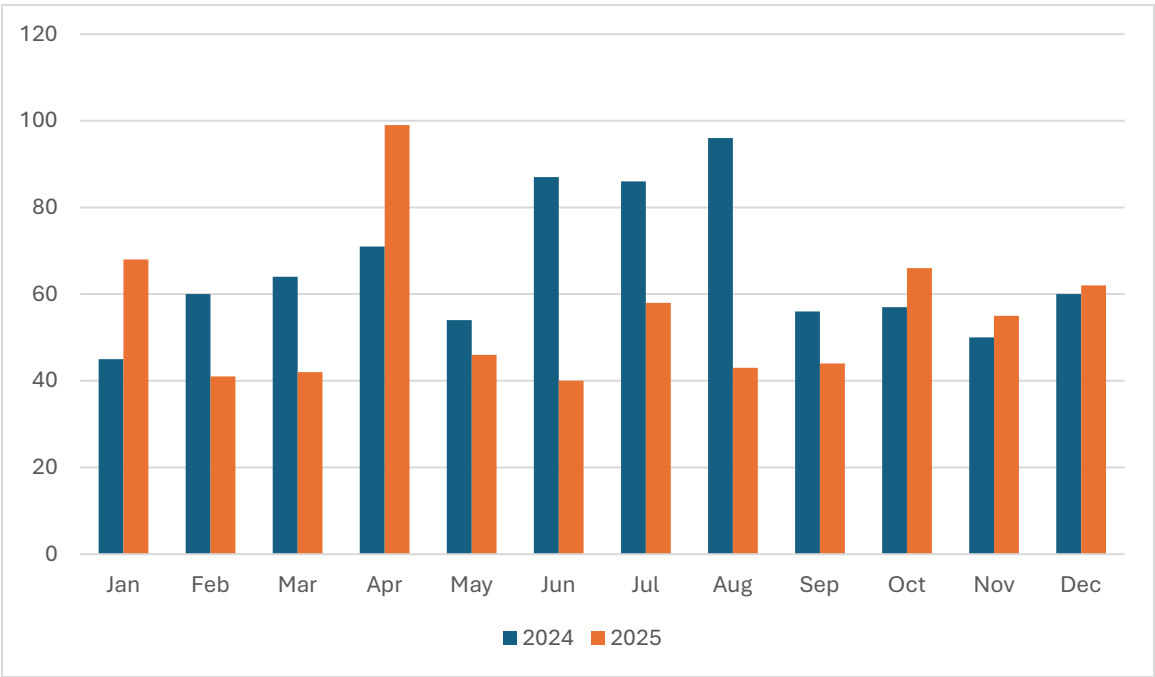


Chart caption: This chart displays the number of PQI cases opened each month in 2024 and 2025 (through October).

Indicator/Goals: CalOptima Health aims to maintain an average of 55–60 new PQI cases opened per month.

In 2024, the average number of cases opened was 66 per month. In 2025, the average dropped to 55 per month.

Chart B - Number of Closed PQIs by Month

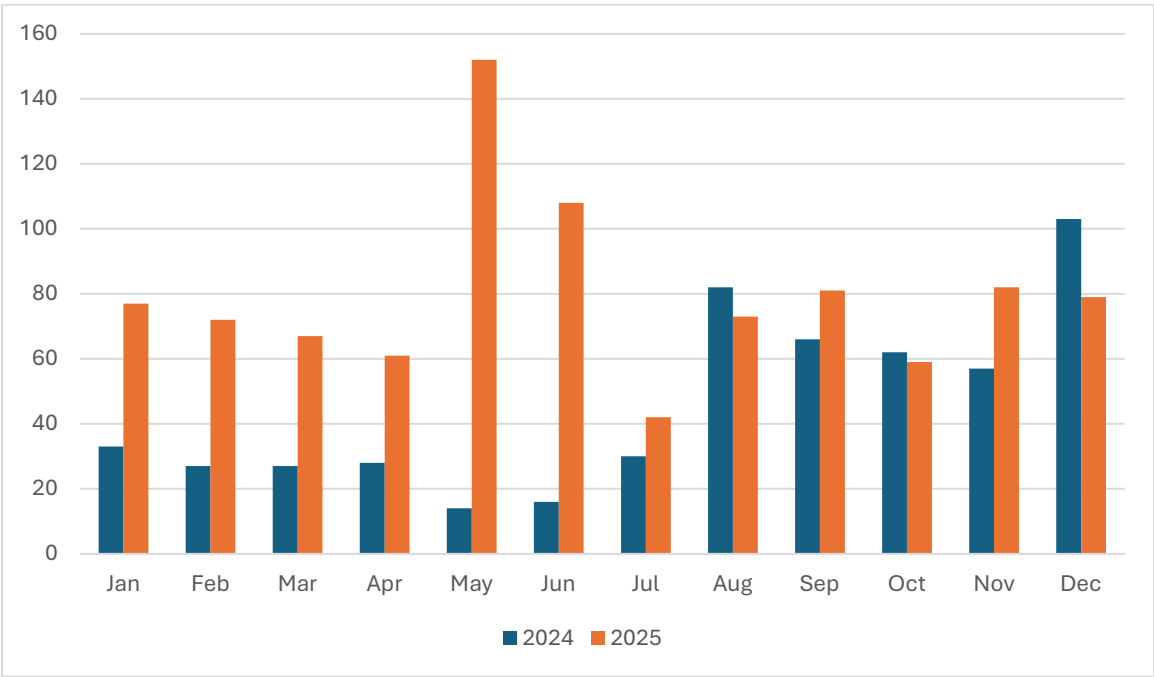


Chart caption: This chart displays the number of PQI cases closed each month in 2024 and 2025 (through October).

Indicator/Goals: CalOptima Health aims to close an average of 60 PQI cases per month.

In 2024, we closed an average of 37 cases per month. In 2025, staff closed an average of 79 cases per month, more than double that of 2024.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Reduce the number of open PQI cases	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	Number of open PQI cases
2. Modify Policy GG.1611: Potential Quality Issues Process	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	Policy was revised May 1, 2025
3. Quality-of-Care grievance provider responses	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	Number of newly opened PQI cases.

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Goal:

I. Reduce the number of open PQI cases in 2025.

The number of open PQI investigations dropped from a high of 730 in July 2024 to roughly 360 in November 2025. This intervention was the result of the following initiatives:

- In collaboration with CalOptima Health's medical directors, all PQI cases opened prior to 2024 have been closed.
- CalOptima Health Policy GG1611: Potential Quality Issue Process was modified to allow nurses to close PQI cases if the case has been deemed quality-of-service by two registered nurses. Reports to quantify this intervention are in development.
- CalOptima Health Policy GG1611: Potential Quality Issue Process was modified to consider a case closed once a severity level has been determined. Reports continue to be modified and developed to pull the closure date.
- Modified the workflow of quality-of-care grievances to allow receipt of the provider response to the grievance after the grievance is closed, rather than opening a PQI investigation for lack of response in all cases.

II. Develop a workgroup to address providers with a high number of grievances.

Established the Provider Action Workgroup co-chaired by the medical director, quality improvement and the director, provider relations.

- The workgroup examines providers with a high number and rate of grievances, and reviews data related to the provider's credentialing; access; HEDIS scores; FSR; Fraud, Waste and Abuse; and other data.
- The workgroup is in the process of developing criteria, a workflow and a set of actions to take for providers who fail to meet regulatory or compliance standards.

VI. Qualitative Analysis

PQI investigation data is analyzed and trended, and barriers are identified by the manager, quality improvement, in collaboration with the medical director, quality improvement. The data is presented quarterly to CPRC and QIHEC.

Causal/Barrier Analysis:

- Jiva, the care management system used to document PQI cases, was implemented in May 2024. CalOptima Health was the first plan to use this new system for PQI cases. Jiva continues to have performance issues and design flaws, which slow down work for both staff and medical directors. CalOptima Health continues to collaborate with ZeOmega to enhance the system.
- Reports to measure productivity and timeliness are under development.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Limited reporting to measure productivity and timeliness	In collaboration with IT, modify or develop reports to pull data from Jiva	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
2. Design and performance improvements for Jiva	Continue to work with ZeOmega and IT to improve Jiva for PQI.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
3. Development of the Provider Action Workgroup	Fully implement the workgroup and begin working with providers to improve their performance and reduce grievances.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The PQI team and medical directors cut the number of open cases by nearly half. We've also made strides in reducing the average number of PQI cases being opened each month by nearly half from 2024 to 2025.

The development of the Provider Action Workgroup established a process for CalOptima Health to address providers with grievances and other ongoing regulatory issues organizationally.

4.3 Provider Credentialing and Recredentialing	
Author(s): Rick Quinones	Department(s): Quality Improvement
Responsible Party(ies): Sharlee LeBleu (Director, Quality Improvement); Rick Quinones (Manager, Quality Improvement)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: All providers are credentialed and recertified according to regulatory requirements.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

The Credentialing department is responsible for ensuring all practitioners are appropriately qualified to provide care to our members. Practitioners and providers must be appropriately licensed and have relevant experience and competence in their field. Providers are assessed and reassessed based on maintaining good standing with licensing and regulatory bodies and being free of sanctions, exclusions and debarment. This is accomplished by applying rigorous standards that verify practitioners' and providers' licenses, education, training, experience, board certification, malpractice history, work history and quality of care performance at the time of recertification (as applicable). To become or maintain designation as a participating practitioner or provider in the CalOptima Health network, the applicant must meet the minimum qualifications, as outlined by DHCS, NCQA and CMS.

II. Data Sources and Methodology

Credentialing and recredentialing data sources (Cactus Credentialing System and Provider Insights from Verisys [CVO]), primary source verification methodology, timelines and the scope of the program can be found in CalOptima Health Policy and Procedure GG.1650: Credentialing and Recredentialing of Practitioners, dated May 1, 2025.

III. Program Results and Quantitative Analysis:

Results:

The tables below depict the 2025 Credentialing report for CalOptima Health.

Table A - CalOptima Health Credentialing and Recredentialing Statistics

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Credentialing	869	1,784	440	319
Recredentialing	234	230	330	305
Total	1,103	2,014	770	624

Quantitative Analysis:

- In Q1–Q4 2025, 3,412 practitioners and providers completed the credentialing process, and 1,099 practitioners and providers completed the recredentialing process.
- Of those recredentialed, 99% successfully completed the process in a timely manner. 1,095 practitioners and providers were recredentialed within the 36-month required timeframe.
- The numbers of credentialing and recredentialing for CHCN practitioners and providers reflects a significant increase from calendar years 2021–2025.
- A majority of the reasons for the volume increase relate to DHCS standards for the credentialing and recredentialing (vetting) of medical groups and behavioral health practitioners.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Burndown and maintenance of the credentialing email inboxes to ensure quality and timely credentialing and recredentialing activities and an excellent level of responsiveness with practitioners and providers.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☒ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Promote timely communication of credentialing and recredentialing decisions to practitioners and providers.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Weekly meetings with CVO to identify quality and compliance issues, track remediation activities and performance, and implement improvements.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☒ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

During 2025, the success of the credentialing email inbox maintenance fluctuated. The reduction of credentialing staff tied to the implementation of a CVO in July 2024 negatively impacted the department's ability to keep current with email inboxes and provide the level of operational excellence expected internally and with contracted groups, practitioners and providers. Additional temporary resources are being hired and trained to provide immediate improvement to this issue in late Q4 2025 and Q1/Q2 2026.

The credentialing team successfully improved compliance with the 30-day regulatory and accreditation timeframe for communicating credentialing decisions during 2025. No compliance issues or failures were identified in quarters 3 and 4.

Weekly meetings with the contracted CVO were mandatory to work through performance issues, ongoing failures in service expectations and to correct poor performance. The results have been inconsistent, and after more than sixteen months of services, many of the top performance concerns have not been resolved, including the CVO's adherence to its own policies and procedures, as well as providing the type of qualitative review expected by CalOptima Health and demonstrating consistent improvement in identified deficiencies.

VI. Qualitative Analysis

Adequate burndown and maintenance of department email inboxes cannot be quantified without the use of manual counting of the number of items received and responded to, which is an ineffective use of resources. The levels of emails that were not responded to within seven calendar days improved in Q2 and then reverted to lower levels in Q3 and early Q4.

Compliance with timely adherence to credentialing and recredentialing decision letters has significantly improved, reaching 100% as of July 2025.

Qualitative analysis with CVO performance was largely anecdotal as specific data points are not measurable beyond the number of issues and associated resolutions. These are topical in nature and cannot be quantified in stratified categories or subcategories for purposes of qualitative analysis.

In September 2025, the new department director began tracking deficiencies and resolutions on a log maintained by credentialing leadership. The number of identified problems has significantly increased since September 2, 2025, with very few successful interventions and resolutions implemented by the CVO to the satisfaction of the department management team as of the end of November 2025.

Causal/Barrier Analysis

The credentialing backlog, which focused on Q2 and Q3 2025, and supporting organization volunteers and onboarding temporary resources, limited the ability to consistently manage the email inbox during the year.

The ongoing identification of CVO deficiencies and their associated processes and workflows has increased significantly during the year. It took months for credentialing management to obtain CVO recognition and process improvement in nearly every area of dissatisfaction. For example, the

credentialing management team's ability to convince the CVO to discontinue mailing paper documents to practitioners and providers took more than six months to finalize.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on achieving operational improvement and excellence. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Development of a Request for Proposal (RFP) to upgrade the existing credentialing system and replace the current CVO is scheduled for mid-January 2026.	Possible change from current credentialing tech and services to a new partner.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Ongoing meetings with CVO to identify and resolve contractual deficiencies, flawed processes and workflow, and improve expected performance will continue. A plan to replace the current vendor if business needs cannot be met, and implement a new partner who must agree to performance guarantees and a contractual agreement to adhere to standard industry expectations.	Possible change from current credentialing tech and services to a new partner.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Development of a proposed future organizational chart and team structure will be presented to executive leadership on January 15, 2026. The future state presentation is part of a multidepartmental approach to address current operational deficiencies and ensure a more effective approach to contracting, provider relations, credentialing, and provider data management is aligned and effectuated in 2026 (next generation of PLM concept).	Note: Planned intervention will not be developed until after feedback is received from the executive team. At present, this is a proposed improvement activity only.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
4. Ongoing credentialing and cross-functional operational improvements, including identification and elimination of non-value add processes and leveraging technology to streamline and automate operationally effective workflow and improvements in 2026.	Note: Planned intervention will not be developed until an enterprise approach is developed in partnership with the Provider Operations team (i.e., PLM relaunch) feedback is received from the executive team.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The Credentialing department has worked with internal and external consultants to identify strengths and opportunities for improvement, which include:

- Creating an environment that promotes change, with management and staff adapting to consistently changing priorities and process improvement activities.

- Cross-training staff to support the CVO service environment and creation of workflow to augment organizational needs in responding to regulatory and accreditation changes.
- Promoting trust and commitment to continuous quality improvement and staff participation in projects, including soliciting staff opinions and recommendations for improved operational effectiveness.

4.4 Special Needs Plan (SNP) Model of Care (MOC)	
Author(s): Megan Dankmyer and Sherry Hickman	Department(s): Medical Management
Responsible Party(ies): Megan Dankmyer (Sr Director, Medical Management); Sherry Hickman (QI Nurse Specialist, Case Management)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

The goal of the OneCare MOC is to improve health outcomes for all OneCare members. Specific measurable goals align with our Special Needs Plan (SNP) population. Measures were selected to monitor specific aspects of the MOC:

Newly enrolled OneCare members are required to have outreach and Health Risk Assessment (HRA) collection within the first 90 days of enrollment. The HRA informs the development of a member-centric care plan by the care team. Members are required to have annual HRA outreach at a minimum on an annual basis, with collection of HRA <365 days from the prior HRA. Data from the initial and annual HRA collections are reported to both DHCS and CMS.

Newly enrolled OneCare members are required to have an Individualized Care Plan (ICP) developed within 90 days of eligibility through the Interdisciplinary Care Team (ICT) process. The ICP is a member-centric plan of care that prioritizes goals and target dates. Attention is paid to needs identified in the health risk assessment and by the ICT. The members' care plan is updated at least annually and whenever there is a change in their health status. Data for the initial and annual ICP development is reported to DHCS.

II. Data Sources and Methodology

Data Source for HRA: Jiva Medical Management Platform provides data for all HRA outreach and categorizes an HRA as collected if 40% or more is completed.

Data Source for ICP and ICT: Jiva Medical Management Platform provides information for members enrolled in CHCN. The OneCare MOC Tracking file, submitted monthly, provides information for members enrolled with external health networks.

HRA data is reported to CMS annually through Measure Data Validation Audit (MDVA), tracked monthly on internal Key Performance Indicators (KPI) and quarterly through the QIHEC committee. Initial ICP data is reported to DHCS, internal KPI and through the QIHEC committee quarterly.

III. Program Results and Quantitative Analysis:

OneCare HRA Internal KPI

Table A

OC HRA KPI Metric 2025	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
New members with an initial HRA completed within 90 days (before or after) of their effective date of enrollment collected	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
New members with an initial HRA completed within 90 days (before or after) of their effective date of enrollment completed.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Members with an annual assessment conducted within 365 days of the prior HRA completion date, or date of enrollment if no initial HRA was collected.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Members with an annual assessment conducted within 365 days of the prior HRA completion date, or date of enrollment if no initial HRA was completed.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Indicator/Goals: OC HRA KPI performance goal is 95%.

OC HRA outreach and collection meet the benchmark for internal KPI.

OneCare Star Status

Table B

SNP Care Management Measure	Completed	Star
2021 Measurement Year	36%	One
2022 Measurement Year	35%	One
2023 Measurement Year	52%	Two
2024 Measurement Year	65%	Three
2025 Measurement Year	*75.19%	*Four (projected)

Chart caption: OneCare Star Status. 2025 Measurement Year is in progress. Four Stars is the projected outcome for the measurement year. As of December 3, 2025, 75.19% of HRAs collected qualify for CMS Star.

Indicator/Goals: A higher Star rating is preferred.

After two years of no growth (2021–2022), MY 2023 improved from 35% to 52%, demonstrating a relative 48% improvement year over year. MY 2023 to 2024 showed an increase from 52% to 65%, demonstrating a relative improvement of 25%. MY 2025 projected growth, from 65% to 73%, demonstrates a 12.3% relative increase.

OneCare DHCS Initial ICP

Table C

Reporting Period	ICP: Members who completed care plan within 90 days of enrollment		
	Members Newly Enrolled	Members Who Completed Care Plan	% Members Who Completed Care Plan
Q4 2024	771	635	82%
Q1 2025	973	772	79%
Q2 2025	971	746	77%
Q3 2025	1015	788	78%
Q4 2025*	Data Collection in Process	Data Collection in Process	Data Collection in Process

Chart Caption: OneCare Initial ICP

* Q4 2025 data collection in process.

Indicator/Goals: For internal KPI the benchmark is 70% and met year-to-date for Initial ICP DHCS reporting.

For DHCS Initial ICP reporting and internal benchmarks, CalOptima Health has met the goal. The enrollment comparison shows an increase of 31.6% from Q4 2024 to Q3 2025. Contrasting quarters by completion rates shows a decrease in Q4 2024 to Q1 2025 of 3.66%, a decrease in Q1 2025 to Q2 2025 of 2.53% and an increase from Q2 2025 to Q3 2025 of 1.30%.

OneCare ICP Face to Face

Table D

Data as of end of month	DEC 2024	JAN 2025	FEB 2025	MAR 2025	APR 2025	MAY 2025	JUN 2025	JUL 2025	AUG 2025	SEP 2025	OCT 2025	Nov 2025	Dec 2025
Total # OC Members	17,487	17,070	17,148	17,167	17,331	17,484	17,675	17,785	18,191	17,993	18,524	18,334	18,634
PCP visit in current year	13,248	848	3,090	5,919	8,489	10,170	11,158	12,426	12,378	12,701	13,313	13,482	13,628
AWV in current year	5,752	104	476	1,252	2,251	3,312	3,947	4,954	5,728	6,073	6,495	6,871	7,091
% AWV in current year	32.9%	0.6%	2.7%	7.3%	12.9%	18.9%	22.3%	27.90%	31.00%	33.75%	35.1%	37.5%	38%
Specialist visit in current year	3,433	680	1,314	1,868	2,228	2,546	2,736	2,972	11,315	11,577	11,872	12,035	12,195

Any visit in current year	13,610	1,439	4,024	6,868	9,401	10,878	11,758	12,955	14,978	15,129	15,630	15,706	15,850
% with visit in current year	78%	8%	23%	40%	54%	62%	67%	73%	82%	84%	84%	86%	85%
PCP visit in last 12 months	13,248	13,305	13,330	13,331	13,525	13,713	13,774	14,006	13,623	13,563	13,816	13,719	13,628
AWV in last 12 months	5,572	5,456	5,207	4,972	5,039	5,508	5,695	6,210	6,675	6,750	6,872	7,043	7,091
% with AWV in last 12 months	31.80%	32.0%	30.0%	29.0%	29.1%	31.5%	32.2%	34.9%	36.70%	37.50%	37.0%	38.4%	38%
Specialist visit in last 12 months	3,433	3,502	3,548	3,587	3,584	3,647	3,641	3,681	12,418	12,336	12,304	12,223	12,195
Any visit in last 12 months	13,610	13,670	13,712	13,723	13,918	14,103	14,164	14,396	15,779	15,665	15,930	15,831	15,850
% with visit in last 12 months	78%	80%	80%	80%	80%	81%	80%	81%	87%	87%	86%	86%	84%
% with visit in last 12 months, excluding members enrolled in last four months	84%	84%	84%	83%	84%	83%	83%	84%	88%	88%	87%	88%	84%

Chart caption: OneCare Face to Face

Indicator/Goals: There is no attached performance goal. However, the percentage of improvement is desired to ensure the OneCare member has an annual face-to-face visit.

Enrollment grew from January to December 2025, increasing from 17,070 to 18,634 members a 9.2% rise. Annual Wellness Visit (AWVs) performance for 2025 surpassed the 2024 rate of 32.9%, reaching 38% by December, an absolute increase of 5.1 percentage points and a 15.5% relative improvement. AWV completions in the past 12 months rose from 5,456 in January to 7,091 in December, reflecting a 30% growth, consistent with targeted interventions to close this care gap. Additionally, 84% of members had a face-to-face visit in the past 12 months by year-end, exceeding the 2024 result of 78% and demonstrating a 7.7% relative improvement.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Monthly communication process with health networks on ICP development with template revision includes face-to-face status to improve compliance.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. SNPE Universe build and testing for ICT reporting to improve oversight of MOC elements compliance.	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Continued HRA initial and annual outreach	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
4. Continued HRA reminders through texting and postcards	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

5. Targeted outreach to members needing reset or catch-up HRA	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
6. QR codes added to HRA cover letters for all threshold languages to allow members to complete them by mobile.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
7. AWW improvement strategies Usher texting and email campaigns	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
8. Targeted gaps in care added to health network data bundle without HRA	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
9. MOC 2025 updated and approved in Q4 2025 approved by both CMS and DHCS.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

1. MOC updates and monthly communication process with networks on ICP development effectively support data integrity for our DHCS reporting, and will be ongoing in 2026.
2. DHCS quarterly reporting in 2025 has been timely and will continue to be reported in 2026.
3. HRA Star status: Interventions for HRA outreach and collection are effective, and data shows an increase in volume of HRAs collected.
4. MOC updates: MOC update submitted to DHCS and CMS and was approved in Quarter 4 2025.
5. Face-to-face interactions:
 - a. Logic changes effective August 29, 2025. New logic recommended by EA utilizes the provider National Provider Identifier (NPI) to compare with CMS National Plan and Provider Enumeration System (NPPES) data and identify specialists based on the provider's taxonomy codes. Nonphysician providers (NPPs) are counted toward specialist visits. The impact shows an increase in claims classified as a specialist visit.
 - b. Monthly notification to the health networks advising of members overdue for a face-to-face visit will continue.
 - c. Additional strategies were implemented
 - i. Usher text and email campaigns to members overdue for AWW by Quality Analytics.
 - ii. AWW Gap in Care notice on Health Network Bundles without HRA beginning Q3 2025.

VI. Qualitative Analysis

1. The structured monthly communication with networks on ICP development and MOC element gaps promotes accurate, reliable data for DHCS and CMS reporting. When gaps are identified, networks take corrective action and Case Management's monthly review and feedback drive continuous improvement in data integrity.

2. Case Management successfully coordinated and ensured the timely submission of mandated DHCS D-SNP quarterly reports from 2025 to date.
3. The HRA Star rating is a key indicator used to assess and compare health plan performance. Recent trends in the SNP Care Management measure reflect meaningful and sustained improvement, driven by targeted strategies and enhanced member engagement. These efforts have resulted in a notable rise in quality ratings over time, demonstrating the effectiveness of ongoing quality initiatives and a strong commitment to excellence in care.
4. The D-SNP MOC, approved by DHCS and CMS in Q4 2025, reflects a comprehensive and person-centered approach to managing the needs of dual-eligible beneficiaries. It demonstrates alignment with regulatory expectations. The MOC provides a detailed understanding of the SNP population, with a focused lens on the most vulnerable enrollees. It outlines a robust care coordination framework supported by a dedicated staff structure, standardized assessments, and personalized care planning. There is integration of face-to-face encounters and ICTs. The provider network is equipped with specialized expertise and guided by evidence-based protocols, while ongoing training ensures alignment with MOC principles. The quality measurement section underscores a commitment to accountability, with clearly defined goals, regular evaluation, and mechanisms to capture and act on patient experience.
5. Efforts to improve annual face-to-face interactions show progress compared to the previous year. Specifically, AWWs for the past 12 months and in the current year have shown an upward trend and are outperforming the previous year. This aligns with targeted strategies to close this care gap.

Causal/Barrier Analysis:

- Members who are unable to contact or decline HRA collection are an existing barrier, not newly identified, carried over from prior years. On a quarterly basis, Case Management QI staff and directors review and discuss QI work plan results and barriers with the use of existing tools, created by Enterprise Analytics, such as the HRA Dashboard. Results are monitored through internal KPIs and reported through QIHEC. Case Management has implemented multiple pathways for addressing the unable to contact barrier, with notable success seen in year-over-year improvement of HRA collection:
 - The letter includes a QR code giving members the additional option to complete the HRA electronically through a smartphone.
 - Usher texting campaign in threshold language provides members with a pathway to complete electronically through a smartphone.
 - Creation of a postcard reminder to encourage members to complete the HRA.
 - Dedicated phone number to complete the HRA.
 - Posting of HRA flyer on CalOptima Health website in the member reward section, which increases visibility.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. SNPE Universe remediation for ICT status	Universe remediation for ICT date in conjunction with IT to 1. Integrate data when members transition between CHCN and external health networks and 2. Differentiate between informal and formal ICT processes.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Supplemental gaps in care and medications with HRA bundle	Implementation of gaps in care notification to health networks when HRA is generated.	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

1. Monthly communication with networks on ICP development and MOC gaps supports data accuracy for DHCS and CMS reporting. Case Management's feedback loop drives improvements in data integrity.
2. Case Management ensured the timely submission of all required DHCS D-SNP quarterly reports in 2025, reflecting a commitment to compliance.
3. Sustained improvement in the HRA Star rating reflects effective strategies and member engagement, resulting in higher quality performance.
4. The CMS- and DHCS-approved D-SNP MOC demonstrates a comprehensive, person-centered approach, with emphasis on care coordination and focus on quality.
5. Face-to-face performance shows meaningful improvements with current performance already surpassing last year's benchmark. With continued data collection, further gains are anticipated.

4.5 Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	
Author(s): Leslie Vasquez	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Leslie Vasquez (Program Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Childhood Immunization Status (CIS-E) Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA-E) Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) Total: Increase from 53.03% to 55.29% by 12/31/2025.	

Lead Screening in Children (LSC)						
LSC: Increase from 63.75% to 63.84% by 12/31/2025.						
Goal Met:	☐ Yes	☐ No	☒ Partial	Status:	☐ Completed	☒ Ongoing

I. Purpose or Background:

EPSDT is a Medicaid requirement that ensures children and adolescents under the age of 21 receive comprehensive preventive care, including regular well-child visits, immunizations, screenings and recommended treatments. The goal of EPSDT is to identify and address health issues early, supporting healthy growth and development.

HEDIS, particularly the measures in the children's health domain, are aligned with EPSDT frameworks that support early and comprehensive care. HEDIS measure performance evaluates the requirements under EPSDT.

CalOptima Health focused on the following measures:

- Childhood Immunization Status — Combination 10 (CIS-Combo10)
- Well-Child Visits in the First 30 Months of Life (W30), two key components:
 - Well-Child Visits in the First 15 Months (W30-First 15 Months)
 - Well-Child Visits for Age 15 Months–30 Months (W30–15 to 30 Months)
- Immunizations for Adolescents-Combination 2 (IMA-Combo 2)
- Child and Adolescent Well-Care Visits (WCV-Total)
- Lead Screening in Children (LSC)

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, CitiusTech. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY2024 is based on MY2022 reported performance results compared to the national percentile from the MY2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CIS-E	Childhood Immunization Status (Combo10)	39.42%	36.50%	38.69%	42.34%	☐ Y ☒ N
IMA-E	Immunizations for Adolescents Combination 2	51.82%	47.45%	45.50%	48.66%	☐ Y ☒ N
W30	Well-Child Visits in the First 30 Months of Life (MY2020) 0-15 months	55.78%	58.92%	70.28%	63.38%	☒ Y ☐ N

W30	Well-Child Visits in the First 30 Months of Life — 15-30 months	71.20%	72.44%	74.4%	73.09%	☒ Y ☐ N
WCV	Child and Adolescent Well-Care Visits	51.49%	53.03%	55.46%	55.29%	☒ Y ☐ N
LSC	Lead Screening in Children	63.02%	63.89%	70.80%	63.84%	☒ Y ☐ N

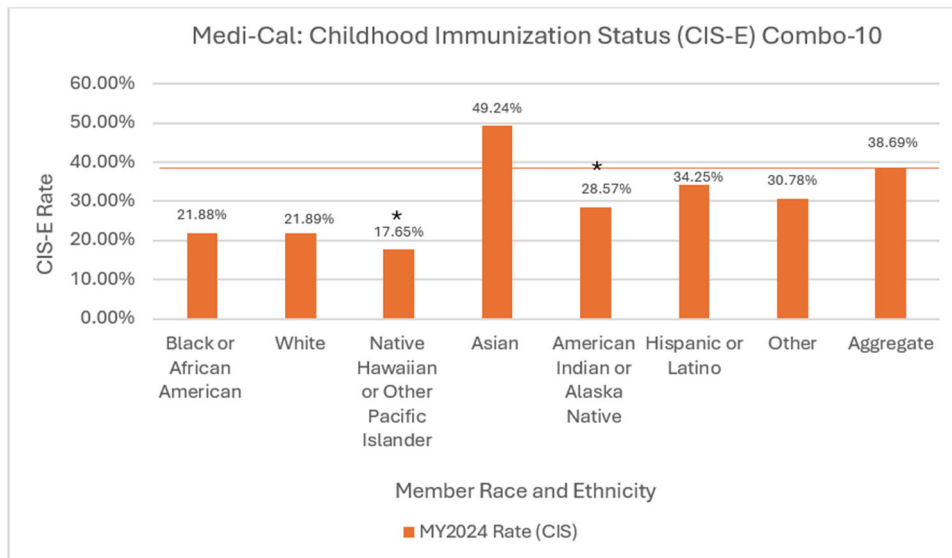
- CIS-E (Combo 10): Following a decline in MY 2023, the measure improved in MY 2024. Although the measure did not reach the organizational goal of 42.34%, it did exceed the MPL benchmark of 27.49%. This reflects consistent performance and highlights an opportunity for continued improvement.
- IMA-E (Combo 2): Year-over-year performance has shown a consistent downward trend. While the organizational goal was not met, the measure surpassed the MPL benchmark of 34.30% by more than 10 percentage points.
- W30 (0-15 months): Year-over-year performance demonstrates an upward trend. Measure performance significantly exceeded both the MY 2024 organizational goal and the MPL of 60.38%.
- W30 (15-30 months): Rates have steadily improved year-over-year. The measure met the organizational goal (1.31 percentage points above) and met the MPL of 69.43% in MY 2024.
- WCV: Rates have shown gradual improvement each year. In MY 2024, the measure narrowly met the organizational goal and surpassed the MPL of 51.81% by 3.48 percentage points. This suggests positive momentum and highlights an opportunity for continued progress.
- LSC: MY 2024 demonstrates a strong upward trend with an increase of 6.91% from the previous year. The measure performed well above the organizational goal and MPL, demonstrating significant improvement.

IV. Data Stratification Data Source and Methodology:

Data pulled from claims and encounters using HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity.

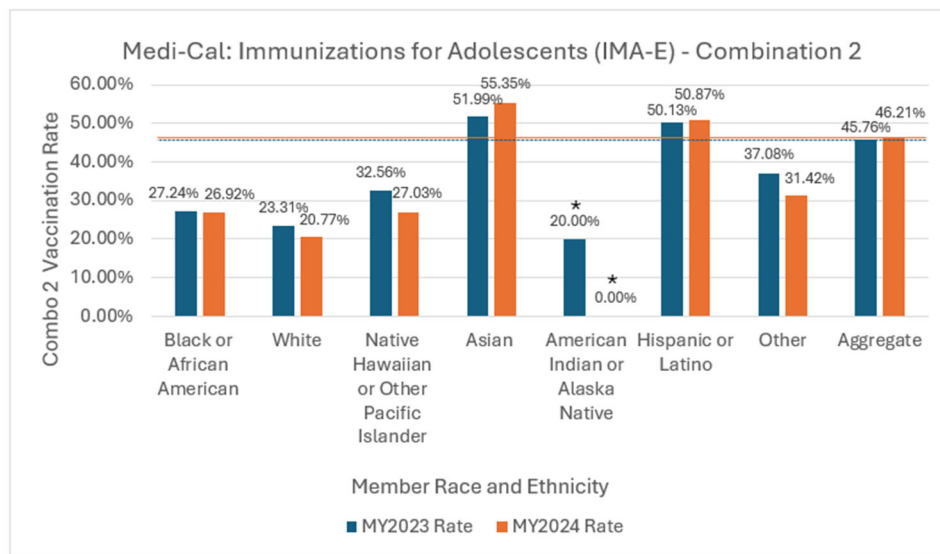
V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better **Medi-Cal**



This bar chart displays the percentage of Medi-Cal members who are children and received a Combo-10 vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

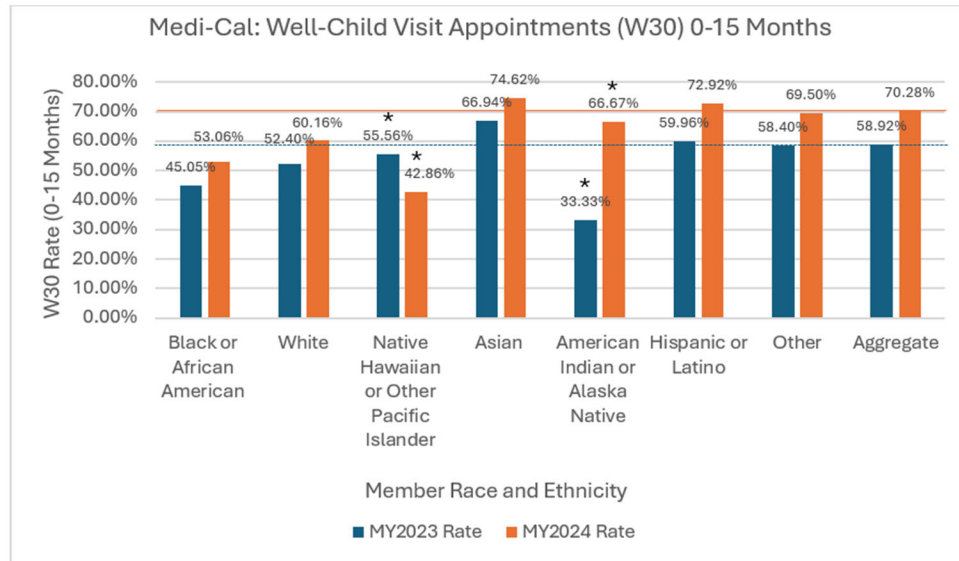
- Across all race and ethnicity groups, the Asian group's performance of 49.24% surpassed both the aggregate and all other groups' performance.
- The Hispanic/Latino group followed as the group with the second-highest performance at 34.25%.
- The following three groups performed below the MPL (27.49%): Native Hawaiian or Other Pacific Islander (17.65%), Black or African American (21.88%) and White (21.89%).



This bar chart displays the percentage of Medi-Cal adolescent members who received a Combination 2 vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

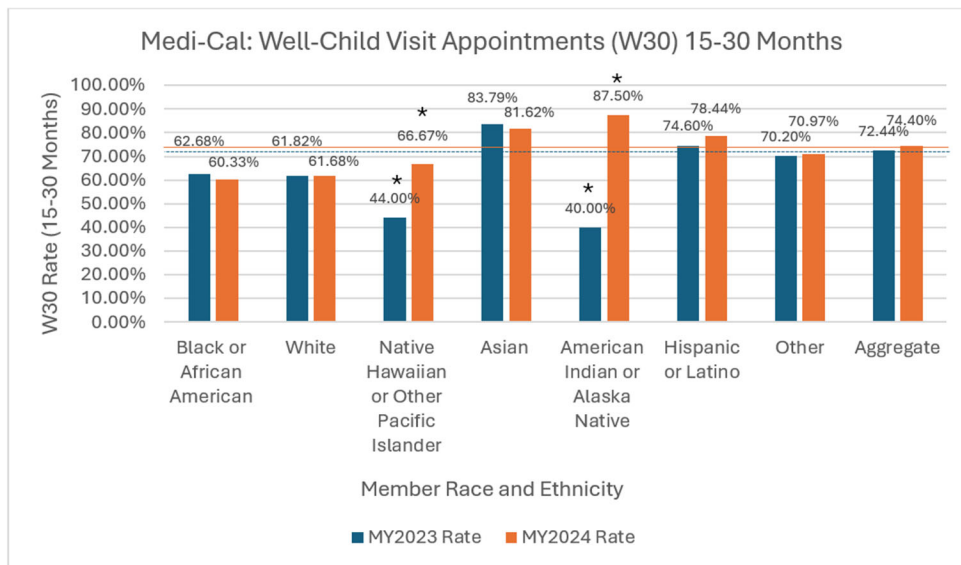
- Across aggregate performance, there was a slight improvement of 0.45 percentage points from the previous year.

- Similar to CIS-E (Combo 10) performance, the Asian group represented the highest performing group at 55.35%, followed by Hispanic/Latino at 50.87%.
- The following groups performed below the MPL of 34.30%: American Indian or Alaskan Native, White, Black or African American, and Other. These same groups showed a decline in their performance compared to the previous year.
- When comparing current to the previous year's performance, only the Asian and Hispanic/Latino groups improved performance, 3.36 and 0.74 percentage points, respectively.



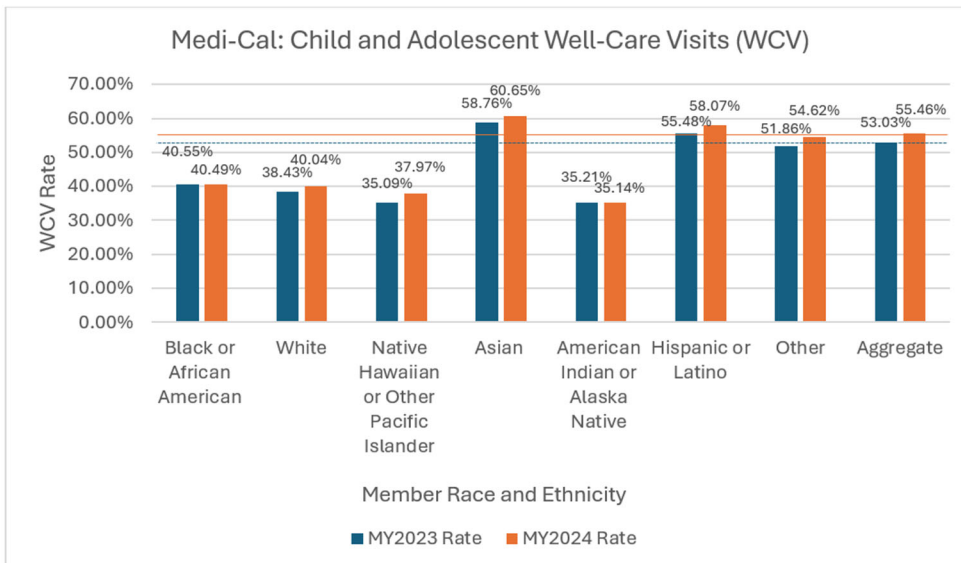
The rates shown in the bar chart were calculated by dividing the number of Medi-Cal members who completed a well-child visit between 0 and 15 months of age by the total number of eligible members in that age group, stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

- Across aggregate performance, there was a significant improvement of 11.36 percentage points from the previous year.
- All groups demonstrated improved performance compared to the previous year. Groups with 30 or more members in the denominator were assessed. The Hispanic or Latino group had the largest year-over-year increase at 12.96 percentage points, followed by the Other group with an 11.1 percentage point gain.
- While there was improvement across all groups, the following groups still trail in performance when compared against the MPL of 60.38%: Native Hawaiian or Other Pacific Islander, Black or African American, and White.



The rates shown in the bar chart were calculated by dividing the number of Medi-Cal members who completed a well-child visit between 15 and 30 months of age by the total number of eligible members in that age group, stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

- Aggregate performance improved slightly from the previous year by 1.96 percentage points.
- When comparing groups with at least 30 members in the denominator against the previous year, performance varied. Some groups, such as Black or African American and White, showed slight declines, while groups such as Hispanic or Latino and Other demonstrated slight to moderate improvements.
- Groups performing below the MPL of 69.43% include: Black or African American, White, Native Hawaiian or Other Pacific Islander.



The rates shown in the bar chart were calculated by dividing the number of Medi-Cal members who completed a child and adolescent well-care visit by the total number of eligible members in that age group, stratified by race and ethnicity.

- Similar to immunization-related measures, the Asian and Hispanic or Latino groups were the two highest-performing groups at 60.65% and 58.07% respectively.
- The groups with the lowest overall performance are: American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander, White and Black or African American. These same groups also performed below the MPL of 51.81%, which underscores that additional support or targeted interventions may be beneficial.

VI. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Postcard mailing targeting members on their first and second birthdays.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS-E, IMA-E, W30, LSC
2. Telephonic outreach (vendor-supported pediatric call campaign)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS-E, IMA-E, W30, WCV, LSC
3. Pediatric text campaigns issued to remind members of the importance of well-child visits and recommended care in alignment with the AAP periodicity schedule	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS-E, IMA-E, W30, WCV, LSC
4. EPSDT dental, vision, and hearing text campaigns: One text to members who were overdue for their dental, vision and hearing services according to the AAP periodicity schedule.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	W30
5. Quality Improvement Grant Program aimed at improving performance rates across various measures via initiatives such as, but not limited to, coordination of care, member education and implementation of lead care analyzers to support in-office lead testing.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS-E, IMA-E, W30, WCV, LSC
6. Well-Child Visit in the First 30 Months Report (ad hoc) - This report details the total number of visits, visit dates, and procedure codes to help identify members with gaps in visits for health network and providers.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30
7. Enhanced Immunization Reports (ad hoc) - This report identified the specific vaccine series members are due for to support member outreach efforts.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS-E, IMA-E
8. Enhanced member mailings tailored with recommended care for various pediatric ages 3–11.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	WCV
9. Pay for Value (P4V) Program	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm	☐ Completed ☒ Ongoing	CIS-E, IMA-E, W30, WCV,

			☐ Data ☐ Other	☐ Incomplete	LSC
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MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VII. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
CIS-E	MC: Childhood Immunization Status – Combo 10	20.19%	28.42%
IMA-E	MC: Immunizations for Adolescents – Combo 2	31.78%	46.73%
W30	MC: Well-Child Visits in the First 30 Months of Life - ≥ 6 Well-Child Visits	35.64%	58.47%
W30	MC: Well-Child Visits in the First 30 Months of Life - ≥ 2 Well-Child Visits	64.92%	75.02%
WCV	MC: Child and Adolescent Well-Care Visits	28.64%	40.95%
LSC	MC: Lead Screening in Children	67.05%	72.59%

MC = Medi-Cal

Indicator/Goal: The performance rate from the same month of the previous year

Overall performance across all pediatric measures demonstrates improved performance when compared to the same point in time last year.

- W30 (≥ 6 Well-Child Visits) showed the most significant gain with a +22.83-percentage point increase.
- LSC (Lead Screening in Children) had the smallest gain at +5.54 percentage points.

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

- Health network and provide partners report continued hesitancy amongst parents/guardians as it relates to completing well-child visits and vaccines.
- Incorrect member contact information impacts the ability to successfully outreach to members and deliver information or coordinate needed care.

IX. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
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1. Development of tailored messaging and strategy across various modalities to complement current text and mailing efforts.	- Development of email communications to support current text and mailing modalities - Automated reminders for members that we'd expect to complete a visit - Prospective outreach for those members who will age into measures - Development of culturally tailored communications	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	CIS-E, IMA-E, W30, WCV, LSC
2. Data bridge to support bidirectional exchange of data and enhance the identification of members due for care	Cozeva data bridge	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	CIS-E, IMA-E, W30, WCV, LSC
3. Address vaccine hesitancy in membership	Member-facing and provider-facing material development to support vaccine hesitancy	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L	CIS-E, IMA-E

MC = Medi-Cal; OC = OneCare

X. Conclusion:

- Member engagement rates vary across modalities. Targeted member engagement and outreach campaigns are still necessary to ensure that messages about recommended care are effectively delivered. A tiered approach that includes alternative outreach modalities in case of unsuccessful communication is recommended.
- While trends indicate overall improvement in performance when compared to the same time last year, there are various groups that are performing lower than other groups, the aggregate rate or MPL. This reflects an opportunity to develop strategies tailored to these groups.
- The Childhood Immunization Status (CIS) Combo 10 and Immunizations for Adolescents (IMA) Combo 2 measures did not meet the goal and will continue to be an area of focus in the 2026 QIHETP work plan.

4.6 Adult Wellness: Preventive and Screening Services

Author(s): Melissa Morales, Dexter Dizon	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Melissa Morales (Quality Improvement Specialist, Quality Analytics); Dexter Dizon (Quality Improvement Specialist, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025.	

OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

According to the American Cancer Society, one in two men and one in three women will be diagnosed with cancer in their lifetime. Breast cancer is the second most common cancer in American women, while cervical cancer is one of the most common causes of cancer death in American women. In addition, colorectal cancer is the fourth most common cancer in men and women, and the fourth leading cause of cancer-related deaths in the United States.

The U.S. Preventive Services Task Force (USPSTF) has recommended screening for cervical, breast, and colorectal cancers. Cancer screening tests can help people find cancer at an early stage before symptoms appear. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs

The following is an evaluation of the cancer screening HEDIS measure performance. Cervical Cancer Screening (CCS) and Breast Cancer Screening (BCS) are part of the DHCS' MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by the NCQA Quality Compass. The BCS and Colorectal Cancer Screening (COL) measures are part of the CMS' Five-Star Quality Rating System.

According to the CDC, vaccine-preventable diseases remain a significant cause of morbidity and mortality among adults in the United States. Each year, thousands of adults are hospitalized or die due to illnesses that could have been prevented through timely immunization. Influenza, pneumococcal disease and tetanus are among the most common and serious vaccine-preventable conditions affecting adults, particularly those with chronic health conditions or weakened immune systems.

USPSTF and ACIP recommend routine immunizations for adults, including annual influenza vaccination, Tdap or Td boosters every 10 years, and pneumococcal vaccines for older adults and those with specific risk factors. These vaccines are critical in reducing disease burden, preventing complications and lowering health care costs through prevention.

The Adult Immunization Status (AIS-E) measure is a HEDIS performance metric for Medicare and OneCare populations that evaluates the percentage of adults aged 19 and older who are up to date on recommended routine vaccines. For these populations, the measure emphasizes timely administration

of influenza, Td/Tdap, zoster, and pneumococcal vaccines, which are essential for preventing serious illness and reducing avoidable hospitalizations. AIS-E is part of DHCS’s MCAS reporting requirements for Medi-Cal managed health care plans and is benchmarked against the NCQA Quality Compass Medicaid 50th percentile. AIS-E reporting for Medicare Advantage and OneCare plans aligns with CMS’s Five-Star Quality Rating System and CalAIM quality improvement goals, supporting value-based care and population health management. Ensuring high performance on this measure not only improves member outcomes but also contributes to plan performance incentives and regulatory compliance.

II. Data Sources and Methodology:

The source of the data is CalOptima Health’s HEDIS engine, CitiusTech. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022-reported performance results compared to the national percentile from the MY 2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. OneCare measure goal setting for MY 2024 is based on the MY 2022 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CCS	Cervical Cancer Screening	57.73%	58.31%	57.86%	60.10%	☐ Y ☒ N
BCS-E	Breast Cancer Screening	57.67%	58.39%	59.13%	59.51%	☐ Y ☒ N
AISINFL-E	Adult Immunization Status - Flu	21.75%	22.19%	17.98%	26.40%	☐ Y ☒ N
AISPNEU-E	Adult Immunization Status - Pneu	N/A	38.18%	38.42%	38.73%	☐ Y ☒ N
AISTD-E	Adult Immunization Status - Tdap	23.35%	25.43%	38.36%	33.40%	☒ Y ☐ N
AISZOS-E	Adult Immunization Status - zoster	14.54%	17.52%	18.49%	20.56%	☐ Y ☒ N

The CCS measure did not meet the MY 2024 Medi-Cal goal of 60.10% but surpassed the MPL of 52.32%. The MY 2024 Medi-Cal rate was 57.86% which is lower than the MY 2023 Medi-Cal rate of 63.52%. The BCS measure did not meet the MY 2024 Medi-Cal goal of 59.51% but surpassed the MPL of 55.87%. The MY 2024 Medi-Cal rate was 59.13%, which is higher than the MY 2023 Medi-Cal rate of 58.39%.

Only Tdap (AISTD-E) met its 2024 goal, showing a strong improvement from 25.43% in 2023 to 38.36% in 2024. Influenza (AISINFL-E) rates declined in 2024, dropping to 17.98%, well below the 26.40% target. Pneumococcal (AISPNEU-E) rates slightly improved from 38.18% to 38.42% but still missed the 38.73%

goal by a narrow margin. Zoster (AISZOS-E) showed gradual improvement over the three years but remains below the target, indicating a persistent gap in uptake.

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
COL	Colorectal Cancer Screening	64.23%	66.84%	66.94%	70.33%	☐ Y ☒ N
BCS-E	Breast Cancer Screening	65.49%	66.88%	68.52%	75.00%	☐ Y ☒ N
AISINFL-E	Adult Immunization Status - Flu	45.37%	47.17%	44.1%	49.12%	☐ Y ☒ N
AISPNEU-E	Adult Immunization Status - Pneu	26.85%	44.96%	45.08%	56.57%	☐ Y ☒ N
AISTD-E	Adult Immunization Status - Tdap	28.24%	24.57%	41.24%	31.56%	☒ Y ☐ N
AISZOS-E	Adult Immunization Status - Zoster	21.76%	23.62%	24.43%	40.94%	☐ Y ☒ N

The COL measure did not meet the MY 2024 OneCare goal of 70.33%. The MY 2024 OneCare rate was 66.94% which is higher than the MY 2022 rate of 64.23%. The BCS measure did not meet the MY 2024 OneCare goal of 75.00%. The MY 2024 OneCare rate was 68.52% which is higher than the MY 2023 rate of 66.88%.

The outcomes for the AIS measures vary by vaccine. Only the Tdap (AISTD-E) measure met its 2024 goal, with a significant improvement from 24.57% in 2023 to 41.24% in 2024. Influenza (AISINFL-E) saw a decline in 2024 (44.10%) compared to 2023 (47.17%), falling short of the 49.12% goal. Pneumococcal (AISPNEU-E) showed steady improvement year-over-year but still did not meet the 2024 target. Zoster (AISZOS-E) had modest gains but remains well below the goal, indicating a persistent gap in vaccination uptake.

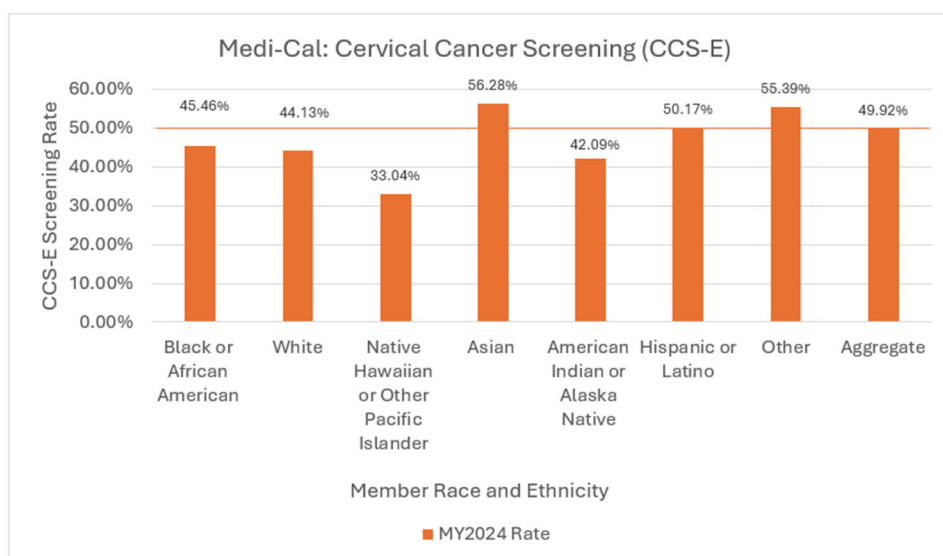
IV. Data Stratification Data Source and Methodology:

Data pulled from claims and encounters using the HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity.

V. Data Stratification Results and Quantitative Analysis:

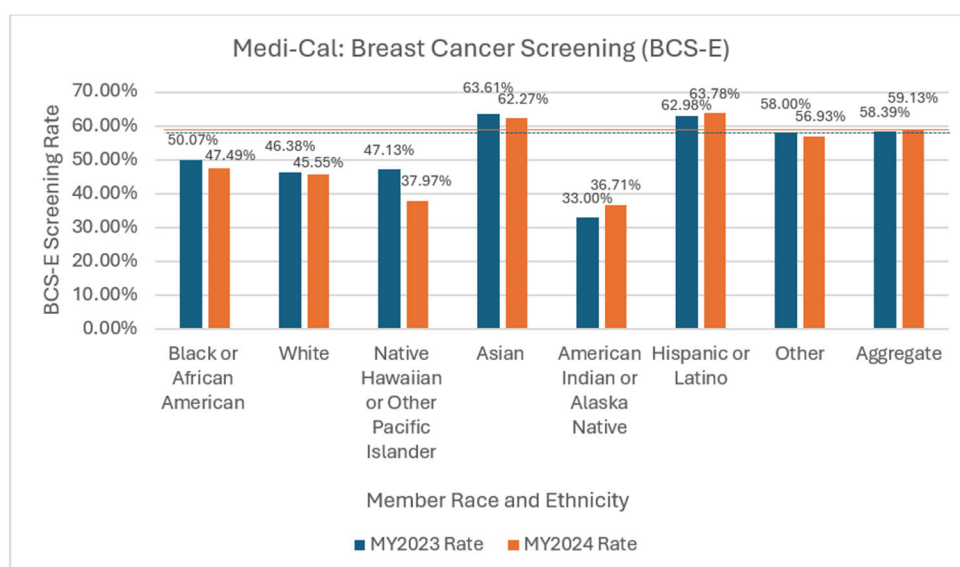
Indicator/Goal: The total or aggregate rate or better

Medi-Cal



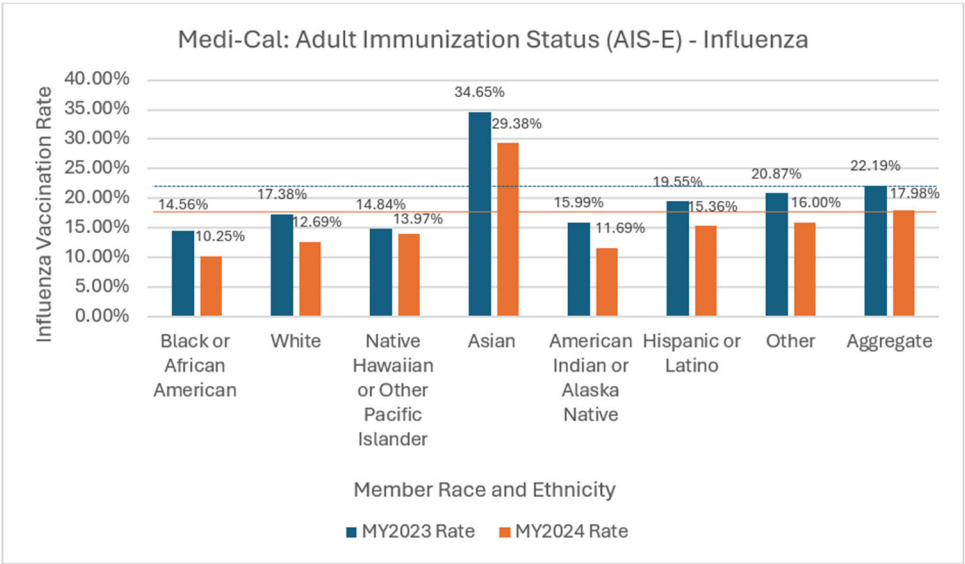
This bar chart shows the percentage of eligible Medi-Cal members who are up to date with cervical cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their cervical cancer screening by the total eligible sample, stratified by race and ethnicity.

The analysis of the stratified data for the Medi-Cal CCS measure indicates differences across various racial and ethnic groups. The overall aggregate of 49.92% for the CCS measure met the MY 2024 MPL. However, disparities are evident when examining the stratified rates. Members identified as Hispanic or Latina, Other, and Asian members show higher rates of cervical cancer screening compared to the aggregate rate, which suggests better access to or utilization of cervical cancer screening services. In contrast, the rates for Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, White and Black or African American members fell below the overall aggregate rate, pointing toward potential obstacles in accessing cervical cancer screening or variations in service delivery that need addressing.



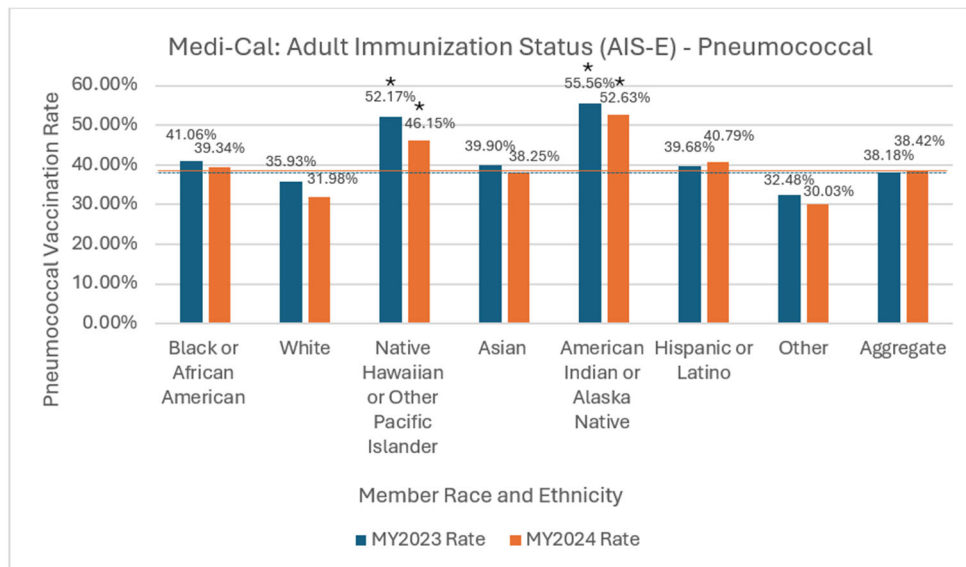
This bar chart shows the percentage of eligible Medi-Cal members who are up to date with breast cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their breast cancer screening by the total eligible population, stratified by race and ethnicity.

The analysis of the stratified data for the Medi-Cal BCS measure indicates differences across various racial and ethnic groups. The overall aggregate of 59.13% for the BCS measure met the MY 2024 MPL. However, disparities are evident when examining the stratified rates. Members identified as Asian and Hispanic or Latino members show higher rates of breast cancer screening compared to the aggregate rate, which suggests better access to or utilization of breast cancer screening services. In contrast, the rates for American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, White, Black or African American, and Other members fell below the overall aggregate rate, pointing toward potential obstacles in accessing breast cancer screening or variations in service delivery that need addressing.



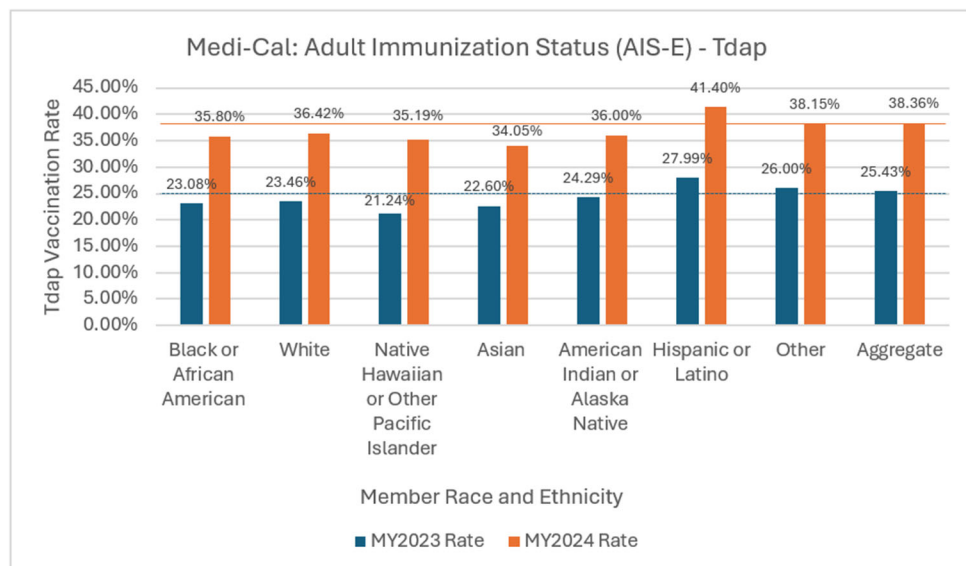
This bar chart displays the percentage of Medi-Cal adult members who received an influenza vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity.

Asian members consistently outperform all other groups, with rates well above the aggregate in both years. All other racial/ethnic groups fall below the aggregate, with Black or African American members showing the lowest rates in both MY 2023 and MY 2024. Overall decline: Every group, including the aggregate, experienced a drop in influenza immunization rates from MY 2023 to MY 2024. Equity gap: The disparity between the highest-performing (Asian) and lowest-performing (Black or African American) groups widened slightly in MY 2024, highlighting a growing equity concern.



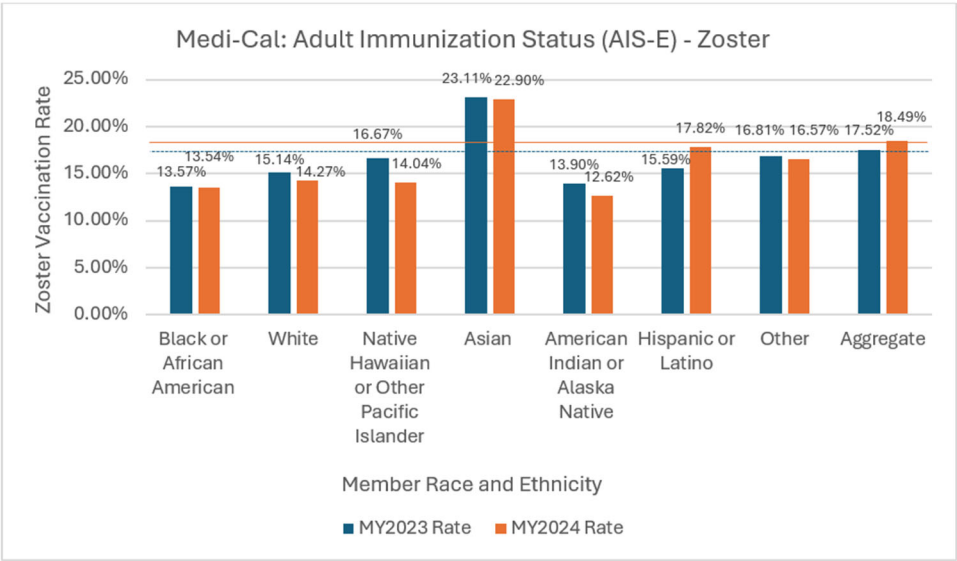
This bar chart displays the percentage of Medi-Cal adult members who received a Pneumococcal vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The top performers based on the AIS Pneumococcal data are American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander groups, which significantly outperformed the aggregate, with rates exceeding it by over 7 and 14 percentage points, respectively. The Hispanic or Latino and Black or African American groups also performed above the aggregate, though by smaller margins. Near aggregate are the Asian members; they were just slightly below the aggregate rate (-0.17 percentage points), indicating near parity. White and Other groups had the lowest rates below the aggregate, falling well below the aggregate by over 6 and 8 percentage points, respectively.



This bar chart displays the percentage of Medi-Cal adult members who received a Tdap vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity.

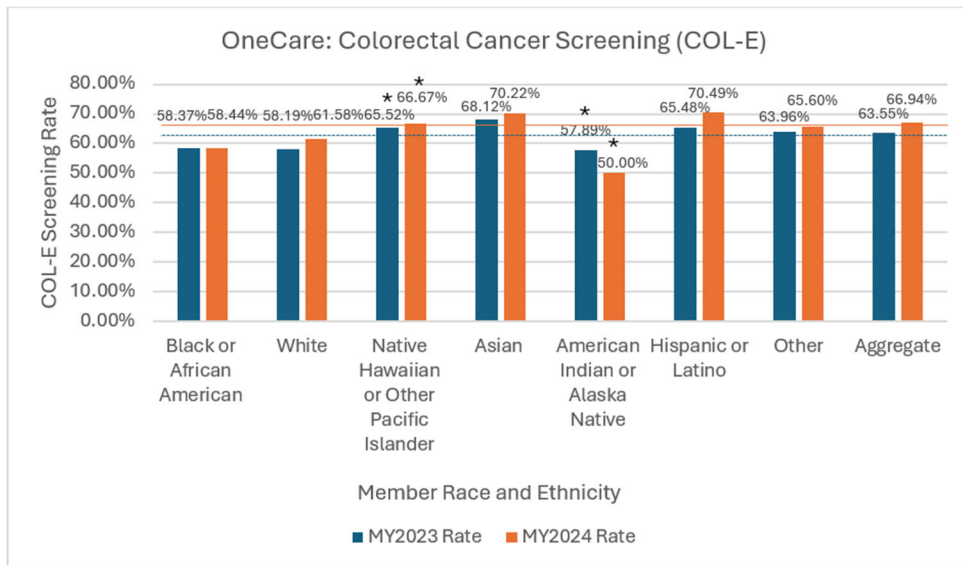
Overall Improvement: All groups showed a substantial increase in rates from MY 2023 to MY 2024, reflecting positive progress in Tdap vaccination rates. Hispanic or Latino consistently outperformed the aggregate in both years, with the highest rates overall (41.40% in MY 2024). The Other racial/ethnic group was slightly above the aggregate in MY 2023 but fell just below it in MY 2024. All other groups remained below the aggregate in both years. Asian and Native Hawaiian or Other Pacific Islander populations had the largest gaps below the aggregate in MY2024 (4.31% and 3.17% below, respectively), indicating potential disparities that may warrant targeted outreach or intervention. Despite overall gains, the persistent gaps between certain racial/ethnic groups and the aggregate suggest a need for continued focus on equitable access and engagement strategies.



This bar chart displays the percentage of Medi-Cal adult members who received a Zoster vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity.

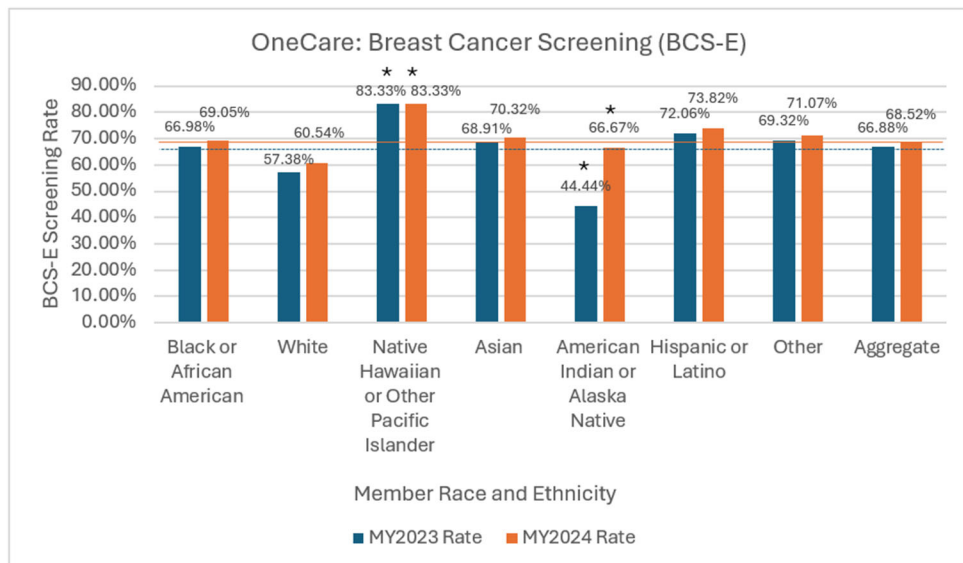
Overall Trend: The aggregate rate increased from 17.52% in MY 2023 to 18.49% in MY 2024, indicating a modest improvement in Zoster vaccination uptake. The Asian group consistently outperformed the aggregate in both years, with the highest rates (22.90% in MY 2024). No other group met or exceeded the aggregate in either year. The American Indian or Alaska Native group had the largest gap in MY 2024 (5.87% below), followed by Black or African American (4.95% below) and White (4.22% below). Native Hawaiian or Other Pacific Islander also saw a notable drop from being close to the aggregate in MY 2023 (0.85% below) to a larger gap in MY 2024 (4.45% below). The widening disparities in MY 2024, especially for American Indian or Alaska Native and Black or African American populations, suggest a need for targeted interventions. The Hispanic or Latino group showed improvement, narrowing the gap to just 0.67% below in MY 2024.

OneCare



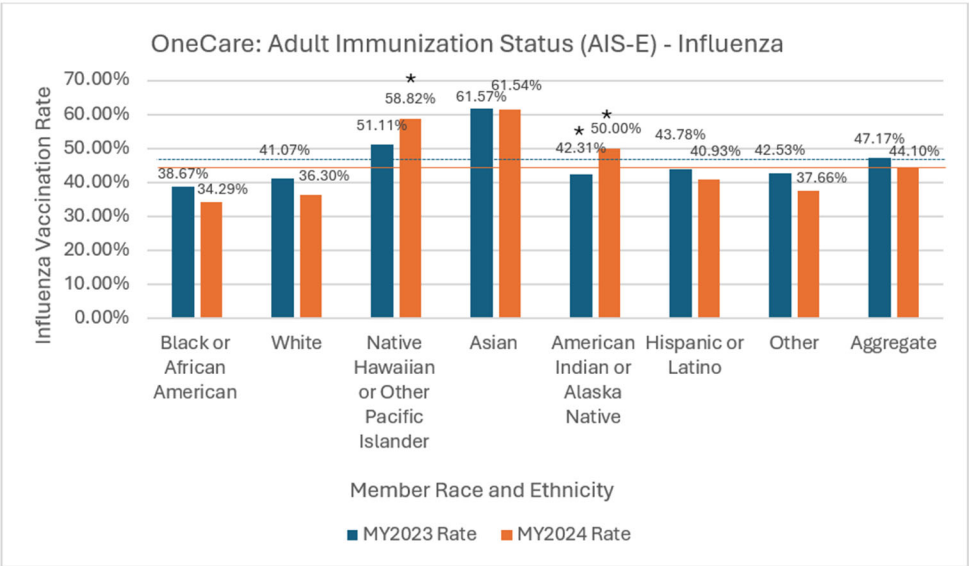
This bar chart shows the percentage of eligible OneCare members who are up to date with colorectal cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their colorectal cancer screening by the total eligible population, stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare COL measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian and Hispanic or Latino show higher rates of colorectal cancer screening compared to the aggregate rate of 66.94%, which suggests better access to or utilization of colorectal cancer screening services. In contrast, the rates for American Indian or Alaska Native, Black or African American, White, Other, and Native Hawaiian or Other Pacific Islander members fell below the overall aggregate rate, pointing toward potential obstacles in accessing colorectal cancer screening or variations in service delivery that need addressing.



This bar chart shows the percentage of eligible OneCare members who are up to date with breast cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their breast cancer screening by the total eligible population, stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare BCS measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Black or African American, Asian, Other, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander members show higher rates of breast cancer screening compared to the aggregate rate of 68.52%, which suggests better access to or utilization of breast cancer screening services. In contrast, the rates for White and American Indian or Alaska Native members fell below the overall aggregate rate, pointing toward potential obstacles in accessing breast cancer screening or variations in service delivery that need addressing.



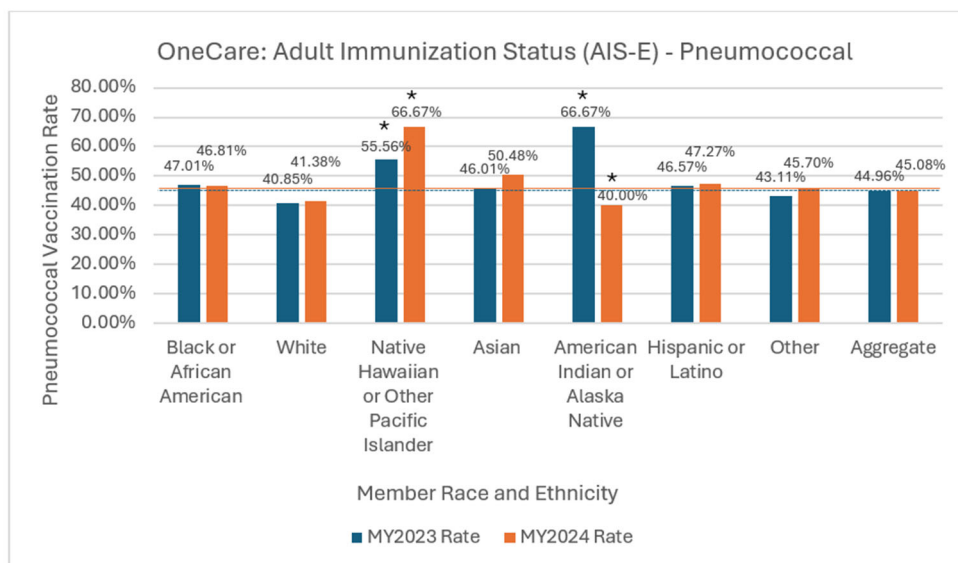
This bar chart displays the percentage of OneCare adult members who received an influenza vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

Overall Trend: The aggregate rate declined slightly from 47.17% in MY 2023 to 44.10% in MY 2024, indicating a modest drop in influenza vaccination uptake across the population.

Above Aggregate: The Asian group consistently had the highest rates, outperforming the aggregate by a wide margin in both years (17.44% above in MY2024). Native Hawaiian or Other Pacific Islander also showed strong performance, improving from 3.94% above the aggregate in MY 2023 to 14.72% above in MY 2024. American Indian or Alaska Native moved from below to above the aggregate, improving by 7.69 percentage points year-over-year.

Below Aggregate: Black or African American and White groups had the largest negative gaps in MY 2024 (9.81% and 7.80% below, respectively), with both showing declines from MY 2023. Other and Hispanic or Latino groups also remained below the aggregate in both years, though the Hispanic or Latino group showed a relatively smaller gap (3.17% below in MY2024).

Equity Consideration: The widening disparities, particularly for Black or African American and White populations, suggest a need for targeted outreach and culturally responsive strategies. The strong performance of Asian and Native Hawaiian or Other Pacific Islander groups may offer insights into effective practices that could be adapted for other populations.



This bar chart displays the percentage of OneCare adult members who received a Pneumococcal vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

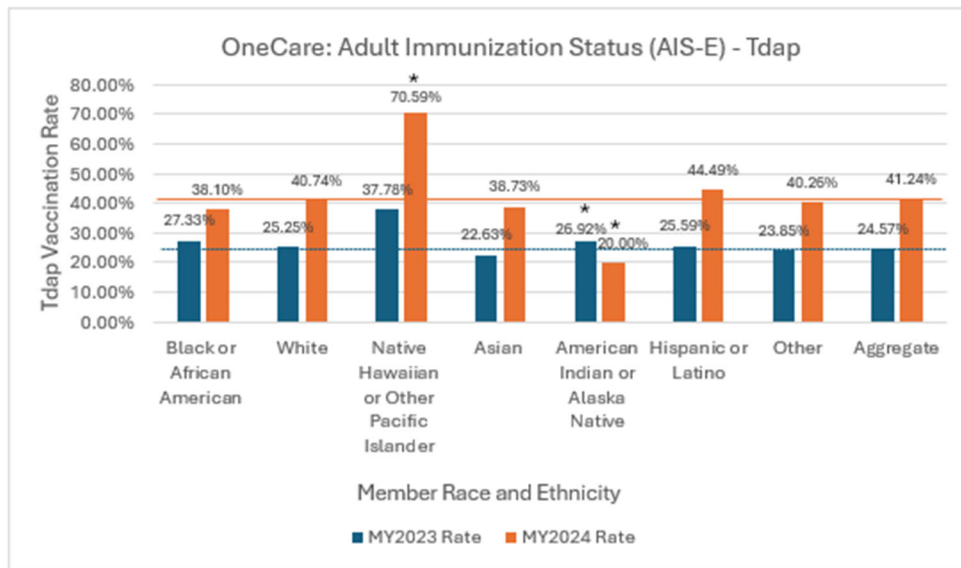
Overall Stability: The aggregate rate remained relatively stable, increasing slightly from 44.96% in MY 2023 to 45.08% in MY 2024.

Top Performers: In MY 2023, American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander groups significantly outperformed the aggregate. In MY 2024, Native Hawaiian or Other Pacific Islander groups showed a dramatic increase (+21.59% above aggregate), becoming the highest-performing group.

Notable Changes: The percentage of American Indian or Alaska Native individuals dropped sharply, from 66.67% to 40.00%, moving from the highest to below the aggregate. Asian and Other groups improved their rates and moved above the aggregate in MY2024.

Consistently Below Aggregate: The White population remained below the aggregate in both years, though it showed a slight improvement.

Equity Considerations: The wide variation in rates across groups, especially the sharp drop for American Indian or Alaska Native and the surge for Native Hawaiian or Other Pacific Islander, suggests a need for targeted quality improvement efforts to ensure more equitable outcomes.



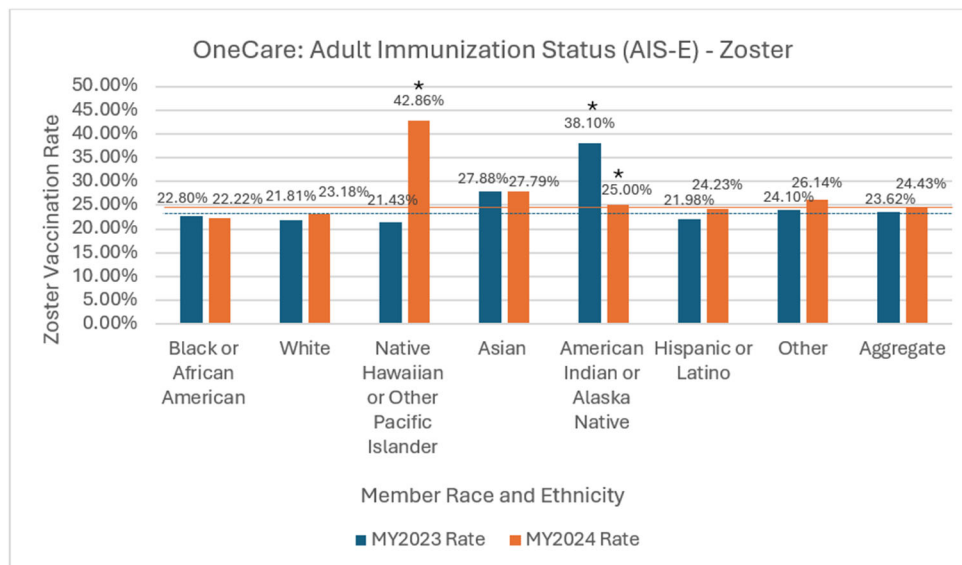
This bar chart displays the percentage of OneCare adult members who received a Tdap vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

Overall Improvement: The aggregate Tdap immunization rate improved significantly from 24.57% in MY2023 to 41.24% in MY2024, a gain of +16.67 percentage points.

Top Performers in MY 2024: Native Hawaiian or Other Pacific Islander showed the most dramatic increase, rising from 37.78% to 70.59%, outperforming the aggregate by +29.35%. Hispanic or Latino also exceeded the aggregate in MY 2024 by +3.25%.

Groups Below Aggregate in MY 2024: American Indian or Alaska Native dropped significantly from 26.92% to 20.00%, now 21.24% below the aggregate. Asian, Black or African American, White, and Other groups all fell slightly below the aggregate, though their rates still improved year-over-year.

Equity Considerations: The disparity between the highest and lowest performing groups widened in MY2024, with a 50.59 percentage point gap between Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native. This suggests a need for targeted outreach or intervention for underperforming groups, particularly American Indian or Alaska Native and Asian populations.



This bar chart displays the percentage of OneCare adult members who received a Zoster vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

Overall Improvement: The aggregate rate increased from 23.62% in MY2023 to 24.43% in MY 2024, indicating a modest overall improvement.

Significant Increase: Native Hawaiian or Other Pacific Islander group saw a dramatic rise from 21.43% to 42.86%, now 18.43 percentage points above the aggregate in MY 2024. This is the most notable shift and may warrant further investigation to ensure data accuracy and program impact.

Reduced Disparities: American Indian or Alaska Native dropped from 38.10% to 25.00%, aligning much more closely with the aggregate in MY 2024 (+0.57%).

Consistently Above Aggregate: Asian and Other groups remained above the aggregate in both years, with Asians showing a consistently strong performance (~+4% in MY 2023 and +3% in MY 2024).

Below Aggregate: Black or African American, White, and Hispanic or Latino groups remained below the aggregate in both years, though the gaps narrowed slightly for White and Hispanic groups in MY 2024.

VI. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Member Health Reward	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CCS, BCS, COL
2. Text Messaging Member Outreach	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CCS, BCS, COL

3. Telephonic Outreach	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CCS, BCS, COL
4. Standing Orders Program (collaboration with PCPs and radiology facilities to schedule members for screening mammography without needing a PCP visit first)	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS
5. Gap-in-Care Reporting	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CCS, BCS, COL
6. Cologuard	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	COL

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Gap-in-Care Reporting	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	AIS
2. Text Messaging Member Outreach	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AIS
3. IVR Member Outreach	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AIS
4. Email Member Outreach	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AIS

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VII. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY2024 September Prospective Rate	MY2025 September Prospective Rate
CCS-E	MC: Cervical Cancer Screening	43.16%	50.19%
COL-E	OC: Colorectal Cancer Screening	58.38%	65.02%
BCS-E	MC: Breast Cancer Screening for 42-74 years of age	49.07%	53.72%
BCS-E	OC: Breast Cancer Screening for 42-74 years of age	61.79%	65.75%
AISINFL-E	MC: Influenza (Total)	14.14%	17.92%
AISINFL-E	OC: Influenza (Total)	39.28%	42.38%

AISPNEU-E	MC: Pneumococcal (66+)	31.77%	50.91%
AISPNEU-E	OC: Pneumococcal (66+)	39.71%	64.23%
AISTD-E	MC: Tdap (Total)	19.92%	40.32%
AISTD-E	OC: Tdap (Total)	22.62%	45.69%
AISZOS-E	MC: Zoster (Total)	12.93%	17.60%
AISZOS-E	OC: Zoster (Total)	19.05%	22.23%

Indicator/Goal: The performance rate from the same month of the previous year

Cancer Screenings:

As of September 2025:

- The MC Cervical Cancer Screening prospective rate was 50.19%, which is 7.03 percentage points higher than the September 2024 prospective rate of 43.16%.
- The OC Colorectal Cancer Screening prospective rate was 65.02%, which is 6.64 percentage points higher than the September 2024 prospective rate of 58.38%.
- The MC Breast Cancer Screening prospective rate was 53.72%, which is 4.65 percentage points higher than the September 2024 prospective rate of 49.07%.
- The OC Breast Cancer Screening prospective rate was 65.75%, which is 3.96 percentage points higher than the September 2024 prospective rate of 61.79%.

AIS:

Strong Projected Improvements:

- All measures show positive growth from MY 2024 to MY 2025.
- The most significant gains are projected in:
 - OC Pneumococcal (66+): +24.52 percentage points
 - OC Tdap (Total): +23.07 percentage points
 - MC Tdap (Total): +20.40 percentage points

Moderate Gains:

- Influenza and Zoster measures show more modest improvements, especially in the Medi-Cal population.

OneCare Outperforms MC:

- Across all measures, OneCare rates are consistently higher than Medi-Cal (MC), both in MY 2024 and MY 2025 projections.

Focus Areas:

- Despite improvements, MC Influenza and MC Zoster remain relatively low and may require targeted outreach or intervention to close the gap.

Qualitative Analysis:

Causal/Barrier Analysis:

- Members did not visit their PCP during MY 2025, so they were not educated or reminded of the cancer screenings they were due for.
- Members may not complete their cancer screening because of discomfort associated with the procedure and/or fear of knowing the test results.
- Members may not be aware of the importance of cancer screening and/or the frequency of screening, especially after having a previous screening with a negative result.
- Appointment access could be limited due to scheduling limitations and/or staff shortage, resulting in long wait times.
- Due to a data lag of approximately 90 days, the September 2025 prospective rate may not provide the most accurate rate of completion of cancer screening measures.
- Members may have vaccine hesitancy or have access issues during the flu season.
- Member education on vaccines and access for older adults.
- Digital literacy may influence disparities.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Member Outreach: Use of disparity analysis to develop targeted interventions.	Bidirectional SMS campaign and email development via digital messaging vendor Ushur. Telephonic outreach via vendor Carenet and internal resources. Adult preventative care mailing.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	CCS, BCS, COL, AIS
Access	Continue at-home screening programs, such as Cologuard, and explore FIT kit testing through labs and other vendors. Continue collaboration with the Medical Management department to offer members mobile mammography services.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	BCS, COL
Training and Education	Provider outreach to provide HEDIS cancer screening training and education, as well as information related to vaccines. Partnership with radiology facilities for BCS, member outreach and scheduling.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	CCS, BCS, COL, AIS
Grant Programs	Issuance of quality improvement grants to health networks that will focus on CCS, BCS and COL.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M	CCS, BCS, COL

				☐ L	
Data Optimization	The Cozeva data bridge will enable bidirectional data exchange with health network partners and facilitate the timelier identification of members due for screening.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	CCS, BCS, COL
Member Health Reward	Continue existing member health rewards and expansion of colorectal cancer screening rewards to include all screening options.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☐ M ☒ L	CCS, BCS, COL
Pay for Value Program	Continue performance-based incentives to prioritize and encourage completion of cancer screenings.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	CCS, BCS, COL
Strengthening seasonal outreach campaigns	Continue vaccine-related member outreach mailers, SMS, IVR and email campaigns	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L	AIS

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

Although we did not meet the internal CalOptima Health goal for the cancer screening measures, we did reach the MPL for the Medi-Cal measures and the 3-Star cut point for the OneCare Stars measures. Breast and colorectal cancer screening measures will continue to be an area of focus in the 2026 QIHETP work plan. Regarding adult vaccinations, while the Tdap measure (AISTD-E) exceeded its 2024 goal with a notable improvement, other vaccines — Influenza, Pneumococcal, and Zoster — fell short of their targets despite some year-over-year gains and will remain on the QIHETP work plan for 2026. Accordingly, CalOptima Health will continue to focus on preventative care screenings and vaccination through the completion of multiple interventions as listed above.

4.7 CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	
Author(s): Tommy, Nguyen	Department(s): Medical Management
Responsible Party(ies): Dr. Richard Pitts (Chief Medical Officer); Tommy Nguyen (Program Manager, Medical Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer, and report key findings and/or activities, analyze barriers, and improvement efforts.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

In December 2022, the CalOptima Health Board reallocated up to \$50.1 million over five years for the Comprehensive Community Cancer Screening and Support Program. The program aims to reduce late-stage cancer diagnoses, enhance early detection through better awareness and access, and improve quality and member experience during cancer screening and treatment for Medi-Cal members.

In February 2024, following stakeholder input, data analysis, and a research review, CalOptima Health staff proposed five program initiatives: community grants, the Orange County Cancer Screening and Support Collaborative, vendor contracts to support the member journey, program research and evaluation, and internal program support. These initiatives were approved by the Board. Because they were estimated to cost \$44.7 million and utilize the remaining program funds, the initiatives were later consolidated into four due to overlaps: awareness and education campaign, community grants, program research and evaluation, and internal program support.

II. Data Sources and Methodology:

Screening goals (benchmarks) are cumulative from January 1, 2025, to December 31, 2026 (covering the two-year grant period) based on HEDIS goals. The latest screening data, reported by each grantee in their progress report for January 1 to August 31, 2025, are specific to CalOptima Health members.

III. Quantitative Analysis:

FQHC Community Grants (Medi-Cal)

FQHCs	Community Grant	Cervical Cancer Screenings Conducted	Breast Cancer Screenings Conducted	Colorectal Cancer Screenings Conducted	Lung Cancer Screenings Conducted
Share Ourselves	Goal	988	422	495	24% screened
	Current	2340	941	1664	N/A
Laguna Beach Community Clinic	Goal	311	7	346	N/A
	Current	406	32	337	N/A
AltaMed Health	Goal	4717	N/A	N/A	3% increase from baseline
	Current	2097	N/A	N/A	N/A
Families Together of OC	Goal	1108	145	846	N/A
	Current	1032	397	693	N/A
UCI Family Health Center	Goal	2666	464	1002	N/A
	Current	500	481	3165	N/A
Hurtt Family Clinic	Goal	478	167	474	90% of all adolescents
	Current	206	70	202	N/A
Korean Community Services	Goal	606	870	1210	N/A
	Current	992	1160	1851	345
Families Together of OC	Goal	1108	145	846	N/A
	Current	1032	397	693	N/A
Friends of Family Health Center	Goal	217	529	252	N/A
	Current	356	456	292	N/A
Celebrating Life Community Health Center	Goal	1176	404	716	25% increase from baseline
	Current	3410	1113	1819	N/A

The number of screenings conducted by each FQHC Community Grant has increased monthly.

Screenings for cervical, breast, and colorectal cancers have met or surpassed program goals, reflecting strong outreach and engagement. Lung cancer screening, not part of current HEDIS measures, remains a focus as community grantees establish baselines in Year 1 and aim for improvement in Year 2.

Indicator/Goal: Achieving the overall or aggregate rate or higher.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Added a six-month no-cost extension to the grant program and increased frequency of payments.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A
Increased frequency of payments and decreased the number of reports to sync with the calendar year.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	N/A
Direct mailers for cancer screening campaigns with Maricich.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS-E, CCS, COL
Included an additional two-week follow-up text message for all cancer screening text campaigns to capture “DONE” responses.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS-E, CCS, COL
Included additional automatic response within all cancer screening text campaigns for member health rewards.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS-E, CCS, COL
Updated Alinea Amendment to reflect clarified mammogram result delivery TAT from seven days to 14 days.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS-E
Coordinated mobile mammography events with health clinics and Alinea.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS-E
1:1 meetings with grantees to capture the total number of cancers detected and their stages.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS-E, CCS, COL
Developed Cancer Screening Dashboard to support tracking HEDIS rates and prospective rates across all FQHC community grants.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete	BCS-E, CCS, COL

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Prospective Rates

Community Grant	Acronym	Measure	MY 2022 Prospective Rate (Baseline)	MY 2025 Prospective Rate (February)	MY 2025 Prospective Rate (September)
AltaMed FQ	CCS	Cervical Cancer Screening	65%	50.3%	55.7%
Celebrating Life	BCS-E	Breast Cancer Screening	51.7%	38.7%	41.6%
	CCS	Cervical Cancer Screening	50.7%	42.0%	46.4%
	COL	Colorectal Cancer Screening	35.2%	30.7%	34.0%

Friends of Family	BCS-E	Breast Cancer Screening	52.9%	40.0%	45.8%
	CCS	Cervical Cancer Screening	44.0%	35.2%	40.3%
	COL	Colorectal Cancer Screening	29.8%	24.7%	32.6%
Families Together of OC	BCS-E	Breast Cancer Screening	38.2%	43.8%	45.3%
	CCS	Cervical Cancer Screening	45.9%	39.9%	44.4%
	COL	Colorectal Cancer Screening	30.0%	24.8%	30.4%
Hurt Family Clinic	BCS-E	Breast Cancer Screening	39.0%	36.2%	35.5%
	CCS	Cervical Cancer Screening	31.0%	31.2%	36.0%
	COL	Colorectal Cancer Screening	24.0%	21.2%	28.2%
Korean Community Services	BCS-E	Breast Cancer Screening	60.0%	44.7%	48.6%
	CCS	Cervical Cancer Screening	42.1%	40.3%	44.3%
	COL	Colorectal Cancer Screening	39.3%	38.2%	42.8%
Laguna Beach Community Clinic	BCS-E	Breast Cancer Screening	30.0%	38.3%	43.1%
	CCS	Cervical Cancer Screening	55.8%	38.2%	45.1%
	COL	Colorectal Cancer Screening	58.0%	34.8%	41.3%
Share Ourselves	BCS-E	Breast Cancer Screening	47.5%	40.8%	42.4%
	CCS	Cervical Cancer Screening	47.9%	35.4%	40.2%
	COL	Colorectal Cancer Screening	32.0%	26.5%	33.8%
UCI Family Health Center	BCS-E	Breast Cancer Screening	54.3%	45.4%	48.7%
	CCS	Cervical Cancer Screening	54.4%	44.3%	52.9%
	COL	Colorectal Cancer Screening	34.5%	36.6%	41.1%

Indicator/Goal: Use the MY 2022 performance rate as the baseline and track progress with February and September MY 2025 data.

Based on the latest MY2025 Prospective Rates for September, overall cancer screening performance across FQHC grantees shows improvement compared to the February MY 2025 Prospective Rate.

- Although there are minor monthly fluctuations, most FQHC community grants experienced up to a 5% increase, with Hurt Family averaging a <1% decline in Breast Cancer Screening.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Challenges were identified in data reporting during the amendment process, particularly in using HEDIS metrics to assess success. Addressed the challenge by adding a volume of screenings as one of the metrics.
- The workgroup continued refining the scope of work for the research and evaluation initiative to objectively evaluate the effectiveness of the cancer screening program in increasing screening rates and awareness, while identifying opportunities for improvement. More updates on this initiative will follow in 2026 as we approach the conclusion of the community grant program.
- Grantees reported that members were not attending their screening appointments due to the current political climate and fear.
- Developing a more accurate member eligibility criteria for lung cancer screening text campaigns, since it is not one of the HEDIS measures within the HEDIS engine.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address higher priority areas first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Development of tailored messaging and strategy across cancer screening campaigns to enhance behavior changes and increase screening rates.	Review and revise campaigns to ensure accurate resources and information are shared, specifically for the cancer treatment campaign.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☐ M ☒ L	BCS-E, CCS, COL
More accurate member eligibility criteria for cancer screenings	Work closely with the Coding and ITS team to ensure that the logic used for member eligibility is accurately reviewed.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☐ M ☒ L	BCS-E, CCS, COL
Support grantees in capturing cancer discoveries and their stages	Collaborate with community partnerships like UCI Chao Family and other grantees, like Laguna Beach, to share best practices. Develop a standardized process for documenting and reporting this data	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	BCS-E, CCS, COL
Member success impact story for communication	Development of a standard communications-focused template	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	BCS-E, CCS, COL
Improvement of tracking and monitoring abnormal mammogram results identified through Alinea and health clinics to close the loop	Collaborate with Alinea to develop a follow-up tracking process between the health clinics.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	BCS-E
Target clinics with high-volume non-compliant breast cancer screening rates for Alinea services	Identify clinics with high-volume non-compliant breast cancer screening rates.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L	BCS-E

	Collaborate with QI to reach out to these clinics and coordinate mobile mammogram events.				
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MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Although the Comprehensive Community Cancer Screening and Support Program is approved until 2027, this year's efforts show significant progress in promoting cancer screening awareness and improving rates. The community grant initiative funding has enabled grantees to hire additional resources, develop targeted cancer screening efforts, and enhance processes that improve overall cancer screening rates among CalOptima Health members and the community. While the FQHC Community Grants have not yet met their overall program HEDIS measure goals and these cancer screening measures will remain on the QIHETP work plan for 2026, their progress reports indicate they have exceeded benchmarks and are on track to meet their proposed goals by the end of 2027.

The Internal Program Support initiative continues to show gradual improvements, ensuring mobile mammogram services are offered to CHCN members. We have doubled the total number of screenings from the previous fiscal year and aim to continue improving processes and outreach.

There are opportunities to enhance collaboration with the UCI Chao Family Comprehensive Center. Although we have not met the launch goals for this initiative, it remains a focus for the upcoming year.

4.8 Maternal and Child Health: Prenatal and Postpartum Services	
Author(s): Leslie Vasquez	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Leslie Vasquez (Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Timely prenatal care is essential to improving maternal and infant health outcomes. Inadequate prenatal care increases the risk of adverse birth outcomes and is a high-risk factor for neonatal complications and death. Postpartum care is equally important for the health of mothers and infants, addressing issues such as fatigue, pain, breastfeeding difficulties, mental health disorders, and social concerns.

HEDIS, particularly the measures in the reproductive health domain, are aligned with care recommended by the American College of Obstetrics and Gynecology (ACOG) and the AAP.

CalOptima Health assessed the following for deliveries on or between October 8 of the year prior to October 7 of the current measurement year:

1. Timeliness of Prenatal Care (TOPC): The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.

2. Postpartum Care (PPC): The percentage of deliveries that received a postpartum care visit on or between seven and 84 days (one to 12 weeks) after delivery.

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, CitiusTech. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the MY 2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
TOPC	Timeliness of Prenatal Care	88.08%	88.08%	88.15%	88.58%	☐ Y ☒ N
PPC	Postpartum Care	81.15%	80.00%	81.11%	80.23%	☒ Y ☐ N

- Prenatal care has remained stable with a slight improvement in MY 2024 (+0.07 percentage points), but it still falls short of the 2024 goal by 0.43 points. The measure did meet the MPL of 84.55% by 3.60%.
- Postpartum care dipped in MY 2023 but rebounded in MY 2024, now exceeding the 2024 goal by 0.88 points. Additionally, the measure met the MPL goal of 81.1%.
- While both prenatal and postpartum care met the MPL, performance was met by a margin of less than 5% indicating a potential risk of falling below compliance in future years.

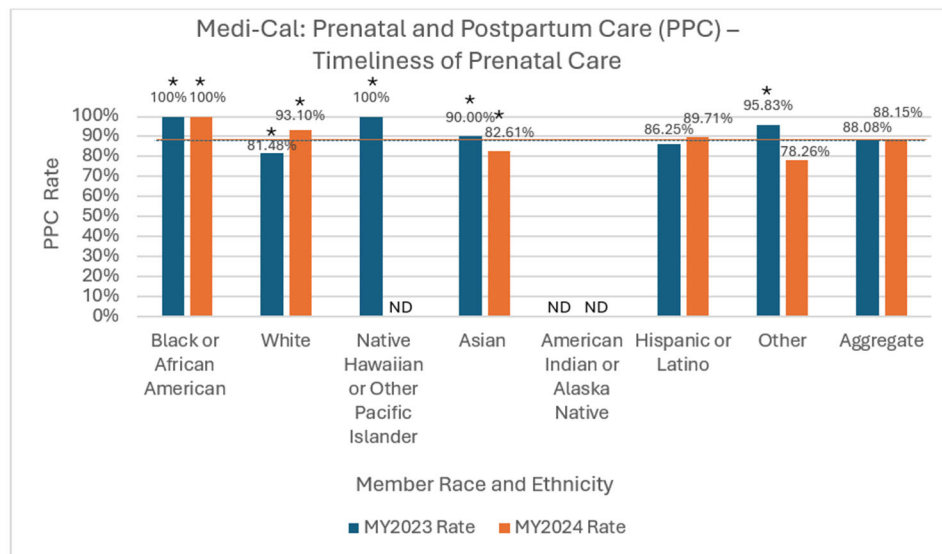
IV. Data Stratification Data Source and Methodology:

Data pulled from claims and encounters using HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity.

V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Medi-Cal

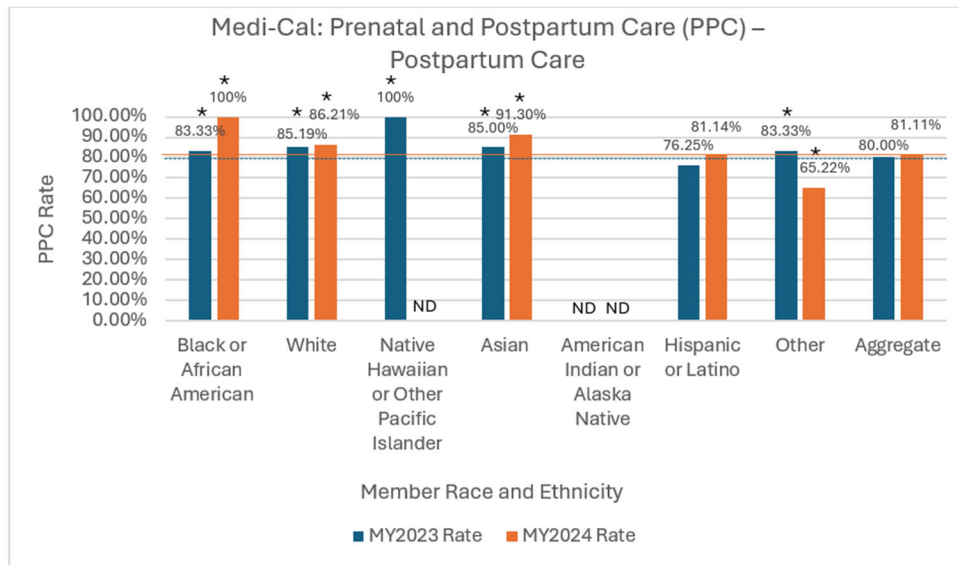


The bar chart displays the percentage of deliveries by Medi-Cal members who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in CalOptima Health. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The following analysis compares prenatal care hybrid rates for MY 2023 and MY 2024, based on a sample of 411 members.

Note: Hybrid rates reflect a small sample of the measured population, not overall care trends.

- Highest Improvement: White group increased by +11.62 percentage points (from 81.48% to 93.10%).
- Largest Decline: Other group decreased by –17.57 percentage points (from 95.83% to 78.26%).
- Stable Performance: Black or African American group maintained a perfect 100% rate in both years.
- Aggregate Rate (overall): Slight increase from 88.08% to 88.15% (+0.07 percentage points), indicating overall stability.
- The groups that performed below the MY 2024 MPL of 84.55% include: Asian and Other.



The bar chart displays the percentage of deliveries that had a post-partum visit on or between seven and 84 days after delivery for Medi-Cal members. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The following analysis compares postpartum care hybrid rates for MY 2023 and MY 2024, based on a sample of 411 members.

Note: Hybrid rates reflect a small sample of the measured population, not overall care trends.

- Highest Improvement: The Black or African American group saw the largest increase by +16.67 percentage points, reaching 100%.
- Largest Decline: Other group decreased by –18.11 percentage points.
- Aggregate Rate (overall): Slight increase from 88.08% to 88.11%.
- The Other group performed below the MY 2024 MPL of 81.1%.

VI. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Transitions of Care Initiative — Outreach to identified CHCN members that delivered to offer support post-delivery and coordination of care, where needed.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PPC
CalOptima Health's Maternal Health Program provides personalized physical and emotional support during pregnancy and up to one year postpartum.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	TOPC, PPC
Postpartum Care Call Campaign — To ensure postpartum care, remind members of the importance of well-child visits, and coordinate appointments as needed.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PPC, W30

Enhanced Member Detail Reporting (monthly) - HEDIS engine-generated reports now identify the due date for timely care.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PPC
Postpartum health reward	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PPC
Radio ads encouraging prenatal and postpartum care	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	TOPC, PPC
Maternal Health Workgroup	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete	TOPC, PPC
P4V Program	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	TOPC, PPC
Doula Integration at CalOptima Health	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	TOPC, PPC
Partnership with HCA to reach out to ECM Birth Equity-eligible members and refer them to programs like Black Infant Health, doula benefits and CalAIM.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	TOPC, PPC

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VII. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY2024 September Prospective Rate	MY2025 September Prospective Rate
PPC	MC: Timeliness of Prenatal Care	67.39%	81.84%
PPC	MC: Postpartum Care	67.15%	68.77%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing current September 2025 performance against the same time last year:

- Timeliness of Prenatal Care saw a significant improvement of +14.45 percentage points, indicating better early engagement with prenatal services.
- Postpartum Care experienced a slight increase of 1.62 percentage points, indicating an improvement in members receiving timely postpartum care.

Postpartum Care Call Campaign Effectiveness

- A total of 10 members were identified as non-compliant for recommended postpartum care. The team successfully reached 66 members (36.7%).
- Five out of 66 members, 7.6%, reported no postpartum visit and cited scheduling conflicts or perception that the visit was not important. Three out of the five members accepted appointment coordination for postpartum care.
- 61 out of 66 members, 92.44%, reported the completion of a postpartum visit, highlighting the delays in data and the need for timelier outreach.
- There is still a large segment of members that are unreachable through telephonic outreach.
- Overall, members responded positively to the call, which also included reminders of well-child visits and recommended cadence.

Doula Integration at CalOptima Health Effectiveness

- Total of 19 contracted doulas; 18 are contracted with CHCN.
- In MY 2024, there was a total of 41 unique members who utilized doula services. Current data for MY 2025 indicate an increase in services, with 94 unique members utilizing doula services.

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

- Challenges persist in the identification of members who have delivered. Outreach efforts often occur after members have already completed care, making interventions reactive rather than proactive.
- The completion rate of prenatal and postpartum care is lowest amongst members who are 18 years of age or younger. Younger birthing populations are likely to face greater barriers (e.g., complications, transportation access issues). Inadequate care can lead to poorer developmental outcomes for infants.
- Doulas are positioned as a key strategy to improve prenatal and postpartum care rates, especially for Black and Native American members. Doulas support culturally appropriate outreach and can integrate with programs like Black Infant Health and ECM. Currently, there is a limited volume of members who are actively utilizing doula services.
- Lack of data to support identification of low-performing versus high-performing OB/GYN providers.

IX. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)

1. Enhance member multimodal communication	Launch culturally tailored outreach campaigns across various modalities	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	TOPC, PPC
2. Data bridge to support bidirectional exchange of data with health network partners and enhance timelier identification of members due for care	Cozeva data bridge	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	TOPC, PPC
3. Increase access to and utilization of doula services among Medi-Cal members	Integrate doula notes into PCP electronic health record systems (EHRs) for shared planning Enhance self-referral modalities for doula access Increase provider awareness of doula benefits	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC
4. Offer quality incentives for OBs tied to prenatal delivery and postpartum care	Infrastructure to support OB to PCP transitions and share data	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC
5. Implement a broader promotion strategy for postpartum health rewards	Include a health reward for prenatal care	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC
6. Enhanced reporting to proactively identify and monitor status of perinatal members	Create and implement a comprehensive maternal health report to identify pregnant members and their risk level to support programmatic approaches and interventions.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC
7. Continue internal maternal health workgroup to ensure alignment of initiatives across the organization.	Identify cross departmental strategies to improve maternal and infant outcomes. Interventions will vary depending on group and data review.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC
8. Targeted intervention for identified at risk populations	Will vary depending on group	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	TOPC, PPC

MC = Medi-Cal; OC = OneCare

X. Conclusion:

- Targeted member engagement and outreach campaigns continue to be a need to ensure that messages about recommended care are delivered. A tiered approach that includes alternative outreach modalities in case of unsuccessful communication is recommended.
- Explore the addition of a specialty incentive program for OB/GYN providers.
- While prenatal and postpartum care is meeting MPLs, there's a need to reassess contributing factors to performance as rates have remained stagnant.

- While trends indicate overall improvement in performance when compared to the same time last year, there are various groups that are performing lower than other groups, the aggregate rate or MPL. This reflects an opportunity to develop strategies tailored to these groups.
- There are opportunities to align with OB/GYN providers and prioritize OB partnerships in areas with low TOPC or PPC rates.
- While PPC did meet goal, both measures will remain on the QIHETP work plan for 2026.

4.9 Maternal and Child Health: Prenatal and Postpartum Depression Screening	
Author(s): Ann Mino	Department(s): Medical Management
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Ann Mino (Sr Manager, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Perinatal depression remains one of the most common complications of pregnancy and is a leading contributor to poor maternal and infant outcomes. Early screening and timely follow-up are essential to ensure that members receive appropriate behavioral health support during a critical period of transition. Untreated depression during pregnancy and the postpartum period can increase the risk of poor self-care, inadequate nutrition, substance use, preterm birth and impaired parent/infant bonding. The HEDIS measures for prenatal and postpartum depression screening and follow-up aim to ensure that depression is identified early and managed through coordinated, member-centered care.

CalOptima Health promotes whole-person care that integrates physical and behavioral health needs to best support each member's individual needs. This is demonstrated by integrating depression screenings and follow-up processes into routine prenatal care and telephonic support programs, thereby strengthening collaboration among providers, behavioral health providers, community partners and managed care organizations.

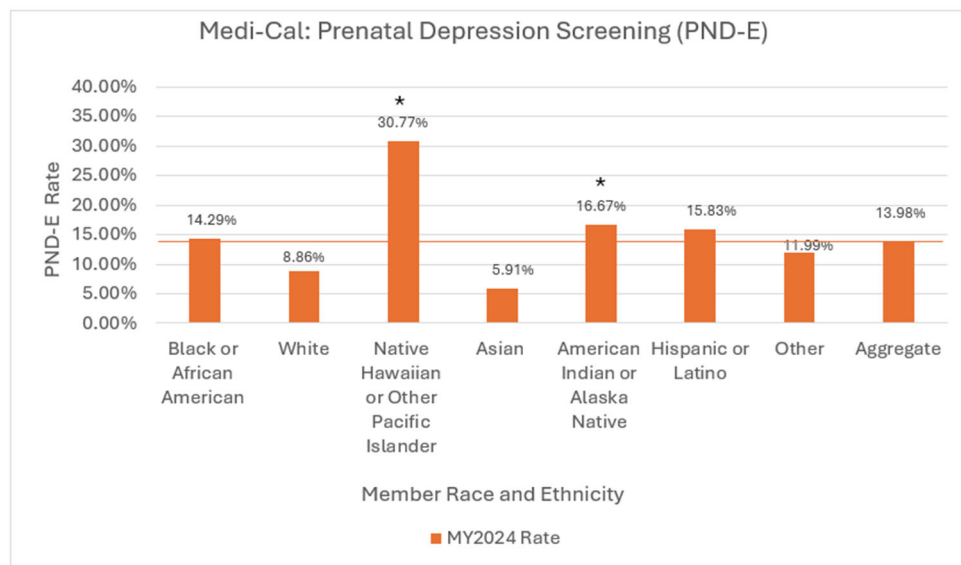
II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, CitiusTech. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the MY 2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

III. Quantitative Analysis:

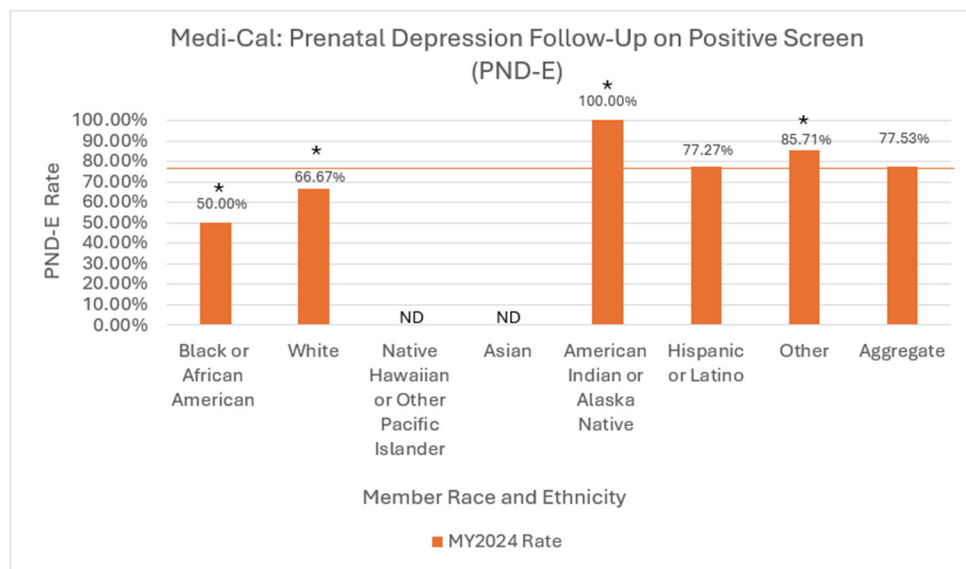
Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
PND-E	Prenatal Depression Screening	8.73%	14.52%	13.98%	16.03%	☐ Y ☒ N
PND-E	Prenatal Follow-Up on Positive Screen	45.16%	52.80%	77.53%	53.33%	☒ Y ☐ N
PDS-E	Postpartum Depression Screening	8.08%	17.33%	9.24%	29.84%	☐ Y ☒ N
PDS-E	Postpartum Follow-Up on Positive Screen	62.96%	56.84%	87.14%	61.70%	☒ Y ☐ N



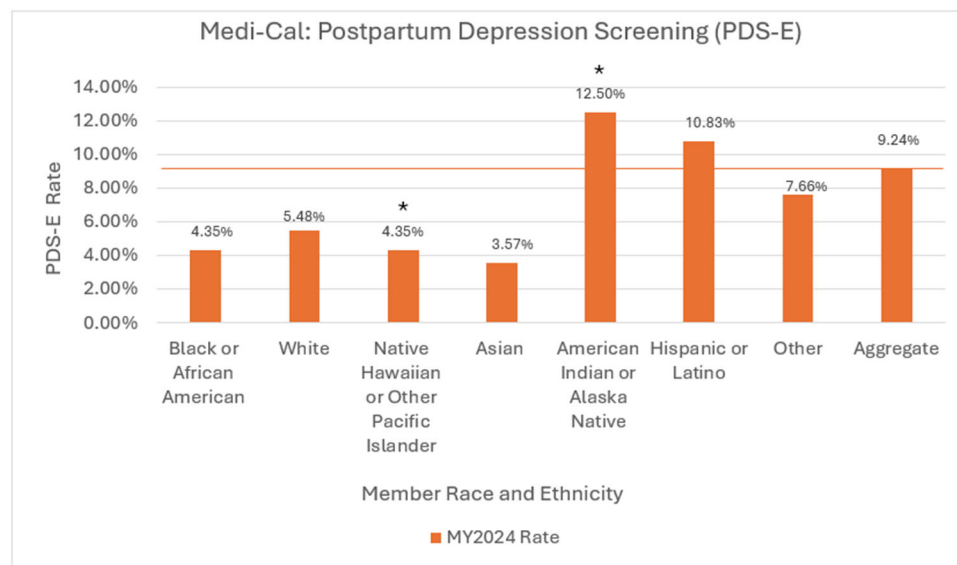
This bar chart shows the percentage of deliveries in which Medi-Cal members were screened for clinical depression using a standardized instrument during pregnancy, based on HEDIS specification. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The Medi-Cal PND-E data for MY 2024 shows significant variation in screening rates across racial and ethnic groups. The overall screening rate was 13.96%, with Native Hawaiian or other Pacific Islanders members having the highest rate at 30.77% and Asian members the lowest at 5.19%. Black or African American, American Indian or Alaska Native, and Hispanic or Latino members were slightly above the aggregate average, while White and Other groups fell below it. These disparities highlight the need for targeted outreach, culturally responsive care and improved integration of depression screening into all prenatal visits.



This bar chart shows the percentage of deliveries in which Medi-Cal members received follow-up care within 30 days of a positive depression screen finding, based on HEDIS specification. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

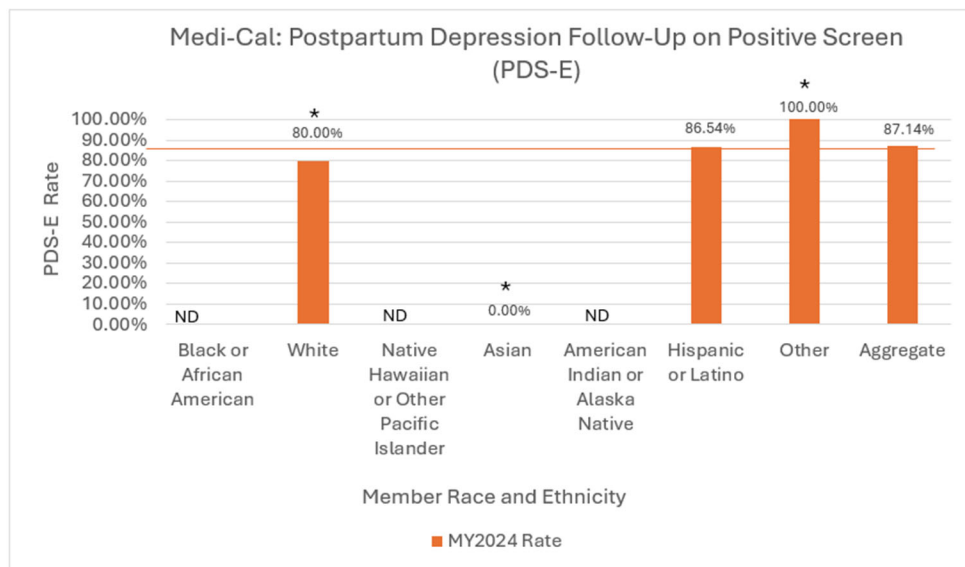
The Medi-Cal PND-E data for MY 2024 shows generally strong follow-up rates among members who screened positive for depression, though some variations exist by race and ethnicity. Follow-up rates ranged from 50.00% for Black or African American members to 100% among both American Indian or Alaska Native members. Hispanic or Latino members were just below the aggregate at 77.27%, while 66.67% of White members received follow-up care.



This bar chart shows the percentage of deliveries in which Medi-Cal members were screened for clinical depression using a standardized instrument during the postpartum period, based on HEDIS specification. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The Medi-Cal PDS-E data for MY 2024 shows significant variation in screening rates across racial and ethnic groups. The overall screening rate was 9.24%, with American Indian or Alaska Native members

having the highest rate at 12.50%, and Asian members the lowest at 3.57%. The Black or African American, White, Native Hawaiian or Other Pacific Islanders, Asian, and Other groups fell below the aggregate rates.



This bar chart shows the percentage of deliveries in which Medi-Cal members received follow-up care within 30 days of a positive depression screen finding, based on HEDIS specification. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The Medi-Cal PNS-E data for MY 2024 shows generally strong follow-up rates among members who screened positive for depression, though some variations exist by race and ethnicity. Follow-up rates ranged from 80.00% for White members to 100% among the Other group. Hispanic or Latino members were just below the aggregate at 86.54%. However, the available data has limited information for the Black or African American, Native Hawaiian or Other Pacific Islander, Asian, and American Indian or Alaska Native groups. This barrier may skew the results due to the unavailable data for four ethnic groups.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
CalOptima Health's Maternal Health Program telephonically outreached to identified pregnant and postpartum members. Assessments include PHQ-2, and when appropriate, the Edinburgh screening is done.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PND-E, PDS-E
CalOptima Health sponsors community partners and contracted providers to participate in an eight-week series for perinatal mental health training.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PND-E, PDS-E
CalOptima Health created a perinatal mental health resource flyer targeted for the perinatal population.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PND-E, PDS-E

The Community Impact Team attended community events to promote maternal mental health and screen members, as appropriate.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PND-E, PDS-E
CalOptima Health participates in the Family Wellness Plan/ Plans of Safe Care Orange County collaborative.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☒ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PND-E, PDS-E

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

To support improvement in prenatal and postpartum depression screening and follow-up rates, several targeted interventions were implemented across both the member and provider levels. These interventions demonstrated measurable progress in identifying members, enhancing provider capacity and strengthening community collaboration to address maternal mental health needs.

Telephonic outreach was conducted to identify and engage members who were pregnant or had recently delivered, with a focus on connecting them to prenatal and postpartum visits that included depression screening. Through this outreach, 1,167 unique members were successfully contacted, and at-risk identified members were connected to behavioral health or provided behavioral health information. This intervention allowed care managers to close care gaps, reinforce the importance of perinatal mental health and improve timely follow-up after positive screenings.

To enhance the capacity of providers and partners, CalOptima Health sponsored an eight-week series of maternal mental health training. A total of 27 individuals, in addition to the 81 previously completed participants, fully completed this training. This training equipped participants with tools to recognize, screen, and manage perinatal depression more effectively.

Additionally, CalOptima Health strengthened its presence in community collaborations by actively participating in the Plans of Safe Care (POSC)/Community Wellness Plans Collaborative. Participation in these initiatives fostered shared learning and alignment with countywide maternal and infant goals, expanding referral pathways and enhancing the continuity of behavioral health and substance-use support for these members.

Collectively, these interventions contributed to observed improvements in HEDIS rates for prenatal and postpartum depression screenings and follow-up between MY 2022 and MY 2024. The combination of member outreach, provider education and community collaboration has proven effective in promoting whole-person care, reducing barriers to behavioral health access, and improving identification and follow-up for perinatal depression within the Medi-Cal population.

Prospective Rates

Acronym	Measure	MY2024 September Prospective Rate	MY2025 September Prospective Rate
PND-E	MC: Prenatal Depression Screening	0.52%	10.94%
PND-E	MC: Prenatal Follow-Up on Positive Screen	100.00%	80.58%
PDS-E	MC: Postpartum Depression Screening	2.18%	6.61%
PDS-E	MC: Postpartum Follow-Up on Positive Screen	33.33%	92.68%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing current September 2025 performance against the same time last year:

- Prenatal Depression Screening saw a significant improvement of +10.42 percentage points, indicating better screening prenatally.
- Prenatal Follow-up on a Positive Screen saw a decrease of –19.42 percentage points, indicating a need for better follow-up care during the prenatal period.
- Postpartum Care experienced a slight increase of +4.43 percentage points, indicating an improvement in members receiving postpartum depression screenings.
- Postpartum Follow-up on a Positive Screening saw a significant increase of +59.35 percentage points, indicating an improvement in members receiving follow-up care during the postpartum period.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Documentation gaps in claims and encounter data.
- Underreporting due to inconsistent billing practices impacts this measure.
- Some members decline screening or follow-up due to cultural perceptions, time restraints and/or access.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Provider education to improve standardized documentation guidance.	Provide a toolkit or training on billing practices to support this measure.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L	PND-E, PDS-E
Refine member outreach.	Incorporate new strategies for follow-up care to ensure the members get into care with a BH provider when needed.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	PND-E, PDS-E

Data stratification	Improve data stratification and identify high-need populations for targeted interventions.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	PND-E, PDS-E
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MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the data demonstrated that CalOptima Health is making measurable progress in improving both prenatal and postpartum depression screenings and follow-up rates. Year-over-year trends show consistent upward movement across the HEDIS measures, indicating greater integration of behavioral health screening into routine perinatal care. The increase in screening rates reflects stronger provider engagement, enhanced documentation practices and more effective care coordination between obstetric, behavioral health and case management teams.

Telephonic outreach has improved member identification and timely follow-up after positive screens, while provider training and resource dissemination have contributed to a more consistent approach to screening and referrals. Engagement in community collaboratives further strengthens systemwide alignment on maternal mental health priorities.

While opportunities for continued improvement remain, particularly in documentation accuracy, member engagement and follow-up after positive screens, the overall trend demonstrates meaningful progress toward HEDIS goals. These results affirm that the current intervention is effective and that CalOptima Health's comprehensive, coordinated approach is yielding positive outcomes for the Medi-Cal perinatal population. Sustained focus on provider partnership, data quality and equitable access to behavioral health services will be essential to maintain momentum and achieve further gains in the next measurement year.

4.10 Maternal and Child Health: Maternity Care for Black Members	
Author(s): Ann Mino & Katie Balderas	Department(s): Case Management/ Medical Management/ Cal AIM/ Quality Analytics
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Kelli Glynn (Director, Quality Initiatives); Katie Balderas (Director, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima Health's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima Health's Black members from 71.43% to 80.23% by December 31, 2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Specific populations of women in the United States experience disproportionately higher rates of maternal morbidity and mortality compared to women of other racial and ethnic groups. Contributing

factors include barriers to accessing timely and culturally responsive care, implicit bias within the healthcare system, and social determinants of health that affect perinatal outcomes. Improving access to timely prenatal and postpartum care is critical to supporting maternal health, early identification of complications, and the overall well-being of both mother and baby.

CalOptima Health is committed to advancing health equity and improving outcomes for the identified population through focused quality improvements. Efforts center on connecting members with culturally aligned support programs, including doulas, ECM services and Black Infant Health program, while strengthening collaboration between community organizations and clinical partners.

II. Data Sources and Methodology:

Data was collected through HEDIS reporting, claims and encounter data for the Medi-Cal Black population. Rates reflect the percentage of Black members who received timely prenatal and postpartum care according to HEDIS definitions. Data from the Quality Improvement and Medical Management teams were analyzed to identify trends.

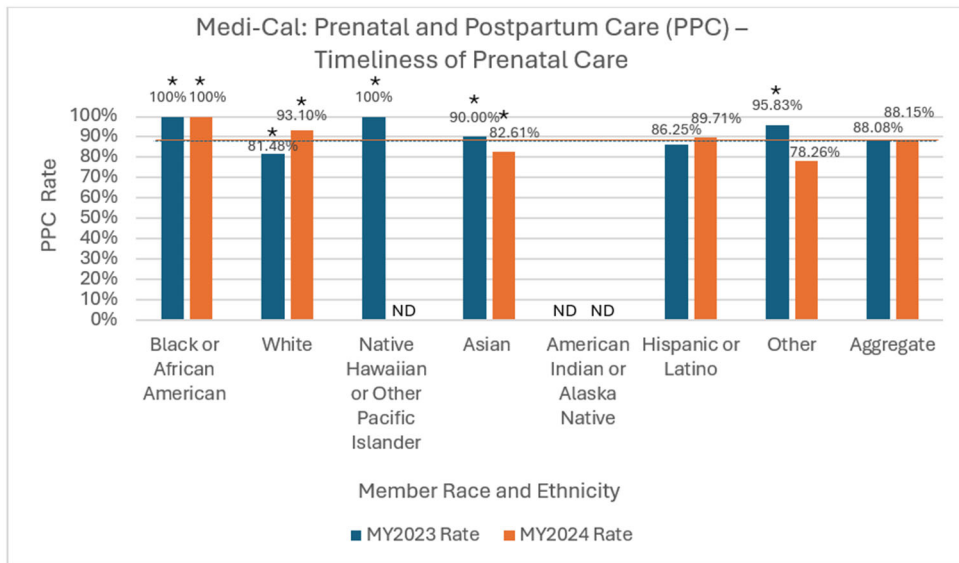
III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi- Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi- Cal Goal	MY 2024 Goal Met / Not Met
PPC	Timeliness of prenatal care (TOPC) for CalOptima Health's Black members	50.00%	75.71%	100.00%	84.55%	☒ Y ☐ N
PPC	Postpartum care (PPC) for CalOptima Health's Black members	100.00%	71.43%	100.00%	80.23%	☒ Y ☐ N

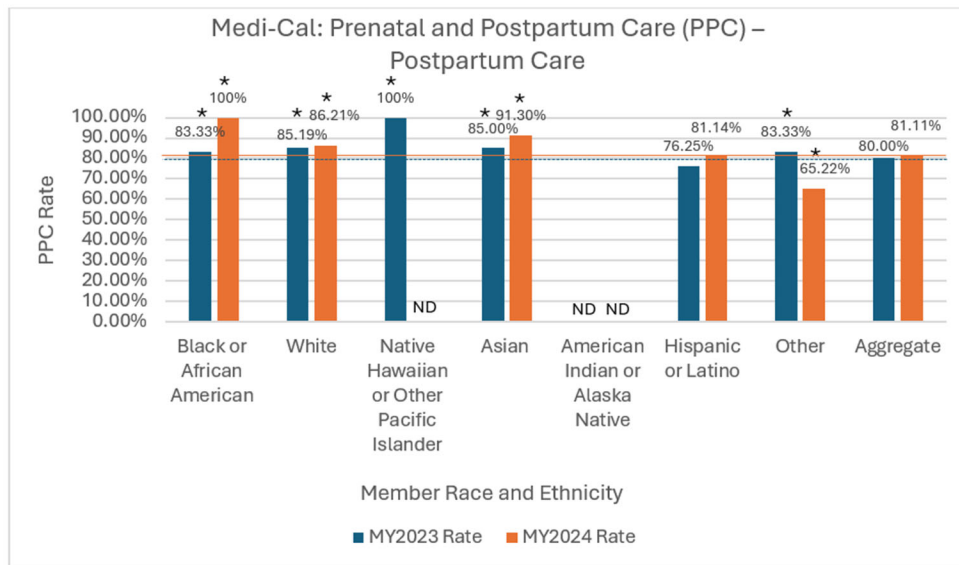
The table above indicates final hybrid rates for the prenatal and postpartum care measures for Black members.

Medi-Cal



The bar chart displays the percentage of deliveries by Medi-Cal members who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in CalOptima Health. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The data shows the PPC prenatal rate for Black or African American has remained steady from MY 2023 to MY 2024, surpassing the annual goal, indicating the initiatives focused on this population are effective.



The bar chart displays the percentage of deliveries that had a post-partum visit on or between seven and 84 days after delivery for Medi-Cal members. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The data shows the PPC postpartum rate for Black or African American has improved from 83.33% in MY2023 to 100% in MY 2024. Full rate compliance suggests barriers that may have contributed to delays in care in MY 2023 are likely not impacting members in MY 2024. To ensure high compliance in future measurement years, targeted outreach and culturally responsive engagement are essential.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Targeted outreach to Black members to promote and offer doula support, Black Infant Health program referral and ECM Services	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PPC
Community engagement/ promotion of services at community events	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PPC
Improve date coordination to support member engagement in services	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PPC

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Multiple targeted interventions were implemented to improve the timeliness of prenatal and postpartum care among Black members, with a focus on reducing disparities and strengthening culturally responsive engagement. These interventions combine direct members' support, provider and community collaboration, and exploration of innovative digital tools to enhance access to care.

Connection to doula, ECM and Black Infant Health (BIH) Programs: CalOptima Health prioritized member connection to culturally aligned and supportive services by referring eligible members to HCA for outreach, education and engagement in ECM, BIH and doula support. These referrals ensured members received person-centered support addressing both clinical and social needs. Forty members within this population of focus have been enrolled in ECM services, receiving individual care coordination and access to community-based resources. Members connected to doula services receive ongoing emotional, educational and advocacy support, which helps increase comfort with prenatal care and confidence in navigating the health system. The coordinated referral approach between CalOptima Health, HCA and community programs improved care continuity and strengthened member trust in their perinatal journey.

Community Outreach Events: Community engagement was a central strategy in increasing awareness and access to timely prenatal and postpartum care. While CalOptima Health implemented and participated in several community events to connect members with services, provided education on the importance of perinatal care and built relationships with trusted community organizations, one event was specifically focused on this targeted population: the OC Black History Parade and Unity Festival. This event provided an opportunity to engage directly with community members and distribute culturally relevant health material and resources.

Exploration of Digital Perinatal Health Tools: Recognizing the growing importance of technology in supporting access to care, CalOptima Health explored digital methods to support best practices and future implementation.

Collectively, these interventions contributed to measurable improvements in member engagement and care coordination for Black members. The referral pathways to ECM, doula and BIH programs helped address both clinical and social determinants of health, resulting in improved adherence to prenatal and postpartum appointments. Community participation efforts increase visibility and connection to trusted resources.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
PPC	MC: Timeliness of Prenatal Care	67.39%	81.84%
PPC	MC: Postpartum Care	67.15%	68.77%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing current September 2025 performance against the same time last year:

- Timeliness of Prenatal Care saw a significant improvement of +14.45 percentage points, indicating better early engagement with prenatal services.
- Postpartum Care experienced a slight increase of 1.62 percentage points, indicating an improvement in members receiving timely postpartum care.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- The completion rate of prenatal and postpartum care is lowest amongst members who are 18 years of age or younger. Younger birthing populations are likely to face greater barriers (e.g., complications, transportation access issues). Inadequate care can lead to poorer developmental outcomes for infants.
- Doulas are positioned as a key strategy to improve prenatal and postpartum care rates, especially for Black and Native American members. Doulas support culturally appropriate outreach and can integrate with programs like BIH and ECM. Currently, there is a limited volume of members who are actively utilizing doula services.
- Lack of data to support identification of low-performing versus high-performing OB/GYN providers.
- Members may not be aware of available ECM, doula or BIH programs or how to access them.
- Complex health care and referral systems can delay or prevent timely engagement in prenatal or postpartum visits and support.
- Historical inequities and experience of bias in healthcare can create hesitancy to seek early or follow-up care.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Analyze current efforts and align new activities with findings	To be determined based on outreach results	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	PPC
2. Increase doula promotion	Develop targeted campaigns and activities to increase benefit awareness and utilization	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L	PPC
3. Strengthen community partnerships	Leverage culturally relevant partners and contracted providers to collaboratively improve measures for the targeted population.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	PPC

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Our targeted interventions for Black members, including referrals to connect them with doula, ECM and BIH programs, as well as the implementation of community events, such as culturally relevant events like the OC Black History Parade and Unity Festival, have shown promise in improving prenatal and postpartum engagement. These efforts have helped address barriers to care, promote a community of maternal health services and foster trust within the community. Continued focus on culturally tailored outreach and supportive care management is essential to sustain improvements in maternal and infant health outreach and to reduce disparities among our Black members.

4.11 Chronic Conditions: Members with Diabetes	
Author(s): Melissa Morales	Department(s): Medical Management and Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Katie Balderas (Director, Case Management); Melissa Morales (Quality Improvement Specialist, Quality Analytics); Elisa Mora (Manager, Case Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status (this measure evaluates percentage of members with glycemic status of <8.0% (control-higher rate is better) and glycemic status (>9.0%) (poor control-lower rate is better) (>9.0%) MC GSD (>9.0%): Decrease from 29.34% to 27.01% by 12/31/2025. OC GSD (<8.0%): Increase from 77% to 92.00% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

According to the CDC, diabetes raises the risk for high blood pressure, which increases a person's chances of heart disease, stroke, vision loss and kidney disease. Tests and screenings are necessary for people with diabetes to catch any changes before they turn into major health problems. They can also help providers create personalized treatment plans tailored to their patients' specific needs.

The following is an evaluation of HEDIS measures related to diabetes care. The Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD) measure is part of DHCS' Medi-Cal MCAS for annual reporting by Medi-Cal managed care plans. This measure is held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. The GSD measure and the Eye Exam for Patients with Diabetes (EED) measure are part of CMS' Five-Star Quality Rating System.

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, CitiusTech. The goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the MY 2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. OneCare measure goal setting for MY 2024 is based on the MY 2022 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
EED	Eye Exam for Patients with Diabetes	62.63%	63.52%	64.34%	64.06%	☒ Y ☐ N
HBD/GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status > 9.0%	30.41%	29.34%	30.92%	27.01%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
EED	Eye Exam for Patients with Diabetes	73.00%	75.00%	78.00%	77.00%	☒ Y ☐ N
GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8.0%	78%	85%	84%	90.00%	☐ Y ☒ N

The EED measure met the MY 2024 Medi-Cal goal of 64.06%. The MY 2024 Medi-Cal rate was 64.34%, which is higher than the MY 2023 Medi-Cal rate of 63.52%. The GSD (>9%) measure did not meet the MY 2024 Medi-Cal goal of 27.01%. The MY 2024 Medi-Cal rate was 30.92%, which is higher than the MY 2023 Medi-Cal rate of 29.34% (lower is better).

The EED measure met the MY 2024 OneCare goal of 77.00%. The MY 2024 OneCare rate was 78.00%, which is higher than the MY 2023 OneCare rate of 75.00%. The GSD (<8%) measure did not meet the MY 2024 OneCare goal of 90%. The MY 2024 rate was 84%, which is lower than the MY 2023 OneCare rate of 85% (higher is better).

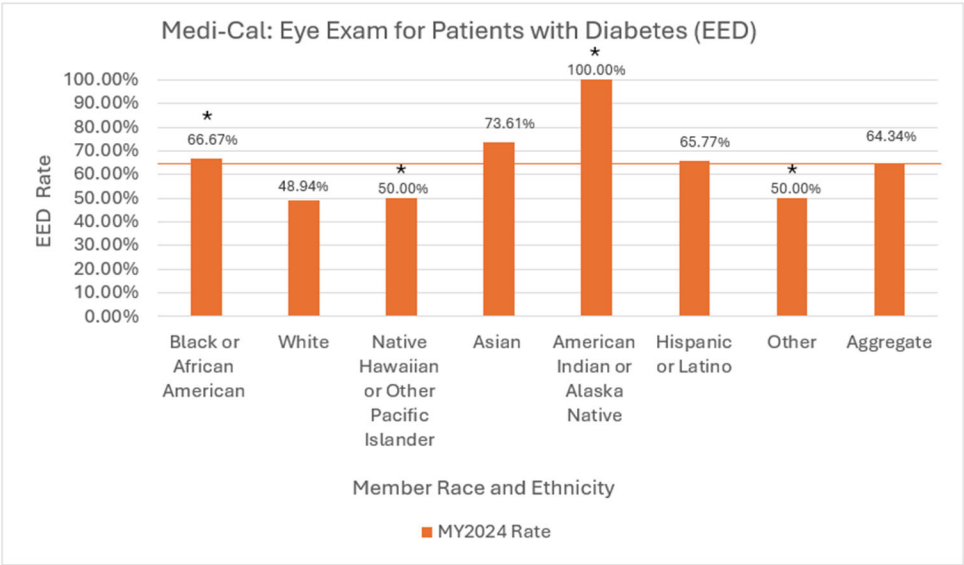
IV. Data Stratification Data Source and Methodology:

Data pulled from claims and encounters using HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race/ethnicity.

V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Medi-Cal

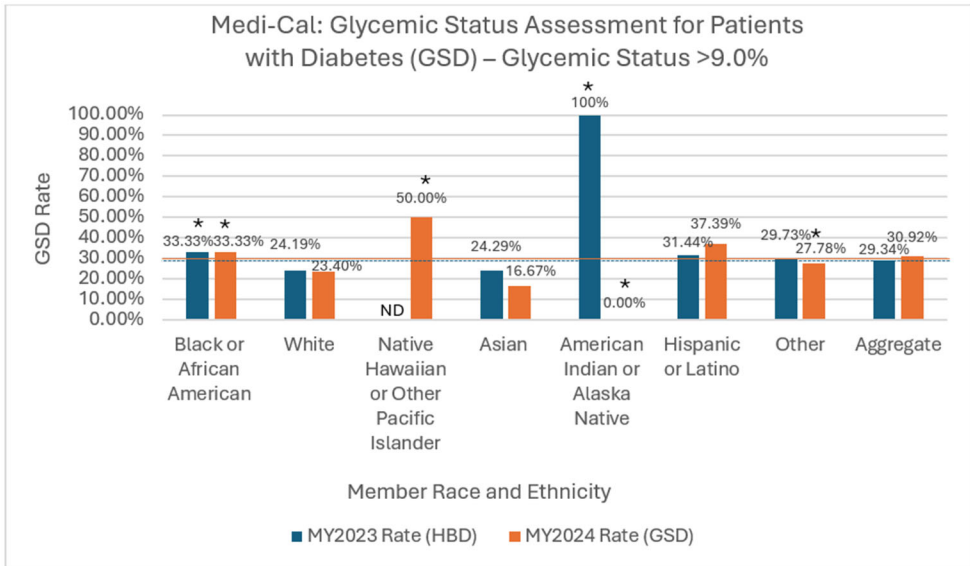


This bar chart shows the percentage of Medi-Cal members within a specified age range with diabetes (types 1 and 2) who had a retinal exam by an eye care professional during the measurement year. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the Medi-Cal EED measure indicates differences across various racial and ethnic groups. The overall aggregate rate of 64.34% for the EED measure met the MY 2024 goal, indicating that the majority of Medi-Cal members with diabetes had a retinal exam during the measurement year. However, disparities are evident when examining the stratified rates.

Members identified as Hispanic or Latino, Black or African American, Asian and American Indian or Alaska Native show higher rates of retinal eye exam completion compared to the aggregate rate, which

suggests better access to or utilization of eye care services. In contrast, the rates for White, Native Hawaiian or Other Pacific Islander, and Other members fell below the overall aggregate rate, indicating potential obstacles in accessing eye care or variations in service delivery that need to be addressed.

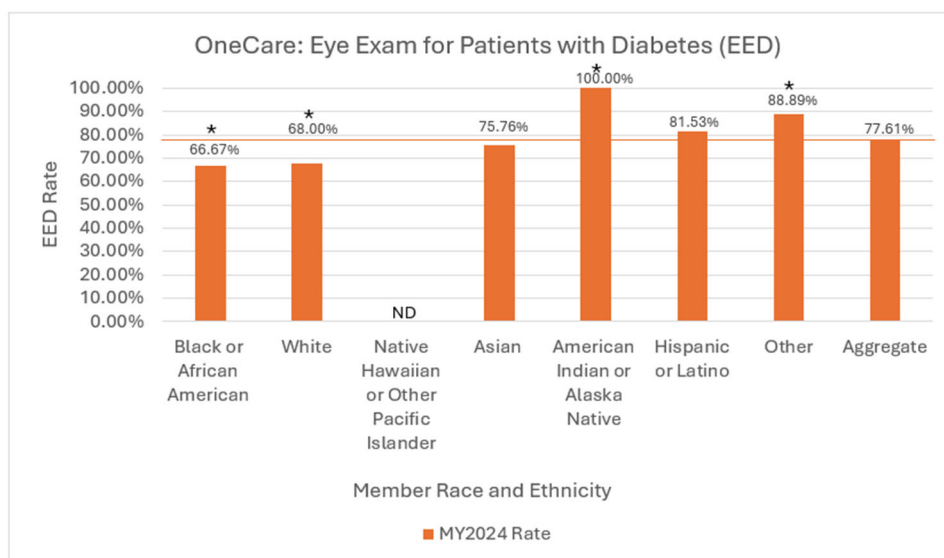


The bar chart illustrates the percentage of Medi-Cal members within a specified age range who have diabetes (type 1 or type 2) and whose most recent glycemic status was above 9.0% during the measurement period. In Measurement Year 2023, the metric used was Hemoglobin A1C Control for Patients with Diabetes (HBD), which exclusively considered HbA1C values. In contrast, Measurement Year 2024 uses the Glycemic Status for Diabetes (GSD) measure, which includes both HbA1C and GMI values. This broader inclusion may offer a more comprehensive view of glycemic control and could contribute to observed variations between the two years. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the Medi-Cal GSD (>9.0%) measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian, White and Other show lower rates of glycemic assessment compared to the aggregate rate of 30.92%, which suggests these groups benefit from better diabetes management programs or have higher compliance with recommended care protocols.

In contrast, the rates for Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander members are above the overall aggregate rate. These findings highlight the need for targeted interventions to address gaps in diabetes care, enhance education on glycemic management and ensure equitable access to essential health services.

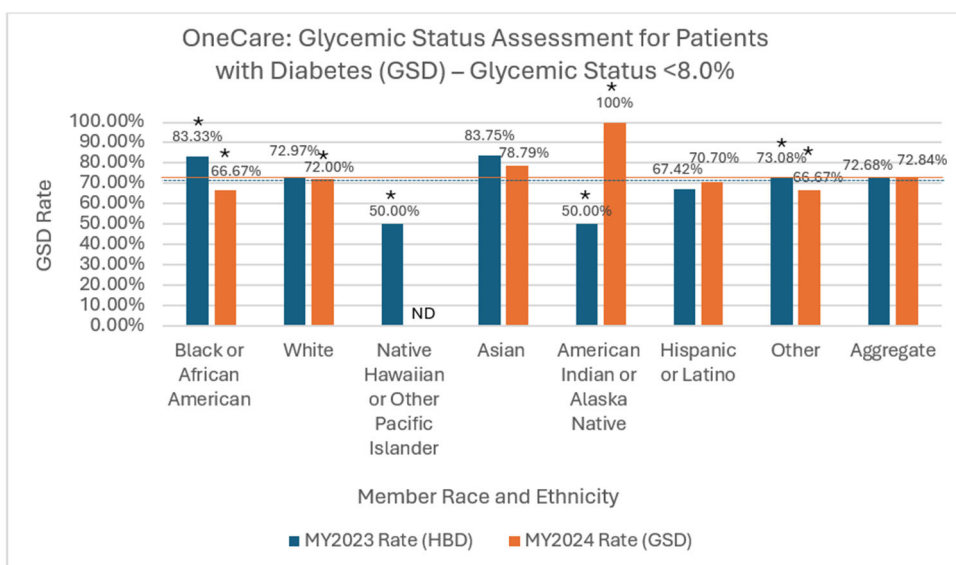
OneCare



This bar chart shows the percentage of OneCare members within a specified age range with diabetes (types 1 and 2) who had a retinal exam by an eye care professional during the measurement year. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare EED measure indicates differences across various racial and ethnic groups. The overall aggregate rate of 77.61% for the EED measure met the MY 2024 goal, indicating that the majority of OneCare members with diabetes had a retinal eye exam during the measurement year. However, disparities are evident when examining the stratified rates.

Members identified as Hispanic or Latino, Other, and American Indian or Alaska Native show higher rates of retinal eye exam completion compared to the aggregate rate, which suggests these groups have better access to or utilization of eye care services. In contrast, the rates for Black or African American, White, and Asian members fell below the overall aggregate rate, pointing toward potential obstacles in accessing eye care or variations in service delivery that need addressing.



The bar chart illustrates the percentage of OneCare members within a specified age range who have diabetes (type 1 or type 2) and whose most recent glycemic status was below 8.0% during the measurement period. In Measurement Year 2023, the metric used was Hemoglobin A1C Control for Patients with Diabetes (HBD), which exclusively considered HbA1C values. In contrast, Measurement Year 2024 uses GSD measure, which includes both HbA1C and GMI values. This broader inclusion may offer a more comprehensive view of glycemic control and could contribute to observed variations between the two years. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare GSD (<8.0%) measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian and American Indian or Alaska Native have higher rates of glycemic assessment compared to the aggregate rate of 30.92%, which suggests that these groups benefit from better diabetes management programs or have higher compliance with recommended care protocols.

In contrast, the rates for Black or African American, Other, and Hispanic or Latino members are below the overall aggregate rate. These findings highlight the need for targeted interventions to address gaps in diabetes care, enhance education on glycemic management, and ensure equitable access to essential health services.

VI. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Member health reward	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Member mailing	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Text messaging	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Telephonic outreach	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
VSP Vision Care Data Exchange	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	EED
Ophthalmologist Provider Outreach Project	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	EED
Home test kit	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Othe	☐ Completed ☒ Ongoing ☐ Incomplete	GSD
Gap-in-care reporting	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED

Quality Improvement Grant Program	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
P4V Program	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VII. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
EED	MC: Eye Exam for Patients with Diabetes	40.70%	48.24%
EED	OC: Eye Exam for Patients with Diabetes	58.64%	67.34%
GSD	MC: Glycemic Status Assessment for Patients with Diabetes – Glycemic Status > 9.0%	59.98%	42.72%
GSD	OC: Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%	52.74%	34.20%

Indicator/Goal: The performance rate from the same month of the previous year

As of September 2025:

- The MC Eye Exam for Patients with Diabetes prospective rate was 48.24%, which is higher than the September 2024 prospective rate of 40.70% by 7.54 percentage points.
- The OC Eye Exam for Patients with Diabetes prospective rate was 67.34%, which is higher than the September 2024 prospective rate of 58.64% by 8.7 percentage points.
- The MC Glycemic Status Assessment for Patients with Diabetes - Glycemic Status >9% prospective rate was 42.72%, which is lower than the September 2024 prospective rate of 59.98% by 17.26 percentage points (lower is better).
- The OC Glycemic Status Assessment for Patients with Diabetes - Glycemic Status >9% prospective rate was 34.2%, which is lower than the September 2024 prospective rate of 52.74% by 18.54 percentage points (lower is better).

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

- The ability to reach members (mail, phone, text) creates challenges around providing members with information on diabetes care.

- Members did not visit their PCP during MY 2024 and did not receive assistance for their diabetes management.
- Lack of knowledge of the importance of A1C testing and retinal eye exam completion.
- Appointment access could be limited due to scheduling ability and/or staff shortage, resulting in long waiting times for appointments.
- Lack of document sharing (e.g., consult notes with the results of diabetic retinal eye exams) between eye care professionals and PCPs.
- Lack of data sharing between VSP due to contract restrictions between CalOptima Health and the VSP provider network, prohibiting direct data sharing with any health network and only permitting data sharing via the health plan.

IX. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Member outreach: Use of disparity analysis to develop targeted interventions.	• Bidirectional SMS campaign and email development via Ushur • Telephonic outreach via Carenet and internal resources • Diabetes management mailing	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	GSD, EED
Access	• At-home testing for A1C and potentially a retinal eye exam. • Establish partnerships with ophthalmologists to perform member outreach and schedule members for eye exams.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	GSD, EED
Training and education	Continued provider education on HEDIS diabetes care measures.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	GSD, EED
Grant programs	Quality improvement grants to health network partners will focus on GSD and EED.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	GSD, EED
Member health reward	Continuing existing member health rewards for A1C testing and retinal eye exam completion.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	GSD, EED
P4V Program	Continue performance-based incentives to prioritize and encourage diabetes management.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	GSD, EED
Data optimization	The Cozeva data bridge will enable bidirectional data exchange with health network partners and facilitate	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	GSD, EED

	the timelier identification of members due for diabetic screenings.				
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MC = Medi-Cal; OC = OneCare

X. Conclusion:

We met the internal CalOptima Health goal for the EED measure, but not for the GSD measure. GSD will remain on the QIHETP work plan for 2026. Both the GSD and EED Medi-Cal measures achieved the 75th percentile for MY 2024. For the OneCare population, the GSD CMS Stars measure reached the 4-Star cutoff, while the EED measure reached the 3-Star cutoff. Because reporting is changing from a hybrid methodology to Electronic Clinical Data Systems (ECDS) reporting, it is important to continue to monitor these measures year-round. CalOptima Health will continue to focus on diabetic care and pursue multiple quality improvement initiatives, as listed in the table above.

4.12 Chronic Conditions: Members with Heart Health (Hypertension)	
Author(s): Elisa Mora	Department(s): Case Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Elisa Mora (Manager, Case Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean-speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese-speaking Medicare members from 50.56% to 77% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Hypertension, or high blood pressure, is the second most common condition among CalOptima Health members, affecting over 122,000 individuals. Left uncontrolled, it can lead to serious health complications such as heart disease and kidney disease. Research shows that home monitoring of blood pressure can improve control rates by 25–30%, making it a powerful tool in managing this condition. Additionally, findings from the OC Black and African American Health Equity Survey revealed that 70% of participants were unaware of their current blood pressure reading, highlighting a significant gap in awareness and self-management. These factors collectively underscore the urgent need for a targeted initiative to improve blood pressure control, reduce health disparities, and enhance overall population health outcomes.

II. Data Sources and Methodology:

Members are identified through the CalOptima Health HEDIS engine, CitiusTech, to track both compliant and non-compliant members with respect to HEDIS and STAR measures.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CBP	Controlling High Blood Pressure (CBP)	65.85%	76.33%	67.54%	72.75%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
CBP	Controlling High Blood Pressure (CBP)	67.82%	74.32%	77.26%	80.00%	☐ Y ☒ N

IV. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Population	LOB	2025 Rate (November)	2024 Rate	Goal
Black and African American	Medi-Cal	35.21%	39.21%	64.48%
2025 Black and African American	Medicare	38.98%	47.24%	77%
Korean Speaking Population	Medi-Cal	19.29%	24.87%	64.48%
Vietnamese-Speaking Population	Medicare	42.76%	50.56%	77%

Rates as of November 2025

While final rates are not yet available, a comparison of preliminary data shows an improvement:

Medi-Cal: 36% in September 2024 to 41% in September 2025

OneCare: 38% in September 2024 to 43% in September 2025

The data indicates a 5-percentage point increase for each line of business (LOB), which suggests we are trending in the right direction.

Although current rates for Black and African American, Korean, and Vietnamese populations are below 2024 levels, it's important to note that the final 2025 data will be captured through December 31.

Because this is a hybrid measure, full data capture typically lags due to the nature of claims and encounter reporting. In the first half of the year, outreach efforts focused on community events targeting

these populations; however, attendance was lower than anticipated. As we transitioned to telephonic outreach, we encountered a high rate of unable to contact (UTC) outcomes, which further impacted early performance. Despite these challenges, the remaining weeks of the year present a valuable opportunity to close the gap and continue engagement efforts.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Outreached to non-compliant members for blood pressure screenings at community events; shared results with PCPs. Hosted county-wide BP check-ins and offered virtual/in-person hypertension education	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Standing order program was launched to allow staff to order blood pressure monitors for members with hypertension.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Training for CalOptima Health staff on BP monitor access	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Health network training on CBP STAR measure and BP monitor access	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
5. In July 2025, interventions shifted from community events to telephonic outreach and virtual classes.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

The interventions implemented to improve blood pressure control have demonstrated meaningful progress and infrastructure-building. Outreach to noncompliant members through community events enabled screenings and timely sharing of results with PCPs, while countywide BP check-ins and hybrid hypertension education sessions expanded access to care. A key success was the launch of a standing order program, which enabled over 500 members with hypertension to receive BP monitors, removing a critical barrier to self-management. Additionally, targeted trainings for CalOptima Health staff and health networks on CBP STAR measures and device access helped strengthen systemwide capacity. The mid-year shift to telephonic outreach and virtual classes ensured continuity of engagement.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
CBP	MC: Controlling High Blood Pressure	35.96%	40.92%
CBP	OC: Controlling High Blood Pressure	38.31%	42.93%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing prospective rates from September 2024 to September 2025, we observed measurable improvements across both lines of business:

OneCare: The performance rate increased from 38.31% in September 2024 to 42.93% in September 2025. Goal: 4 Star, 82%

Medi-Cal: The rate improved from 35.96% to 40.92% over the same period. Goal: 50th Percentile, 67.88%

These gains reflect the effectiveness of our targeted interventions and sustained outreach efforts.

VII. Qualitative Analysis:

The Controlling Blood Pressure initiative has demonstrated strong engagement and adaptability across multiple phases. In the early stages, community-based outreach created meaningful opportunities for face-to-face education and screening, helping to build trust and awareness among members.

In Q1 and Q2, we targeted community events with higher concentrations of African American, Vietnamese and Korean populations, such as Black History Unity Parade, the Vietnamese American Cancer Foundation Community Events and the Korean Community Services Resource Fair. While these events were well attended, participation from CalOptima Health members varied, despite outreach efforts that included text message invitations.

The launch of the standing order program in Q2 further empowered members by providing tools for self-monitoring. Staff identified this as a key driver of increased member confidence and accountability. As a result of the internal BP standing order program, more than 600 members have gained access to a blood pressure monitor as of December 5, 2025.

As the initiative transitioned to telephonic outreach in Q3 and Q4 due to organizational restructuring, health coaches continued to deliver personalized support, reinforcing healthy behaviors and connecting members to their PCPs. This shift also expanded our reach, allowing us to engage members who may not have been able to attend in-person events.

Between Q3 and Q4, 1,900 OneCare members received outreach calls due to non-compliance with CBP measures. These calls aimed to educate members on self-management strategies for blood pressure control and to facilitate connections with their PCPs.

Overall, the initiative has improved access to and awareness of hypertension management while fostering a culture of proactive health engagement.

Causal/Barrier Analysis:

Barrier:

- Despite active outreach efforts by staff, the rate of UTC remains high, limiting the effectiveness of interventions aimed at improving blood pressure control among noncompliant members.

- Outreach to African American, Vietnamese, and Korean communities may have been hindered by a lack of culturally tailored messaging or language support.
- Even when members are referred to PCPs, they may face:
 - Long wait times
 - Lack of insurance clarity
 - Transportation issues
 - Additional barriers related to the political climate (e.g., immigration concerns, fear of system engagement)

Causal Consideration:

- Because this is a hybrid measure, final outcomes are dependent on both administrative data and medical record review. As a result, the full impact of interventions will not be visible until after the measurement period has closed, potentially delaying real-time performance insights.
- CBP outreach was expanded to include Medical Management and Case Management staff, increasing member touchpoints.
- Staff demonstrated adaptability and continued support despite organizational restructuring, helping maintain program continuity.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Standardize BP data collection during outreach	Standardize BP data collection during outreach	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP
Integrate BP monitoring process/access in the care continuum	Provide ongoing refresher training for staff to ensure consistent use of tools and protocols, and to reinforce the importance of timely documentation and follow-up.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP
High UTC rates	Implement multi-channel outreach (text, calls, mailing)	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

While the CBP measures did not meet the goal and will remain on the QIHETP work plan for 2026, the data clearly indicate that the Controlling Blood Pressure initiative is yielding positive results. Both the OneCare and Medi-Cal LOB have shown year-over-year improvements in prospective rates, reflecting the effectiveness of our targeted interventions. From community outreach and the standing order program to telephonic coaching and virtual education, each phase of the initiative has contributed to increased

member engagement, improved access to self-monitoring tools and greater awareness of hypertension management. While some barriers — such as high UTC rates and disparities across racial and ethnic groups — remain, the overall trend is one of progress.

4.13 Chronic Conditions: Members with Osteoporosis	
Author(s): Mahmoud Elaraby	Department(s): Medical Management (Case Management)/ Quality Analytics
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Kelli Glynn (Director, Quality Initiatives); Sherry Hickman (QI Nurse Specialist, Case Management); Mahmoud Elaraby (Program Manager, Quality Analytics)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Osteoporosis is the most common bone disease and greatly increases the risk of fractures from minor injuries. While medication can lower the risk of fractures by 30–50%, follow-up care and treatment rates remain low. The Osteoporosis Management in Women Who Had a Fracture (OMW) HEDIS measure tracks whether women ages 67 to 85 with a fracture receive appropriate follow-up care, such as a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis, in the 180 days (six months) after the fracture. Improving OMW performance at CalOptima Health is critical because osteoporotic fractures are associated with pain, disability, loss of independence and increased mortality. Improving this measure supports healthy aging, reduces the risk of repeat fractures and enhances member outcomes.

II. Data Sources and Methodology:

HEDIS OMW performance for MY 2022 to MY 2024 was evaluated using data from CalOptima Health's HEDIS engine, CitiusTech. The measurement period for each year was July 1 of the year prior to the measurement year to June 30 of the measurement year, in accordance with the HEDIS specification.

The denominator includes women aged 67 to 85 years who experienced an eligible fracture and met the continuous enrollment criteria. The numerator includes members who, on the day of the fracture or in the 180 days following, received either:

- A BMD test, in any setting
- A dispensed prescription to treat osteoporosis

Data was extracted and reported by the Quality Analytics team in accordance with NCQA HEDIS technical specifications. The data was analyzed to identify qualifying fractures and numerator-qualifying events. Trend analysis was completed quarterly to evaluate progress toward the annual goal.

III. Quantitative Analysis:

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
OMW	Osteoporosis Management in Women Who Had a Fracture	33.33%	34.67%	43.64%	39.00%	☒ Y ☐ N

For OneCare, the OMW rate improved from 34.67% in MY 2023 to 43.64% in MY 2024, an increase of approximately 9 percentage points. One Care met the organizational goal for MY 2024 of 39.00%. This upward trend demonstrates the positive impact of member outreach, provider notification, and increased coordination with case management and health network partners.

IV. Data Stratification Data Source and Methodology:

Data source: CalOptima Health's HEDIS engine, CitiusTech.

Stratified OMW results were produced by race and ethnicity for the OneCare population using the same HEDIS MY 2024 administrative data set described above. Race/ethnicity values were derived from eligibility and enrollment records and supplemented, where available, by health network data. Only records with a valid race/ethnicity category were included in the stratified analysis; members with missing or unknown race/ethnicity are shown as a separate category.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Case Management led telephonic outreach to members identified as needing follow-up for OMW.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Quality team performed outreach to noncompliant members via SMS, mail and telephone.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Members were provided with facility listings to improve access to BMD testing.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Sent PCPs notification of noncompliant members to support timely follow-up post fracture.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Case Management completed email outreach to health network partners to identify members requiring follow-up.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Medical director led provider outreach to increase awareness of OMW requirements and discuss any barriers.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm	☐ Completed ☒ Ongoing

			☐ Data ☐ Other	☐ Incomplete
Case Management flags OMW noncompliance as a member-specific care gap on outbound bundles when a OneCare member declines or cannot be reached for an HRA, providing additional visibility for the health networks.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
When health networks reported OMW compliance, but CalOptima Health data did not, evidence was requested and shared with the Quality team for care gap closure in CalOptima Health's HEDIS engine.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
34. Case Management implemented notification for OMW emergency room ER visit through the Key Event notification process.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
OMW	OC: Osteoporosis Management in Women Who Had a Fracture	20.00%	42.11%

Indicator/Goal: The performance rate from the same month of the previous year

Prospective OMW performance using continuous enrollment data demonstrates the effectiveness of the above interventions. The September 2023 prospective rate of 20.00% increased to 42.11% in September 2024, an improvement of 22.11 percentage points and a more than 100% relative increase at the same point in time. This substantial gain can be attributed to intensified member outreach efforts, expanded provider notifications and enhanced data sharing with health networks.

Overall, the prospective trend supports that:

- Member telephonic and mail/SMS outreach is increasing awareness and completion of follow-up services.
- Provider and health network notifications are enabling earlier and more focused gap closure.
- Ongoing collaboration between the Quality and Case Management teams is helping to address access barriers for members with mobility or transportation challenges.

VII. Qualitative Analysis:

The Case Management team identified barriers, including member disengagement, inaccurate contact information, limited provider familiarity with OMW requirements, and low awareness of osteoporosis medication benefits. These insights support ongoing improvement in communication and provider education.

Causal/Barrier Analysis:

The causal and barrier analysis was conducted collaboratively by Quality Analytics, Case Management and health network partners. Quality Analytics led the data review and identified performance trends; Case Management and health network leadership provided operational insights regarding member access, outreach challenges and provider engagement barriers.

- Member contact information: Inaccurate or outdated phone numbers and limited member responsiveness reduce the effectiveness of telephonic outreach.
- Access to BMD testing: Some at-home testing vendors do not meet HEDIS diagnostic criteria, and some members do not have easy access to contracted imaging sites, particularly those with mobility limitations or transportation barriers.
- Knowledge and acceptance of osteoporosis therapy: Members may be unfamiliar with the benefits of osteoporosis medications or may be concerned about side effects, leading to delays in starting treatment even when prescribed.
- PCPs manage multiple chronic conditions and may not always prioritize OMW at the time of fracture follow-up, especially when information about the fracture is delayed.
- Data timeliness: Claims lag can delay the appearance of eligible fractures and completed services in monitoring reports, making it more difficult for health networks to track progress in real time.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Improve member reach rate and contact accuracy	Implement expanded contact search to enhance telephonic outreach success	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Strengthen osteoporosis medication education and initiation	Collaborate with the Pharmacy department to launch a program to educate members, coordinate prescriptions with PCPs, and follow up.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Increase provider education efforts	Create and distribute provider-facing educational materials.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Explore at-home bone mineral density testing	Partner with vendors to provide at-home bone mineral density testing to members.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

The OMW data shows a significant improvement over the past two years, with the OneCare rate increasing from 34.67% in MY 2023 to 43.64% in MY 2024. These results reflect the success of coordinated member outreach, provider notifications and improved reporting to health networks. Continued collaboration among the Quality team, Case Management team, Pharmacy team, and health networks will be essential to sustain and further improve performance. Targeted interventions remain necessary to improve equity, member adherence and provider engagement.

4.14 Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Author(s): Megan Dankmyer and Sherry Hickman	Department(s): Case Management
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Sherry Hickman (QI Nurse Specialist, Case Management)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

This measure assesses emergency department (ED) visits for Medicare members aged 18 years and older who have multiple high-risk chronic conditions and who received a follow-up service within seven days of an ED visit.

The importance of this measure relates to Medicare beneficiaries are at particular risk following ED visits because of their functional limitations, audio and visual impairments and use of multiple medications.

II. Data Sources and Methodology:

Data source: Data from Claims, Encounters and Citius platform.

Stratified results were produced by race and ethnicity for the OneCare population using the same HEDIS MY 2024 administrative data set described above. Race/ethnicity values were derived from eligibility and enrollment records and supplemented, where available, by health network data. Only records with a valid race/ethnicity category were included in the stratified analysis; members with missing or unknown race/ethnicity are shown as a separate category.

III. Quantitative Analysis:

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
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FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	47.40%	51.27%	55.62%	53.00%	☒ Y ☐ N
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For OneCare, the FMC rate improved from 47.40% in MY 2022 to 51.27% in MY 2023. The organizational goal for MY 2024, 53%, was achieved with the final MY 2024 HEDIS result of 55.62% demonstrating improvement year over year. Quarterly QI work-plan monitoring in 2025 showed higher performance for MY 2025 when compared to the same point in time for MY 2025 in two quarters:

- Quarter Two: 48% in May 2025 versus 40% in May 2024
- Quarter Three: 50% in July 2025 versus 43% in July 2024

Current projections, per Hyperlift based on October Citius data, signal we are on track to achieve the MY 2025 goal of 53%.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Sharing key event reminders and education for emergency visits with health networks, March 6, 2025, and November 13, 2025	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Continue to share emergency visits with health networks through key event reporting.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Case Management implemented notification for FMC ER visit through the key event notification process	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
FMC	OC: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	45.34%	50.17%

Indicator/Goal: The performance rate from the same month of the previous year

Prospective FMC performance using continuous enrollment data demonstrates the effectiveness of the above interventions. The MY 2024 September prospective rate of 45.34% increased to 50.17% in MY 2025 September. This represents an improvement of 4.83% and aligns with the following interventions:

- Sharing key event reminders and education for emergency visits with health networks.

- Ongoing key event reporting that identifies FMC members for prioritization

VI. Qualitative Analysis:

Case Management identified a barrier to provider access within seven days of an ED visit. Based on current projections, per Hyperlift based on October Citius data, we are on track to exceed the goal.

Causal/Barrier Analysis:

Provider access within seven days from ED visit

- Limited visibility to this specific subset of members prevented prioritization. This visibility enhanced in Q4 2025 through specific identification of FMC members on daily key event reporting.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Education reminder for health networks on FMC visibility on key event reporting.	Remind health networks of enhanced visibility and encourage prioritization of members who qualify for FMC. Provide this education twice in 2026.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L
Collaboration with Emergency Department Diversion staff at UCI.	Explore collaboration with Emergency Department Diversion staff at UCI to assist with appointment scheduling for FMC-identified members.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

While we are projected to meet this goal for 2025, the measure is performing below the 75th percentile and will remain on the work plan for 2026. There is overall improvement with this measure, despite barriers. The value of enhanced identification on key event reporting for prioritization of FMC qualifying members will continue to be seen in 2026.

4.15 Behavioral Health Services: Child and Adolescent Health on Antipsychotics	
Author(s): Mary Barranco	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Behavioral Health Integration); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	

Goal Met: ☐ Yes ☒ No ☐	Status: ☐ Completed ☒ Ongoing
Partial	

I. Purpose or Background:

This measure is vital because antipsychotic medications can lead to serious metabolic complications in children and adolescents, such as elevated blood sugar and cholesterol levels, which increase the risk of cardiovascular disease later in life. This measure ensures that healthcare providers consistently monitor these young patients through routine metabolic testing, helping to detect and address issues early on. By standardizing care practices across health plans, APM enhances behavioral health management and safeguards vulnerable youth from long-term cardiometabolic harm, ultimately improving the quality and safety of care.

II. Data Sources and Methodology:

The data is uploaded to Citius by CalOptima Health's Quality Analytics team. Behavioral Health Integration (BHI) retrieves and downloads the data, filtering it to evaluate the measure's needs. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.

III. Quantitative Analysis:

Despite the outreach efforts, we did not meet the goal of 41.41%. The final rate was 34.58% for Total Blood Glucose and Cholesterol Monitoring. The decline from the previous year is due to timely access to data.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.41%	36.76%	34.58%	41.41%	☐ Y ☒ N

The performance did not meet the established benchmark of 41.41%. MY 2022 to MY 2025: A gradual decline in performance from 37.41% to 34.58%, indicating a downward trend in compliance or monitoring efforts.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Created a draft to update the prescriber tip tool sheet. 2. Updated the Best Practices Prescriber letter—pending management approval. 3. Created a Quick Reference Guide (QRG) and PowerPoint presentation for providers and staff on how to use the Provider Portal. Pending report availability.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete

4. Created a social media post for this HEDIS measure. 5. Created article for Fall member newsletter.				
1. Prescribing provider letter finalized June 9, 2025. 2. HEDIS provider tool tip sheet finalized June 6, 2025. 3. Social media post, posted on April 14, 2025. 4. Article for the Fall member newsletter approved and going through the MMA process. 5. Text campaign sent out a. April 10, 2025 — 75 texts sent b. May 8, 2025 — 52 texts sent 6. Created a QRG and PowerPoint presentation for providers and staff on how to use the Provider Portal. Pending report availability.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. PCP provider mailout: a. July 29, 2025 — 103 letters b. August 28, 2025 — 75 letters 2. Request submitted to add codes to the provider tip tool sheet. 3. Text Campaign sent out: a. June 12, 2025 b. July 10, 2025 c. August 14, 2025 4. HEDIS provider tool tip sheet finalized and sent to providers in the Health Network Weekly Communication on August 11, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The prospective rate for APM-E increased slightly from 26.05% in September MY 2024 to 27.06% in September MY 2025, indicating a modest improvement in metabolic monitoring for individuals on antipsychotics. While the increase is positive, the rate remains below typical HEDIS benchmarks.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
APM-E	MC: Blood Glucose and Cholesterol Testing (Total) — All Ages	26.05%	27.06%

Indicator/Goal: The performance rate from the same month of the previous year

The prospective rate increased by 1.01% from MY 2024 to MY 2025. While there was an increase, the goal was not met.

VI. Qualitative Analysis:

BHI program specialists are responsible for processing the data and implementing targeted interventions.

Causal/Barrier Analysis:

The implementation of a new software system during the measurement year impacted the timeliness and completeness of data capture. This affected:

- Real-time tracking of metabolic monitoring compliance
- Provider visibility into member testing status
- Accuracy of prospective rates, potentially underreporting actual performance

This barrier likely contributed to delayed interventions and missed opportunities for follow-up testing. It may have also limited the effectiveness of outreach efforts by BHI program specialists due to incomplete or lagging data.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
• Improve collaboration with network providers	• Share aggregate performance data with provider groups to highlight trends and encourage alignment with quality goals.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
• Improve provider engagement	• Share provider-level performance reports to increase awareness and accountability. • Offer targeted training on the importance of metabolic monitoring.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
• Enhance member targeting and outreach	• Use stratified data to identify non-compliant members and prioritize outreach based on risk level or historical gaps in care.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data indicates a modest year-over-year improvement for the APM-E measure, with the prospective rate increasing from 26.05% in MY 2024 to 27.06% in MY 2025, a 1.01% percentage point gain. While this reflects a positive trend, the goal for the measure was not met and the measure will remain on the work plan for 2026. The program, led by BHI program specialists, has shown some success, with early signs of progress likely impacted by barriers such as limited data availability resulting from the new software implementation. Continued efforts are necessary to enhance member outreach and support internal coordination, thereby accelerating improvement and achieving future performance targets.

4.16 Behavioral Health Services: Depression	
Author(s): Mary Barranco	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Antidepressant Medication Management (AMM) MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025. MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025.	

OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025. OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025. Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

AMM assesses the percentage of members aged 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication and remain on the medication for an effective duration during the measurement year.

DSF-E assesses the percentage of members aged 12 years and older who were screened for depression using a standardized tool during the measurement year.

II. Data Sources and Methodology:

The data is uploaded to Citius by CalOptima Health's Quality Analytics team. BHI retrieves and downloads the data, filtering it to evaluate the measure's needs. Data is drawn from HEDIS results and healthcare claims. HEDIS rates are used to establish performance trends.

III. Quantitative Analysis:

AMM — The final rate for effective acute phase treatment was 68.35%, exceeding the goal of 67.21%. The final rate for effective continuation phase treatment was 48.16%, which fell short of the goal of 50.64%. Year-over-year changes were minimal, indicating stable performance in the acute phase but ongoing challenges in maintaining adherence during the continuation phase. It is important to note that, effective in MY 2024, NCQA retired the AMM measure due to its limited alignment with current clinical practices and overlap with other behavioral health measures that better reflect integrated, patient-centered care.

DSF-E— The MC final rate was 8.65% and did not meet the goal of 16.22%. The OC final rate was 78.09%, which exceeded the goal of 54.28%. The increase from year to year may be due to an increased ability to capture supplemental data that reflects completed screening scores.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
AMM	Antidepressant Medication Management — Effective Acute Phase Treatment	67.00%	68.08%	67.21%	68.35%	☐ Y ☒ N
AMM	Antidepressant Medication Management — Effective Continuation Phase Treatment	48.62%	48.06%	50.64%	48.16%	☒ Y ☐ N

DSF-E	Depression Screening and Follow-up for Adolescents and Adults — Depression Screening (Total)	1.98%	6.57%	8.65%	16.22%	☐ Y ☒ N
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AMM — Antidepressant Medication Management (Acute Phase Treatment)

The performance did not meet the goal of 68.35%. In MY 2024, the rate was 67.21%, remaining just below target. Between MY 2022 to MY 2024 the rate fluctuated slightly, from 67.00% to 68.08%, then declined to 67.21%, indicating a need for renewed focus on early-phase medication adherence.

AMM – Antidepressant Medication Management (Continuation Phase Treatment)

The performance met and exceeded the goal of 48.16%, reaching 50.64% in MY 2024. From MY 2022 to MY 2024, after a slight dip from 48.62% to 48.06%, the measure improved to 50.64%, showing a positive upward trend suggesting that interventions to support long-term medication adherence have been effective.

DSF-E – Depression Screening and Follow-Up (Depression Screening Total)

The performance did not meet the goal of 16.22%. In MY 2024, the rate was 8.65%, remaining below target. From MY 2022 to MY 2024, the measure improved from 1.98% to 6.57%, and then to 8.65%, reflecting a steady upward trend. While the goal was not met, the data indicates growing adoption of depression screening practices, and continued progress is expected with sustained efforts.

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
AMM	Antidepressant Medication Management – Effective Acute Phase Treatment	75.51%	75.52%	73.71%	78.39%	☐ Y ☒ N
AMM	Antidepressant Medication Management – Effective Continuation Phase Treatment	55.10%	60.77%	58.22%	62.58%	☐ Y ☒ N
DSF-E	Depression Screening and Follow-up for Adolescents and Adults – Depression Screening (Total)	0.04%	62.38%	78.09%	54.28%	☒ Y ☐ N

AMM – Antidepressant Medication Management (Acute Phase Treatment)

The performance did not meet the goal of 78.39%. In MY 2024, the rate declined to 73.71%, remaining below target. From MY 2022 to MY 2024, performance remained stable between 75.51% and 75.52%, but dropped in MY 2024 to 73.71%, indicating a downward trend.

AMM – Antidepressant Medication Management (Continuation Phase Treatment)

The performance did not meet the goal of 62.58%. In MY 2024, the rate was 58.22%, just short of the goal. From MY 2022 to MY 2024, the measure improved from 55.10% to 60.77% in MY 2023, but declined to 58.22% in MY 2024, reflecting a partial regression.

DSF-E – Depression Screening and Follow-Up (Depression Screening Total)

The performance met and exceeded the goal of 54.28%, achieving a rate of 78.09% in MY 2024. From MY 2022 to MY 2024 the measure showed a large, sustained increase, rising from 0.04% in MY 2022 to 62.38% in MY 2023, and further to 78.09% in MY 2024. This reflects a highly successful upward trend, indicating strong and effective adoption of depression screening practices across the OneCare population.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Created a draft to update the prescriber tip tool sheet 2. Updated prescriber letter 3. Created a QRG and PowerPoint presentation for providers and staff on how to use the Provider Portal 4. Created a social media post for this HEDIS measure 5. Created article for Fall member newsletter	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AMM
1. HEDIS provider tool tip sheet finalized June 6, 2025 2. Prescribing provider letter finalized June 9, 2025 3. Created social media posts	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	DSF-E
1. Provider letter: a. Presented provider letter to Behavioral Health Quality Improvement (BHQI) Workgroup on August 14, 2025 b. BHQI finalized on August 26, 2025 2. PCP provider mailout: a. August 28, 2025 - 595 letters. 3. HEDIS Provider Tool Tip Sheet Finalized and sent to providers in the Health Network Weekly Communication on August 11, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	DSF-E

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

AMM: NCQA retired the measure, and it was removed from the QI workplan in Q2.

DSF-E: For the Medi-Cal population, the rate increased significantly from 0.02% in September MY 2024 to 3.94% in September MY 2025, indicating that recent interventions are beginning to take effect. Although the rate remains low, the relative increase reflects positive momentum.

For the OneCare population, no data was reported in MY 2024, but a prospective rate of 4.56% was captured in MY 2025, suggesting that screening efforts are now being tracked. While the goal/MPL targets were not specified, the data suggests that the program is moving in the right direction, and continued

focus on provider engagement, data capture, and member outreach will be essential to sustain and build on this progress

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
DSF-E	MC: Depression Screening:12 years and older (Total)	0.02%	3.94%
DSF-E	OC: Depression Screening:12 years and older (Total)	N/A	4.56%

Indicator/Goal: The performance rate from the same month of the previous year

Q2 Intervention – Data and Provider Focused (Completed)

- HEDIS Provider Tool Tip Sheet finalized on June 6, 2025
- Prescribing Provider Letter finalized on June 9, 2025

Effectiveness: These Q2 interventions were foundational tools that may have laid the groundwork for the Q3 gains.

Member and Provider Engagement (Completed)

Social media posts were created and targeted both members and providers.

Effectiveness: While difficult to quantify directly, this outreach likely supported broader awareness and engagement, reinforcing the importance of depression screening among both audiences.

Q3 Intervention – Direct Provider Outreach (Ongoing)

- Provider letter presented to BHQI Workgroup on August 14, 2025, and finalized on August 26, 2025
- PCP mailout: 595 letters sent on August 28, 2025
- HEDIS Provider Tool Tip Sheet included in Network Weekly Communication on August 11, 2025.

Effectiveness: These Q3 interventions align closely with the observed increase in the September MY 2025 rate. The timing suggests that direct provider communication and education had an impact on screening behavior and documentation.

VI. Qualitative Analysis:

BHI program specialists are responsible for processing the data and implementing targeted interventions.

Causal/Barrier Analysis:

- Data collection remains the primary barrier. Currently, information is being captured through supplemental data sources. The BHQI Workgroup is exploring additional methods to obtain supplemental data that more accurately reflects completed screenings and follow-up visits.
- Additional provider engagement strategies may be needed to increase awareness among both providers and members, such as implementing a member text messaging campaign.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Sustain and expand provider education	• Continue distributing HEDIS Tool Tip Sheets, ensuring they are accessible through provider portals and our website • Offer virtual training or review DSF-E requirements and documentation tips • Collaborate on office visits with Provider Relations for provider outreach and education	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	DSF-E
Increase member awareness and engagement	• Targeted social media campaign to members who may need a depression screening • Partner with community-based organizations to amplify the importance of depression screenings	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	DSF-E

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data indicates we are making measurable progress in improving depression screening rates among the Medi-Cal population. The prospective rate for DSF-E increased significantly from 0.02% in September MY 2024 to 3.94% in September MY 2025, reflecting a positive response to recent interventions. The upward trend suggests we are gaining traction. Interventions such as provider tool tip sheets, targeted mailouts and social media outreach appear to be contributing to increased awareness and documentation. Although the overall goal has not yet been met and the measure will remain on the work plan for 202, the data shows that the initiative is moving in the right direction. Continued focus on provider engagement, data capture and member outreach will be essential to sustain this momentum and achieve future performance targets.

4.17 Behavioral Health Services: Schizophrenia	
Author(s): Nathalie Pauli	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Nathalie Pauli (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Workplan Goal/Objective: Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health’s program assesses the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members with severe mental illness who use antipsychotics are at increased risk of diabetes. In the United States, diabetes is one of the leading causes of death. Lack of care for individuals with diabetes who use antipsychotic medications can lead to deteriorating health and death. Screening and monitoring these conditions are important.

CalOptima Health’s program monitors the percentage of members aged 18 and older within the measurement year who have been diagnosed with schizophrenia or schizoaffective disorder and who received antipsychotic medication consistently. Consistently defined as having the medication for at least 80% of their treatment period. This measure aims to support treatment adherence and improve health outcomes for individuals with serious mental illness. Up to 60% of individuals with schizophrenia do not consistently take their antipsychotic medication, which is essential for managing symptoms and avoiding hospitalization. Poor adherence can lead prescribers to misinterpret treatment effectiveness, resulting in unnecessary changes to medication or dosage

II. Data Sources and Methodology:

Diabetes Screening (SSD – MC)

CalOptima Health promotes diabetes screening for early detection and management for members who take antipsychotic medication and are diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder. Antipsychotic medications raise the risk of developing diabetes. This measure focuses on the percentage of members aged 18-64 who fall under the SSD criteria and complete a diabetes screening during MY 2025 (January 1, 2025, to December 31, 2025). Data is drawn from HEDIS results and health care and pharmacy claims.

Antipsychotic Medication Adherence (SAA – MC and OC)

CalOptima Health encourages members aged 18 and older diagnosed with schizophrenia or schizoaffective disorder and who receive antipsychotic medication to remain on their medication for at least 80% of their treatment period. Poor adherence may cause prescribers to mistakenly adjust medication or dosage. This measure tracks the percentage of members aged 18 and older who adhered

to their medication during MY 2025 (January 1, 2025, to December 31, 2025). HEDIS rates are used to identify performance trends and are reported based on data collected during the measurement period.

III. Quantitative Analysis:

The Medi-Cal performance data for MY 2022 through MY 2024 highlights mixed trends across two key behavioral health quality measures: Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder (SSD) and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).

Diabetes Screening (SSD – MC)

The SSD measure showed a positive trajectory in MY2024, increasing from 74.69% in MY 2023 to 76.86%, surpassing its MY 2022 level of 75.97%. This improvement reflects progress in preventive care for individuals prescribed antipsychotic medications. However, despite the upward trend, the measure did not meet the MY 2024 goal of 79.51%, falling short by 2.65 percentage points. Continued efforts are necessary to close this gap, particularly in care coordination and outreach for screening.

Antipsychotic Medication Adherence (SAA – MC)

In contrast, the SAA measure has experienced a steady decline over the three-year period. From 72.27% in MY 2022, the rate dropped to 70.19% in MY 2023 and further to 69.86% in MY 2024. This downward trend resulted in a 4.97 percentage point shortfall from the MY 2024 goal of 74.83%. The consistent decline suggests persistent challenges in medication adherence, possibly related to access, engagement or continuity of care.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.97%	74.96%	76.86%	79.51%	☐ Y ☒ N
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.27%	70.19%	69.86%	74.83%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	79.63%	77.37%	79.47%	77.93%	☒ Y ☐ N

Antipsychotic Medication Adherence (SAA – OC)

The OneCare program's performance on the SAA measure, which evaluates adherence to antipsychotic medications for individuals with schizophrenia, has remained consistently strong over a three-year period, with a notable rebound in MY 2024.

The MY 2024 performance not only reversed the previous year's decline but also exceeded the OneCare goal by 1.54 percentage points, representing a 1.98% relative improvement over the target.

The data reflects high-quality performance and resilience, positioning OneCare as a leader in behavioral health outcomes for individuals with schizophrenia.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
- Best Practice PCP Letter approved on August 6 - Launched a mailing campaign to PCPs, featuring the SSD Best Practice PCP Letter, Tool Tip Sheet and Member Reward Flyer on: - August 6 to 162 PCPs - October 30 to 117 PCPs - November 21 to 109 PCPs - Mailed SSD reward flyer on - August 6 to 2,391 members - October 30 to 90 members - November 21 to one member - Text messaging campaign launched to 1,100 members on July 17, August 21 - Social media reminder about no-cost diabetic screenings posted July 15 - Spring member newsletter mailed on April 22, 2025; article on notice of SSD member health reward of \$25 - Fall member newsletter mailed on September 15, 2025; article on important reminders for members prescribed psychotropic medicine, notice of the SSD member health reward of \$25	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	SSD
- Best Practice PCP Letter approved on September 8 - Launched a mailing campaign featuring the SAA Provider Letter and Tool Tip Sheet on: - September 8 to 114 PCPs - October 30 to 257 PCP's for both Medi-Cal and Medicare - November 21 to 170 PCP's for both Medi-Cal and Medicare - Fall member newsletter mailed on September 15, 2025; article on important reminders for members prescribed psychotropic medicines	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	SAA

MC = Medi-Cal; OC= OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The year-over-year improvements in prospective rates for key behavioral health measures suggest that recent interventions are beginning to yield measurable results.

The SSD measure for the Medi-Cal population also showed improvement, rising from 68.67% to 69.50%. While the 0.83 percentage point increase may appear modest, it reflects consistent upward movement in diabetes screening rates for individuals with serious mental illness, a population that often faces barriers to preventive care. This suggests that interventions aimed at integrating behavioral and physical health services, or improving provider follow-up, are contributing to better screening compliance.

In contrast, the SAA measure for the Medi-Cal population saw only a 0.24 percentage point increase, from 39.55% to 39.79%. This minimal change highlights a continued opportunity for improvement. It may indicate that current interventions are not sufficiently addressing the unique challenges faced by this group, such as medication side effects, stigma or fragmented care systems. Additional strategies, such as peer support, case management or digital adherence tools, may be necessary to drive more meaningful progress.

The most notable improvement was observed in the SAA measure for the OneCare population, where adherence to antipsychotic medications increased from 40.54% in MY 2024 to 46.41% in MY 2025, a 5.87 percentage point gain, representing a 14.49% relative increase.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
SSD	MC: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.67%	69.50%
SAA	MC: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	39.55%	39.79%
SAA	OC: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	40.54%	46.41%

Indicator/Goal: The performance rate from the same month of the previous year

VI. Qualitative Analysis:

The BHQI Workgroup is a multidisciplinary team responsible for overseeing the evaluation and improvement of behavioral health performance measures. This group plays a central role in conducting both qualitative and quantitative analyses, as well as identifying barriers that impact the achievement of quality goals. A qualitative analysis was conducted by BHI program specialists in collaboration with clinical leadership, executive management and data analysts. This team is collectively responsible for identifying barriers to achieving performance goals.

Causal/Barrier Analysis:

SSD

- No data for quarters 1 and 2 from the ITS Data Warehouse team.
- Member compliance is a challenge with this population due to:
 - Some members with this diagnosis may not see their PCP regularly

- Some members may refuse to get their lab work completed
- Inability to conduct prescribing provider outreach due to missing data

SAA

- Due to a lack of data from the county, we are unable to track and trend accurate analysis for this measure
- Inability to conduct prescribing provider outreach due to missing data.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out member health rewards flyers to eligible members • Mail out all prescribing providers with the following: ○ Medical Director Letter ○ List of members/patients in need of screening ○ Provider Tool Tip Sheet	• Continue to track members in need of a glucose screening test • Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Continue to follow up on data pull for text messaging campaign • Mail out member health rewards flyers to eligible members • Continue to mail out to all PCP offices the following: ○ Best Practice PCP Letter ○ Provider Tool Tip Sheet ○ Member Reward Flyer • Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report availability.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	SSD
• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out all prescribing providers with the following: ○ Medical Director Letter ○ List of members/patients in need of screening ○ Provider Tool Tip Sheet	• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out all prescribing providers with the following: ○ Medical Director Letter ○ List of members/patients in need of screening ○ Provider Tool Tip Sheet • Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report availability	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	SAA

VIII. Conclusion:

The prospective rates for MY 2025 show modest but positive trends across all three measures. The SSD MC measure, which tracks diabetes screening for individuals with schizophrenia or bipolar disorder on antipsychotic medications, increased slightly from 68.67% to 69.50%, indicating continued progress in preventive care. While we have seen improvements, the SSD measure will remain on the work plan for 2026. The SAA MC measure, reflecting adherence to antipsychotic medications, also saw a marginal improvement from 39.55% to 39.79%, suggesting stability in medication management efforts. Notably, the SAA OC measure demonstrated a more substantial increase from 40.54% to 46.41%, highlighting a significant improvement in adherence outcomes. These trends suggest that targeted interventions and sustained efforts may be contributing to better health outcomes for individuals with serious mental illness.

4.18 Behavioral Health Services: Care Coordination and Follow-up Care	
Author(s): Jeni Diaz, Valerie Venegas	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jeni Diaz (Program Specialist Sr, Behavioral Health Integration); Valerie Venegas (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

For the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure, CalOptima Health's QIHETP monitors the proportion of ED visits among members aged 6 years and older who present with a principal diagnosis of mental illness or intentional self-harm, and who subsequently receive follow-up care for mental health conditions. The program reports on two specific performance measures:

1. The percentage of ED visits followed by a mental health follow-up within seven days.
2. The percentage of ED visits followed by a mental health follow-up within 30 days

The Follow-Up After Emergency Department Visit for Substance Use (FUA) measure is the percentage of ED visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- 2. The percentage of ED visits for which the members received follow-up within seven days of the ED visit (eight total days).

The reason why CalOptima Health focuses on the FUA measure is that many individuals with SUD face barriers to care (e.g., stigma, lack of access, housing instability). Proactive follow-up helps address these disparities by ensuring equitable access to treatment and support.

The Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) measure is the percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

- 1. The percentage of visits or discharges for which the members received follow-up for substance use disorder within the 30 days after the visit or discharge.
- 2. The percentage of visits or discharges for which the members received follow-up for substance use disorder within the seven days after the visit or discharge.

Focusing on the FUI measure helps CalOptima Health ensure that treatment for SUD is not just a one-time event, but part of a comprehensive, ongoing recovery process. It is about saving lives, improving health outcomes and building a more responsive and equitable healthcare system.

II. Data Sources and Methodology:

The data used for this analysis is derived from HEDIS for MY 2025 (January 1, 2025, through December 31, 2025). Data is collected through administrative claims and encounter records submitted by providers and facilities. CalOptima Health utilizes Citius as its HEDIS engine to extract, process and validate data in alignment with HEDIS technical specifications, ensuring accuracy and consistency in reporting.

For the purposes of this analysis, data is reported and trended on a quarterly basis to monitor performance over time and identify opportunities for improvement. The HEDIS methodology, including measure definitions, eligible population criteria and follow-up timeframes, is applied to assess compliance with follow-up care after ED visits.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
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FUM	Follow-Up After Emergency Department Visit for Mental Illness – 30 days (Total)	58.83%	35.73%	52.33%	53.82%	☐ Y ☒ N
FUM	Follow-Up After Emergency Department Visit for Mental Illness – 7 days (Total)	38.78%	21.38%	32.96%	33.01%	☐ Y ☒ N
FUA	Follow-Up After Emergency Department Visit for Substance Use – 30 days (Total)	24.05%	21.41%	28.63%	36.18%	☐ Y ☒ N
FUA	Follow-Up After Emergency Department Visit for Substance Use – 7 days (Total)	12.98%	11.23%	16.81%	18.76%	☐ Y ☒ N
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder – 30 days (Total)	22.33%	20.25%	30.69%	44.53%	☐ Y ☒ N
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder – 7 days (Total)	8.07%	7.99%	13.65%	26.90%	☐ Y ☒ N

In MY 2024, performance on the FUA measures demonstrated a notable increase following a decline in MY 2023. Both the seven-day and 30-day follow-up rates improved year-over-year, reflecting renewed efforts to re-engage members in timely SUD treatment following emergency care. The FUA-30 Day rate increased from 21.41% in MY 2023 to 28.63% in MY 2024, a 7.22 percentage point improvement, and a 4.58 percentage point gain over the MY 2022 rate. Similarly, the FUA seven-day rate rose from 11.23% to 16.81%, marking a 5.58-percentage point increase from the prior year and a 3.83-percentage point improvement over MY 2022. Despite this positive trajectory, neither measure met the MY 2024 Medi-Cal performance goals. The 30-day follow-up rate fell short of the 36.18% target by 7.55 percentage points, while the seven-day rate was 1.95 percentage points below the 18.76% goal. These gaps highlight the continued need for system-level improvements in post-ED care coordination and access to timely SUD treatment services.

In MY 2024, performance on the FUI measures showed modest improvement, but both the seven-day and 30-day follow-up rates remain below Medi-Cal performance goals. The FUI 30-day follow-up rate increased from 20.25% in MY 2023 to 30.69% in MY 2024, representing a 10.44 percentage point improvement and an 8.36 percentage point gain over the MY 2022 rate of 22.33%. This upward trend suggests that efforts to improve care transitions following inpatient or residential SUD treatment are beginning to take effect. Similarly, the FUI seven-day rate rose from 7.99% in MY 2023 to 13.65% in MY 2024, a 5.66 percentage point increase year-over-year and a 5.58 percentage point improvement from MY 2022. While this growth is encouraging, the measure remains below the MY 2024 Medi-Cal goal of 26.90%, with a gap of 13.25 percentage points. The 30-day measure also falls short of its 44.53% goal, with a 13.84-percentage point gap.

Between MY 2023 and MY 2024, there was a significant improvement in both the seven-day and 30-day FUM measures. The 30-day follow-up rate increased from 35.76% to 52.33%, achieving 97.2% of the MY 2024 goal of 53.82%. Similarly, the seven-day follow-up rate rose from 21.38% to 32.96%, reaching 99.8% of the MY 2024 goal of 33.01%. These substantial year-over-year gains suggest that recent interventions have been highly effective. While both measures are just shy of their respective goals, the minimal gaps

indicate that with continued focus and targeted efforts, full attainment of the goals is within reach. Sustaining these improvements and identifying the key drivers behind this progress will be essential for long-term success.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Participation in DHCS/HCA BH collaboration project which is focusing on improving the rates for FUA/FUM measures	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
2. Member outreach via BH telehealth vendor to assist with scheduling follow-up appointments. Outreach based on daily ED data feed	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
3. Weekly text message campaign to remind members who have visited the ER to contact their providers to schedule a follow-up appointment	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
4. Sharing FUA/FUM data with HNs via sFTP	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
5. BHI Quality team attended HN Quality Meetings to educate and remind HNs on the importance of ED follow-up.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
6. Importance of follow-up visit after ED articles shared in Spring and Fall member newsletter	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete	FUA/FUM
7. Emailed the HEDIS Provider Tool Tip Sheet to providers in the HN Weekly Communication	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	FUA/FUM/FUI

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Throughout the measurement year, a multipronged strategy was implemented to improve performance on FUA and FUM measures. These interventions targeted both members and providers, leveraging data-driven outreach, collaborative partnerships and educational efforts.

1. Member-Focused Interventions

Several initiatives were designed to directly engage members and encourage timely follow-up after ED visits:

- Telehealth outreach: A behavioral health telehealth vendor conducted proactive outreach based on daily ED data feeds. This real-time approach enabled the timely scheduling of follow-up appointments, reducing barriers to care.
- Text message campaigns: Weekly text reminders were sent to members who had recently visited the ED, prompting them to contact their providers.
- Newsletter articles: Educational content was included in both Spring and Fall member newsletters, emphasizing the importance of follow-up visits after ED discharges. This helped raise awareness and normalize follow-up care as part of the recovery process.

These member-focused strategies have shown positive engagement trends and improved member awareness of the importance of follow-up care.

2. Provider and Health Network Engagement

To support provider compliance and reinforce the importance of timely follow-up, several interventions were implemented:

- HEDIS Tip Sheet Distribution: Providers received a targeted tip sheet via the Health Network Weekly Communication. This resource offered actionable guidance on improving FUA/FUM/FUI performance, indicating successful dissemination.
- Participation in HN Quality Meetings: The BHI Quality team actively participated in HN quality meetings to educate and remind HNs of the importance of ED follow-up. These sessions fostered collaboration and accountability.
- Data Sharing via sFTP: FUA/FUM data was shared regularly with HNs, enabling them to identify gaps and take corrective action. This transparency has supported data-driven decision-making and performance monitoring.

These provider-facing efforts have contributed to greater alignment across the care continuum, with improved provider awareness and responsiveness to follow-up care requirements.

3. Collaborative Partnerships

The organization's participation in the DHCS/HCA Behavioral Health collaboration project has been instrumental in aligning local and state-level efforts to improve behavioral health outcomes. This collaboration has facilitated shared learning, the dissemination of best practices and system-level improvements.

The combination of real-time data use, member engagement, provider education and interagency collaboration has created a robust framework for improving FUA and FUM performance. While most interventions are ongoing, early indicators suggest increased follow-up rates, enhanced provider engagement and greater member awareness. Continued monitoring and refinement of these strategies will be essential to sustaining and building on these gains.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
FUM	MC: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (Total)	26.98%	39.23%
FUM	MC: Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	14.76%	23.25%
FUA	MC: Follow-Up After Emergency Department Visit for Substance Use – 30 Days (Total)	21.12%	25.87%
FUA	MC: Follow-Up After Emergency Department Visit for Substance Use – 7 Days (Total)	11.33%	13.94%
FUI	MC: Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days (Total)	N/A	25.97%
FUI	MC: Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (Total)	11.40%	8.76%

Indicator/Goal: The performance rate from the same month of the previous year

A review of the September prospective rates for MY 2024 and MY 2025 reveals notable improvements in follow-up care after ED visits for behavioral health conditions. The data reflects the impact of targeted interventions implemented across member outreach, provider engagement, and data sharing strategies.

The most significant gains were observed in the FUM measure:

- 30-day follow-up improved from 26.98% to 39.23%, an absolute increase of 12.25 percentage points.
- Seven-day follow-up rose from 14.76% to 23.25%, an 8.49-percentage point increase.

These results suggest that interventions such as telehealth outreach, text message reminders and provider education have been highly effective in promoting timely follow-up care for mental health.

FUA measures also demonstrated positive momentum:

- 30-day follow-up increased from 21.12% to 25.87%, a 4.75-percentage point gain.
- Seven-day follow-up rose from 11.33% to 13.94%, a 2.61 percentage point increase.

While the gains are more modest compared to FUM, the upward trend indicates that member-facing interventions and data-driven outreach are contributing to improved substance use follow-up rates.

The FUI measure presented mixed results:

- The 30-day follow-up rate was newly reported in MY 2025 at 25.97%, establishing a strong baseline.

- However, the seven-day follow-up rate declined from 11.40% to 8.76%, a 2.64 percentage point drop.

This decline highlights a potential gap in early engagement following high-intensity care for SUD. It suggests a need for targeted intervention refinement, such as earlier outreach, improved discharge planning or enhanced provider coordination.

The data demonstrates that the implemented interventions are driving measurable improvements, particularly in mental health follow-up (FUM). Continued focus on real-time data use, member engagement and provider alignment will be essential to improve the rate and address areas of concern, especially the early follow-up for high-intensity substance use care (FUI seven-day).

VI. Qualitative Analysis:

The analysis of the 2025 interventions was conducted by the BHI Quality Team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies and identifying barriers to achieving targeted rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal medical directors, and representatives from other member-facing and provider-facing departments. regularly participate in promoting cross-functional collaboration and ensuring alignment of behavioral health quality initiatives.

Causal/Barrier Analysis:

In 2025, while the overall FUM and FUA rates showed significant improvement, ongoing challenges were identified through qualitative feedback and data review. Barriers included:

- Member disengagement or difficulty reaching members post-ED visit due to inaccurate contact information
- Data lags or inconsistencies in ED encounter reporting
- Variability in health network engagement regarding post-ED member outreach
- Technology limitations in provider access to real-time FUA/FUM data (addressed by the development of daily reports for the Provider Portal)

The BHI Quality team remains responsible for tracking these barriers, engaging stakeholders in solution development and adjusting strategies as needed to sustain and further improve FUM and FUA performance.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Ensure that all data exchanges continue to follow the established processes between CalOptima Health and HCA	Continue participation in the IHI Collaborative through August 2026 to support ongoing quality improvement efforts	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	FUM/FUA
Use stratified data (e.g., by diagnosis, age, geography) to identify high-risk members and tailor outreach efforts	Use of decision point insights to obtain stratified data.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	FUM/FUA

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the analysis supports the conclusion that the interventions implemented have created a strong foundation for sustained improvement in behavioral health follow-up care. By centering the member experience, engaging providers, and fostering system-level collaboration, CalOptima Health is well-positioned to continue driving progress on FUA and FUM measures. However, opportunities remain, particularly in addressing the decline in FUI seven-day follow-up rates. This suggests a need to revisit early engagement strategies for members discharged from high-intensity substance use care, possibly through enhanced discharge planning or more immediate outreach. All measures (FUM, FUA and FUI) will remain on the work plan for 2026.

4.19 Behavioral Health Services: Medication Management	
Author(s): Jaylene Ramirez, Valerie Venegas	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jaylene Ramirez (Program Specialist, Behavioral Health Integration); Valerie Venegas (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): While antipsychotic medications are effective for a specific subset of psychotic disorders affecting children and adolescents, their use frequently extends beyond these indications to include nonpsychotic conditions. For these latter conditions, psychosocial interventions are typically recommended as the first-line treatment. CalOptima Health assesses the rate of children receiving psychosocial care prior to being prescribed an antipsychotic medication.

Pharmacotherapy for Opioid Use Disorder (POD): The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. Focusing on the POD measure is essential because treatment retention is directly linked to improved health outcomes. Research consistently shows that individuals who remain on medications such as buprenorphine, methadone or extended-release naltrexone for six months or longer experience significantly lower rates of relapse, overdose and mortality. The 180-day benchmark is not arbitrary; it represents a meaningful threshold for treatment stability and long-term recovery. This measure also provides insight into the effectiveness of care coordination and access to services. Low performance may signal barriers such as limited provider availability, stigma, transportation challenges or gaps in follow-up care. By identifying and addressing these issues, health plans and providers can improve continuity, reduce avoidable ED visits and support members in achieving recovery goals.

II. Data Sources and Methodology:

APP: The data is pulled from Citius. The data is updated monthly, and we download a quality report to review and evaluate the members who are not in compliance with the measure. Data is drawn from claims.

POD: The data used for this analysis is derived from HEDIS for MY 2025 (January 1, 2025, through December 31, 2025). Data is collected through administrative claims and encounter records submitted by providers and facilities. CalOptima Health utilizes Citius as its HEDIS engine to extract, process and validate data in alignment with HEDIS technical specifications, ensuring accuracy and consistency in reporting. For the purposes of this analysis, data is reported and trended on a quarterly basis to monitor performance over time and identify opportunities for improvement.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	25.00%	28.95%	53.10%	54.55%	☐ Y ☒ N
POD	Pharmacotherapy for Opioid Use Disorder	20.77%	7.79%	4.93%	21.36%	☐ Y ☒ N

APP: The APP measure for Medi-Cal showed a significant year-over-year improvement, increasing from 25.00% in MY 2022 to 53.10% in MY 2024. This reflects a strong upward trend in performance. While the MY 2024 goal was set at 54.55%, the current rate is just 1.45 percentage points below target, indicating that the team is very close to achieving its goal and demonstrating substantial progress over the past year.

POD: This measure serves as a critical indicator of how effectively the health system is supporting individuals with OUD through access to and retention in evidence-based medication treatment. An analysis of Medi-Cal performance from MY 2022 through MY 2024 reveals a concerning downward trend and a significant gap in meeting the established performance goal.

In MY 2022, the POD rate stood at 20.77%, reflecting relatively strong engagement in pharmacotherapy among eligible members. However, in MY 2023, the rate dropped sharply to 7.79%, a decline of nearly 13 percentage points. This downward trajectory continued into MY 2024, with the rate falling further to 4.93%, representing a total decrease of 15.84 percentage points over the two-year period.

The MY 2024 goal for this measure was set at 21.36%, underscoring the importance of sustained treatment engagement in combating the opioid crisis. With a current rate of 4.93%, the organization is 16.43 percentage points below its target.

This trend suggests systemic challenges in maintaining continuity of care for members with OUD. Potential contributing factors may include:

- Limited access to providers offering medication-assisted treatment (MAT)
- Stigma associated with OUD and its treatment
- Gaps in care transitions following ED or inpatient discharges
- Barriers related to transportation, housing or social support
- Incomplete or delayed data capture of pharmacotherapy events

The consistent decline over three years signals an urgent need for targeted intervention. Strategies such as expanding MAT provider networks, enhancing member outreach and education, improving care coordination, and strengthening data systems are essential to reversing this trend.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
In Quarter 3, we began to mail out monthly provider tip tool sheets and best practices letters. An app text message campaign was also drafted, with the hope of sending it to members in 2026. Provider tip tool sheets were submitted to communications for editing with CPT/HCPCS codes	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	APP
HEDIS Provider Tool Tip Sheet sent to providers in the Health Network Weekly Communication.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	POD

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

APP: The APP measures's September prospective rate for MY 2025 (37.92%) shows a substantial improvement over the same month in MY 2024 (22.73%), reflecting a 66.8% year-over-year increase. This

indicates that intervention is driving meaningful progress. However, the current rate remains 16.63 percentage points below the MPL of 54.55%, suggesting that while the intervention is effective, further enhancements are needed to fully close the performance gap.

POD: To support improvement in this measure, CalOptima Health implemented a provider-focused intervention during Q3 of the measurement year. A HEDIS Provider Tool Tip Sheet was distributed through the Health Network Weekly Communication, targeting providers with concise, actionable guidance on how to support members with OUD through evidence-based pharmacotherapy.

This intervention aimed to:

- Increase provider awareness of the POD measure and its clinical importance
- Encourage consistent prescribing and follow-up practices
- Reinforce the value of MAT as a standard of care

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
APP	MC: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	22.73%	37.92%
POD	MC: Pharmacotherapy for Opioid Use Disorder	9.72%	5.29%

Indicator/Goal: The performance rate from the same month of the previous year

APP: The APP measure’s September prospective rate improved significantly year-over-year, rising from 22.73% in MY 2024 to 37.92% in MY 2025. This marks a 15.19 percentage point increase, or a 66.8% relative improvement. The data indicates a strong positive trend in performance, with the MY 2025 rate showing substantial progress compared to the same point in the previous year.

POD: This measure continues to serve as a critical indicator of how well the health system is supporting members with OUD through access to and retention in evidence-based medication treatment. However, the September prospective rates for MY 2025 reveal a concerning decline in performance. In MY 2024, the POD prospective rate was 9.72%. By MY 2025, that rate had dropped to 5.29%, representing a 4.43 percentage point decrease in performance. This means that fewer than six out of every 100 eligible members are maintaining pharmacotherapy for OUD, a significant gap in care for a population at high risk of relapse, overdose and mortality. The significant decline in POD performance between MY 2024 and MY 2025 highlights a critical area for improvement. Addressing this issue is not only a quality metric priority but also a public health imperative in the ongoing response to the opioid crisis.

VI. Qualitative Analysis:

APP: The analysis of the 2025 APP interventions was conducted by the BHI Quality team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies

and identifying barriers to achieving targeted APP rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal Medical Directors, and representatives from other member-facing and provider-facing departments regularly participate to promote cross-functional collaboration and ensure alignment of behavioral health quality initiatives.

POD: The analysis of the 2025 POD interventions was conducted by the BHI Quality team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies and identifying barriers to achieving targeted POD rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal Medical Directors, and representatives from other member-facing and provider-facing departments regularly participate to promote cross-functional collaboration and ensure alignment of behavioral health quality initiatives. The qualitative insights into the POD measure performance underscore the need for a comprehensive, multilevel strategy that addresses both clinical and nonclinical barriers to care. Improving this measure is not only a quality improvement priority but also a public health imperative. With focused action and cross-sector collaboration, CalOptima Health can begin to close the treatment gap and improve outcomes for individuals living with OUD.

Causal/Barrier Analysis:

APP:

- Due to system changes and updates, we did not have access to data for the first two quarters
- Lack of data in Quarter 1 and Quarter 2 prohibited CalOptima Health from beginning our interventions

POD:

- The barrier with POD is that pharmacy claims data for Medi-Cal members comes through the state, as it; pays for those prescriptions. However, sometimes the claims are not being billed through the state. If a member is getting their prescription at the county, CalOptima Health does not know the process for them obtaining their prescription outside of the state's coverage.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

MC = Medi-Cal; OC= OneCare

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
More accessibility and transparency for providers to access the data and view which of their members are not compliant	In 2026, we will continue to send out monthly provider mailouts. We also hope to send out an APP text message campaign to members starting in January 2026	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	APP
Re-engaging providers through education, performance feedback and support for MAT integration.	Educate providers on the measure and best practice guidelines	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	POD
Collaborating with community partners to extend the reach of interventions and address social determinants of health.	Educate providers on the measure and best practice guidelines	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	POD

VIII. Conclusion:

APP: While the APP measure prospective rate met the goal for the year 2025, the MY2024 rate did not meet goal and the measure will remain on the work plan for 2026. Despite the prospective rate goal being met, we are still planning new interventions in 2026 to ensure that more members are compliant and receiving quality care as directed by the NCQA.

POD: The continued decline in the POD measure highlights a critical gap in the health care system's ability to support individuals with opioid use disorder through sustained, evidence-based treatment. Quantitative data shows a sharp drop in performance, while qualitative insights point to systemic, operational and behavioral barriers that are limiting access, engagement and retention in care. Despite these challenges, the path forward is clear. The POD measure will remain on the work plan for 2026 and improving POD performance will require a coordinated, multilevel strategy that includes expanding provider capacity, enhancing member outreach, strengthening care transitions and addressing social determinants of health. It also calls for a renewed focus on data accuracy, real-time monitoring and cross-sector collaboration. Ultimately, improving this measure is not just about meeting a benchmark; it is about saving lives, reducing harm and ensuring that every member with opioid use disorder has access to the care and support they need to recover and thrive. With intentional action and sustained commitment, meaningful progress is both possible and necessary.

4.20 Behavioral Health Services: School-Based Services Mental Health Services	
Author(s): Sherie Hopson	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Sherie Hopson (Project Manager, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No

Workplan Goal/Objective: Develop and deliver a comprehensive final report that highlights key accomplishments and outcomes of the SBHIP initiative.				
Goal Met:	☒ Yes	☐ No	☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

The Student Behavioral Health Incentive Program (SBHIP) was established by state law and administered by the DHCS over its three-year timeline, from January 1, 2022, to December 31, 2024. During this period, Medi-Cal managed care plans (MCPs) across California were eligible to receive up to \$389 million in incentive payments for developing programs aimed at increasing access to preventive care, early intervention and behavioral health services delivered by school-affiliated behavioral health providers. These payments were tied to the achievement of specific performance metrics. As part of this initiative, DHCS allocated up to \$25,459,676 to CalOptima Health, the MCP serving Orange County. CalOptima Health successfully earned the full allocation by meeting all program requirements and performance metrics.

II. Data Sources and Methodology:

CalOptima Health, in partnership with the Orange County Department of Education (OCDE), all 28 school districts, Hazel Health, Western Youth Services (WYS), Children’s Hospital of Orange County (CHOC), part of Rady Children’s Health, and HCA, implemented and supported key focus areas under SBHIP.

- Improve coordination of behavioral health services for children and adolescents by enhancing communication among Medi-Cal MCPs, schools, providers and county behavioral health plans.
- Increase access to behavioral health services for K–12 students enrolled in Medi-Cal through schools and affiliated partners.
- Expand availability of nonspecialty behavioral health services on or near school campuses.
- Addresses health equity gaps and disparities in access to behavioral health services.

III. Program Results:

OCDE and the 28 Public School Districts

- School districts initiated new partnerships with community-based organizations to expand access to behavioral and mental health support for students and families across the county.
- SBHIP funding increased behavioral health staffing by 38.45% over the 2023–24 and 2024–25 school years, expanding capacity to serve more students.
- Training for school personnel in behavioral health significantly improved, strengthening early identification and support for student needs.
- Screening and referral processes were streamlined and enhanced, resulting in more timely and effective connections to care for students.
- Districts modernized IT infrastructure and systems, improving data sharing, service coordination and overall program efficiency.

Hazel Health (Telehealth services)

- 20 of the 28 school districts signed direct contracts with Hazel Health
- More than 260,000 students have access to telehealth services
- Hazel Health extended its services through the 2025–2026 school year

WYS

- Developed an on-demand Behavioral Health Training Program for Orange County school staff, focused on trauma-informed, brain-based strategies.
- 65% of the 28 school districts' personnel have accessed the training via live sessions, workshops or the Learning Management System platform.
- WYS continues to provide post-training consultative support to school behavioral health staff.

CHOC, part of Rady Children's Health

- CHOC expanded its School Reintegration Program by hiring a dedicated coordinator to support students transitioning back to school after acute mental health care, ensuring continuity and collaboration between clinical teams and schools.
- CHOC's Mental Health Crisis Clinic (MHCC) expanded access to timely care, providing evaluations within 72 hours followed by up to three stabilization sessions specifically for youth experiencing suicidal ideation who do not have a current therapist.
- Through SBHIP, a deaf psychologist was hired to support Orange County school districts in addressing the mental health needs of deaf and hard-of-hearing students.
- Launched the Autism Comprehensive Care Program in Q1 2025, serving students aged 12–17 with autism and severe mental health needs.
- Installed 10 WellSpaces across Orange County school districts to support the mental health and well-being of Medi-Cal eligible youth, including those with private insurance.

IV. Actions/Interventions Implemented in 2025:

CalOptima Health continues to lead and collaborate with SBHIP partners by supporting school districts as they modernize billing systems and prepare to submit claims under the Children and Youth Behavioral Health Initiative (CYBHI) Multi-Payer Fee Schedule Program. In partnership with Carelon Behavioral Health, the DHCS-designated third-party administrator, CalOptima Health is working to ensure accurate and timely reimbursement for the eligible fee schedule mental health services delivered in Orange County schools and by their school-affiliated providers.

V. Conclusion:

The approval of CalOptima Health's SBHIP Project Outcome Reports by DHCS marked a significant milestone. By earning the full \$25.5 million allocated to Orange County, CalOptima Health demonstrated its capability to deliver measurable results that align with the program's goals. This achievement reflects

notable progress and sets the stage for continued collaboration with our partners to support expanding access to mental health services for students throughout Orange County.

4.21 Medication Management: Pharyngitis and Bronchitis	
Author(s): Dexter Dizon	Department: Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Dexter Dizon (Quality Improvement Specialist, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

According to the CDC, inappropriate antibiotic prescribing remains a critical public health concern, contributing to the rise of antibiotic-resistant bacteria and avoidable adverse drug events. Acute respiratory infections, such as pharyngitis and acute bronchitis, are among the most common conditions for which antibiotics are often prescribed unnecessarily, despite clinical guidelines recommending against this practice.

CMS and NCQA emphasize the importance of evidence-based prescribing practices through HEDIS quality measures such as Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB). These measures aim to reduce the misuse of antibiotics by promoting diagnostic stewardship and adherence to clinical guidelines.

The CWP measure evaluates the percentage of episodes for members aged 3 years and older with a diagnosis of pharyngitis who were dispensed an antibiotic and received a group A streptococcus (strep) test. The AAB measure assesses the percentage of episodes for members aged 3 months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic. Both measures are critical for improving care quality, minimizing unnecessary medication use and promoting efforts to prevent antimicrobial resistance.

For Medi-Cal and OneCare populations, performance on these measures is tracked annually and benchmarked against DHCS MCAS goals and NCQA Quality Compass percentiles.

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, Citius. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CWP	Appropriate Testing for Pharyngitis	35.21%	43.66%	52.38%	76.71%	☐ Y ☒ N
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	43.91%	47.55%	39.70%	56.73%	☐ Y ☒ N

For CWP: This measure shows consistent year-over-year improvement, with a 17.17 percentage point increase from 2022 to 2024. However, the current rate (52.38%) still falls short of the 2024 goal (76.71%).

For AAB: After a slight improvement in 2023, the 2024 rate declined to 39.70%, which is not only below the goal but also lower than the 2022 baseline. This suggests a potential area for targeted quality improvement.

Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Create provider educational materials for AAB and CWP	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AAB, CWP
2. Identify the top 10 lowest performing providers	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AAB, CWP
3. Send HEDIS measure information and invitation to review measure-level data (noncompliant members) with our Quality medical director to the lowest performing providers	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	AAB, CWP

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

IV. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
CWP	MC: Appropriate Testing for Pharyngitis - Ages 3 years and Older (Total)	51.72%	51.74%
AAB	MC: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	39.51%	37.14%

Indicator/Goal: The performance rate from the same month of the previous year

CWP (Pharyngitis Testing):

- MC rates are stable, showing a slight increase from 51.72% to 51.74%.

AAB (Antibiotic Avoidance):

- MC rates declined slightly from 39.51% to 37.14%.

V. Qualitative Analysis:

Analysis of the 2025 CWP and AAB interventions was conducted by the Quality Analytics team.

AAB

- **Clinical practice variation:** Providers may continue to prescribe antibiotics for acute bronchitis/bronchiolitis despite guidelines, due to diagnostic uncertainty or perceived patient expectations.
- **Patient expectations:** Members may expect antibiotics for respiratory symptoms, pressuring providers to prescribe even when not clinically indicated.
- **Lack of provider education or reinforcement:** Inconsistent reinforcement of evidence-based guidelines may lead to overprescribing, especially in urgent care or telehealth settings.
- **Documentation gaps:** Incomplete or inaccurate coding may misclassify encounters, affecting measure performance.
- **Access to Non-antibiotic symptom relief:** Limited access to supportive care (e.g., cough suppressants, inhalers) may lead providers to default to antibiotics for symptom management.

CWP

- **Low testing rates:** Underutilization of strep testing before prescribing antibiotics.
- **Workflow barriers:** In fast-paced clinical environments, providers may skip testing due to time constraints or lack of immediate test availability.
- **Telehealth limitations:** Increased use of telehealth may hinder the ability to perform in-person strep testing, leading to empirical antibiotic prescribing.
- **Member reluctance for testing:** Discomfort with throat swabs or a lack of understanding of their importance may reduce member compliance with testing.
- **Data lag and reporting gaps:** Delays in claims data submission or incomplete encounter documentation may underrepresent actual testing rates.

Causal/Barrier Analysis:

AAB

- **Clinical practice habits:** Despite guidelines, some providers may continue prescribing antibiotics for bronchitis/bronchiolitis due to habit, diagnostic uncertainty or perceived patient satisfaction pressures.
- **Patient expectations:** Members may expect antibiotics for respiratory symptoms, leading to overprescribing when providers aim to meet patient demands.

- **Documentation and coding issues:** Inaccurate or incomplete coding of diagnoses and prescriptions may misrepresent actual clinical decisions, affecting measure performance.
- **Access to alternative treatments:** Limited access to nonantibiotic symptom relief options (e.g., inhalers, cough suppressants) may lead providers to prescribe antibiotics as a default.
- **Health literacy:** Members may lack understanding of when antibiotics are appropriate, reducing their acceptance of nonantibiotic treatment plans.

CWP

- **Operational barriers:** In busy clinical settings, providers may skip testing due to time constraints or lack of immediate test availability.
- **Telehealth limitations:** Increased use of telehealth may hinder the ability to conduct in-person strep tests, leading to empirical antibiotic prescribing without confirmation.
- **Member reluctance:** Discomfort with throat swabs or a lack of understanding of their importance may reduce members' willingness to undergo testing.
- **Data lag and reporting gaps:** Delays in claims data submission or incomplete encounter documentation may underreport actual testing rates, skewing performance metrics.

VI. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Continued provider education/training	Targeted provider outreach via faxes/teleconference	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	AAB, CWP
2. Patient education	Education on antibiotic avoidance	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	AAB

MC = Medi-Cal; OC = OneCare

VII. Conclusion:

The evaluation of the AAB and CWP HEDIS measures reveals a mixed picture of performance and progress and will remain on the work plan for 2026. CWP did not meet the goal and remains a critical area for improvement. AAB shows prior success but signs of regression in prospective data. CalOptima Health will explore provider refresher training on the measures, as well as provide patient education on the appropriate use of antibiotics.

4.22 Medication Adherence: Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes

Author(s): Nicki Ghazanfarpour, Pharm.D.

Department(s): Pharmacy Management

Responsible Party(ies): Nicki Ghazanfarpour, Pharm D. (Manager, Pharmacy Management); Susan Vigil, Pharm.D. (Clinical Pharmacist)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☒ No
Workplan Goal/Objective: Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CMS Medicare Part D Star Ratings incentivize high-quality care and improve health outcomes for beneficiaries. CMS specifically focused on adherence for three classes of medications due to the high clinical impact of managing these conditions and strong evidence linking adherence to improved health outcomes: oral antidiabetic medications (excluding insulin), renin-angiotensin system (RAS) antagonists (for hypertension) and, statins (for high cholesterol).

II. Data Sources and Methodology:

Real-time data using pharmacy claims data (starting January 2025) in combination with monthly Acumen Patient Safety Reports (first report available April 2025). Pharmacy claims data is obtained through the data warehouse, and Acumen reports are downloaded from the Patient Safety Analysis Web Portal. Data is analyzed at a minimum of once a month.

III. Quantitative Analysis:

OneCare

Measure	MY 2023 Star Rating	MY 2024 Star Rating
Medication Adherence for Diabetes Medications	87.0%	87.0%
Medication Adherence for Hypertension (RAS antagonists)	86.0%	87.0%
Medication Adherence for Cholesterol (Statins)	83.0%	85.0%

Medication Adherence for Diabetes Medications remained stable at a high level, with an adherence rate of 87.0% in both MY 2023 and MY 2024.

Medication Adherence for Hypertension (RAS antagonists) improved slightly, increasing from 86.0% in MY 2023 to 87.0% in MY 2024.

Medication Adherence for Cholesterol (Statins) showed a notable improvement, rising from 83.0% in MY 2023 to 85.0% in MY 2024.

IV. Data Stratification Data Source and Methodology:

Patient Safety Report results, based on claims from October 2025, were used to compare performance across health networks. Internal efforts have included all health networks; however, high-touch efforts for

1Q 2025–3Q 2025 have been focused on CHCN. Results demonstrate the effectiveness of high outreach in CHCN as compared to other comparably sized health networks. All health networks have been included in high-touch outreach efforts during Q4 2025.

Medication Adherence for Diabetes (MAD)		
Health Network	% Adherent	Denominator
AltaMed	89%	218
AMVI Care	93%	98
CHCN	92%	847
Family Choice	92%	466
HPN - Regal	84%	51
Noble	86%	85
Optum	89%	1501
Prospect	87%	552
United Care	94%	214
Disenrolled	92%	235
Overall	90%	4267

Medication Adherence for Hypertension (MAH)		
Health Network	% Adherent	Denominator
AltaMed	89%	396
AMVI Care	92%	144
CHCN	90%	1377
Family Choice	90%	878
HPN - Regal	89%	100
Noble	80%	122
Optum	89%	2682
Prospect	90%	924
United Care	92%	342
Disenrolled	92%	340
Overall	90%	7305

Medication Adherence for Cholesterol		
Health Network	% Adherent	Denominator
AltaMed	88%	469
AMVI Care	90%	185
CHCN	90%	1641
Family Choice	89%	1101
HPN - Regal	87%	123
Noble	78%	137
Optum	86%	3146
Prospect	85%	1020
United Care	90%	433
Disenrolled	89%	388

Overall	87%	8643
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V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Medication adherence outreach calls for members, providers, and pharmacies (daily calls and provider faxes)	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
2. Monthly member IVR refill reminders	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
3. Targeted reports for health networks to intervene to positively impact medication adherence and convert members to a 100-day supply	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
4. Targeted outreach to promote free prescription mailing services to reduce barriers for medication adherence	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
5. Member mailing on the importance of medication adherence (targeted for the highest part D utilizers)	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC
6. Provide a newsletter distributed via fax and posted to the CalOptima Health provider page on strategies to improve medication adherence. Content with best practices is also shared with health network partners	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC
7. Member text refill reminder	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 October Prospective Rate	MY 2025 October Prospective Rate
MAD	Medication Adherence for Diabetes	88.8%	90.1%
MAH	Medication Adherence for Hypertension (RASA)	88.6%	89.7%
MAC	Medication Adherence for Cholesterol (Statins)	86.2%	87.5%

All three measures are performing slightly higher than at the same time last year. Projected cut points from vendor Hyperlift for the 2027 Stars year (CY 2025) are included below for reference.

Hyperlift 2027 Stars Estimated Cut Points (2025 Data)				
	2	3	4	5
MAD	84% to <87%	87% to <89%	89% to <92%	≥92%
MAH	85% to <89%	89% to <92%	92% to <94%	≥94%
MAC	85% to <88%	88% to <90%	90% to <93%	≥93%

VII. Qualitative Analysis:

Causal/Barrier Analysis:

- Members picking up medications at the pharmacy
- Lack of real-time analytics to support more targeted interventions due to Acumen data lag
- Call attempts are very labor-intensive and require multiple outreaches to successfully speak to members who have valid contact information
- Members are overwhelmed by the volume of prescriptions they have to manage
- Members have misconceptions about the side effect profile of certain medications and often do not think the medications are working when they don't experience immediate results
- Providers often lower dosages without rewriting the prescription; therefore the member has ample medication at home and does not need additional supply
- Many members decline mailing service due to current pharmacy satisfaction

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Improve data analytics capabilities for real-time targeted outreach	Implementation with a new software vendor to support internal workflow and external health network needs.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC
2. Mail order prescription services	New contract for mail-order prescription services. Targeted advertisement via postcard mailing will commence in January 2026	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC
3. Targeted medication adherence outreach program	Continue adherence outreach calls to target members, providers and pharmacies that need action	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC

IX. Conclusion:

The data indicate that the multifaceted approach is effective; however, it requires a broader partnership within the health network to further enhance outcomes. Consistently, adherence rates among internally managed health network members have exceeded those of other large-volume health networks due to our comprehensive intervention strategy and member engagement efforts. The projected increases in Stars cut points, as forecasted by vendor Hyperlift, present a challenge for performance improvement. Despite continuous year-over-year advancements, our projections indicate that the Star rating for medication adherence will remain the same in CY 2024 (Stars 2026) and, as a result, will remain on the work plan for 2026. The implementation of higher-quality Stars analytics reports for internal and external use in 2026 will help support a more expansive partnership.

4.23 Performance Improvement Projects (PIPs) Medi-Cal	
Author(s): Leslie Vasquez	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Leslie Vasquez (Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

The California 2020 Health Disparities Report revealed that African American children experienced worse health outcomes than other groups across all six key measures in DHCS's children's health domain. To address this, DHCS required MCPs to establish a Performance Improvement Project (PIP) to reduce racial and ethnic disparities in well-child visits (the W30 HEDIS measure).

Key barriers addressed:

- Parent/guardian gaps in knowledge about the purpose and value of well-child visits
- Lack of reminders for parents/guardians to complete the well-child visits
- Limited resources for health networks to coordinate well-child visit appointments with a PCP for African American child members

II. Data Sources and Methodology:

Data pulled from claims and encounters using HEDIS engine, Citius, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity. Rates were identified for Black/African American child members.

III. Quantitative Analysis:**Medi-Cal**

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
W30	Well-Child Visits in the First 30 Months of Life for Black/African American Members (First 15 Months)	N/A	45.05%	53.06%	55.78%	☐ Y ☒ N

- Well-child visits in the first 15 months of life have shown steady improvement from MY 2023.
- The MY 2024 rate is 2.72 percentage points below the goal of 55.78%.
- While there is progress toward the goal, additional efforts are needed to close the remaining gap.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Telephonic outreach to remind families of the importance of scheduling well-child visits and assess for barriers to completion	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30
2. Care coordination support to help African American families schedule and complete visits in accordance with the AAP periodicity schedule	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Indicator/Goal: The success rate in delivering well-child visit information and coordinating well-child visit appointments.

Well Child Call Campaign Effectiveness

- Between March and July 2025, 125 unique members were contacted. Of those, 48 (38.4%) were successfully reached by phone and received information about the recommended well-child visit tailored to the member's current age and its importance.
- None of the members contacted accepted appointment coordination for the well-child visit.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Limited engagement with the health care system: Parents/guardians may lack knowledge about the importance and benefits of well-child visits for preventive care and early detection.
- Trust and cultural factors: Historical mistrust of the health care system impacts willingness to seek preventive care.
- Segment of parents that perceive well-child visits as vaccine-only visits: For families who prefer to delay or skip vaccines, these visits may not be seen as offering additional benefits.

- Socioeconomic constraints may play a role: Competing priorities such as work schedules, childcare for other children and financial stress can reduce the ability to attend these visits.
- Communication gaps: Insufficient reminders or follow-up from health plans and providers to prompt parents about upcoming visits. Communication efforts are also hindered by bad contact information. Organizational efforts are needed to improve member contact information and thus the reach rate.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Improved partnerships with health networks and providers	Outreach to members' assigned providers	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	W30
2. Improved community engagement	Collaborate with trusted community leaders and organizations to promote well-child visits (e.g., Black Infant Health)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	W30
3. Multimodal outreach campaigns to improve compliance for CIS, IMA and WCV	Collaboration with multiple departments to improve compliance for pediatric measures among Black, White, and Native Hawaiian/Other Pacific Islander populations Revised member-facing materials that address the scope and importance of well-child visits	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	W30

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

- While improvements were seen in MY 2023 versus MY 2024, W30 performance amongst the target population, the improvement was not statistically significant. This suggests the need for more targeted, high-impact strategies to close care gaps.
- Appointment coordination was not successful. This suggests that members require multiple touchpoints to ensure that all members receive recommended care. This also suggests that improving child visit completion rates requires increased engagement during the pregnancy period. Early connection allows the plan to establish trust, identify barriers sooner and support a stronger continuum of care for underserved members.

4.24 Performance Improvement Projects (PIPs) Medi-Cal Behavioral Health

Author(s): Diane Ramos, Jeni Diaz, Mary Barranco

Department(s): Behavioral Health Integration/
Quality Analytics

Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jeni Diaz (Program Specialist Sr, Behavioral Health Integration); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health aims to achieve a 2% increase in the percentage of Medi-Cal-only members (aged 21 and older) with CHCN or COD who are enrolled in care management (CM), complex care management (CCM) or ECM within 14 days of an ED visit where a diagnosis of serious mental illness (SMI) or SUD was made.

The goal is to strengthen the timely linkage to provider follow-up appointments post-ED visit and to ensure prompt initiation of referrals to CalOptima Health's CM, CCM or ECM programs.

II. Data Sources and Methodology:

An internal report was developed to identify members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD during an ED visit.

Measure Description	The percentage of CHCN and COD CalOptima Health Medi-Cal only members enrolled into CM, CCM or ECM, within 14 days of a provider ED visit where the member was diagnosed with SMH/SUD.
Numerator Description	Members aged 21 years or older, identified by an ED visit with a diagnosis of SMH/SUD, who are enrolled in CM, CCM or ECM. The member should be enrolled within 14 days of the ED visit.
Denominator Description	Members 21 years or older identified by the ED visit with a diagnosis of SMH/SUD. The members already enrolled in the CM, CCM and ECM programs will be excluded from the denominator.
Baseline Measurement Period	January 1, 2023, to December 31, 2023
Remeasurement 1 Period	January 1, 2024, to December 31, 2024
Remeasurement 2 Period	January 1, 2025, to December 31, 2025

III. Quantitative Analysis:

Medi-Cal

Measurement Period Dates	Performance Indicator Measurement Period	Numerator	Denominator	Percentage	MY 2024 Goal	MY 2024 Goal Met / Not Met
January 1, 2023-December 31, 2023	Baseline	29	2679	1.08%	N/A for baseline	N/A for baseline

January 1, 2024– December 31, 2024	Remeasurement 1	65	2807	2.32%	MY 2024 goal 2% increase from baseline	☒ Y ☐ N
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CalOptima Health significantly exceeded its goal of a 2% increase in enrollment into CM/CCM/ECM within 14 days of an ED visit for members with SMI/SUD. The actual rate improved from 1.08% in 2023 to 2.32% in 2024, representing a 114.8% relative increase, well above the targeted 2% improvement.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Member outreach via BH telehealth provider to schedule follow-up appointments after an ED visit	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Monthly collaboration meetings with stakeholders to develop workflow for member outreach and engagement.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Collaboration with HCA and CalOptima Health IT regarding 837 data exchange	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The interventions implemented in 2024 were instrumental in improving the BH Nonclinical PIP outcome, resulting in an increase in the enrollment rate from 1.08% in 2023 to 2.32% in 2024. Member outreach through the BH telehealth provider played a key role by proactively scheduling follow-up appointments after ED visits, ensuring timely engagement and increasing the likelihood of enrollment into CM, CCM or ECM within the 14-day target. Monthly collaboration meetings with internal and external stakeholders helped streamline workflows, align outreach strategies and address operational barriers, resulting in more efficient and coordinated member engagement. Additionally, collaboration with HCA and CalOptima Health IT to improve the 837 data exchange enhanced the accuracy and timeliness of identifying eligible members, allowing outreach teams to act quickly and effectively. Together, these interventions created a more responsive, data-driven and collaborative approach that significantly contributed to the more than doubling of the enrollment rate and the overall success of the PIP.

VI. Qualitative Analysis:

In 2024, key interventions contributed to the improvement of the BH Nonclinical PIP, including member outreach via a BH telehealth provider, monthly stakeholder collaboration meetings, and enhanced 837 data exchange with HCA and CalOptima Health IT. Telehealth outreach enabled timely follow-up scheduling after the ED visit, increasing member engagement and enrollment in CM, CCM or ECM. Regular collaboration meetings helped align workflows and address barriers, while improved data sharing allowed for faster identification of eligible members. These efforts led to more coordinated, data-

driven outreach, resulting in significantly improved outcomes. Ongoing monitoring will focus on sustaining progress and addressing remaining challenges, such as member responsiveness and provider availability.

Causal/Barrier Analysis:

Barrier Analysis – BH Nonclinical PIP

- **Data Integrity Issues**
 - Ineligible members were included due to incorrect coding
 - Resolution: Codes were reviewed and corrected to ensure only eligible members are included in the dataset
- **Internal Stakeholder Coordination**
 - Difficulty engaging departments due to competing priorities
 - Resolution: Regular collaboration meetings helped maintain alignment and communication
- **Challenges Engaging Member Population**
 - Difficulty connecting with members diagnosed with SMI/SUD
 - Resolution: Partnered with a BH telehealth provider to automate real-time ED data sharing and support timely outreach
- **Implementation of New Care Management System (February 2024)**
 - Transition required staff to learn new referral processes
 - Resolution: Staff were trained, and a new referral workflow was implemented
- **Delays in PHI Data Sharing with Community Partners**
 - Approvals for sharing protected health information caused delays
 - Resolution: Automated daily ED data sharing via sFTP was established to improve coordination
- **Delay in Data Exchange with County Behavioral Health System**
 - Lack of infrastructure and agreements delayed data sharing
 - Resolution: An MOU was executed, a data dictionary was developed, and testing was completed to ensure data accuracy and integrity

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Use stratified data (e.g., by diagnosis, age, geography) to identify high-risk members and tailor outreach efforts	Conduct member outreach through the behavioral health telehealth provider to coordinate follow-up appointments after the ED visit	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

2. Implement targeted strategies to address disparities in access and outcomes.	Facilitate monthly collaboration meetings with key stakeholders to design and refine workflows for member outreach and engagement	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Ensure 837 data exchange continues to follow the established process between HCA and CalOptima Health	Ongoing partnership with HCA and CalOptima Health IT teams to support the exchange of data files	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC= OneCare

VIII. Conclusion:

The BH Nonclinical PIP in 2024 marked a significant turning point in the approach to care coordination and member engagement. Through a series of targeted, collaborative and data-informed interventions, the project achieved a remarkable increase in enrollment from 1.08% in 2023 to 2.32% in 2024, demonstrating the power of strategic innovation in behavioral health outreach. At the heart of this success was the integration of a BH telehealth provider, which enabled timely and proactive follow-up with members after they visited the ED. This not only improved the speed of engagement but also increased the likelihood of members enrolling in appropriate care management programs within the critical 14-day window. Monthly collaboration meetings with internal and external stakeholders further strengthened the initiative by aligning workflows, addressing operational barriers and fostering a shared commitment to member-centered care. Equally transformative was the improved 837 data exchange process, developed in partnership with HCA and CalOptima Health IT. This enhancement allowed for more accurate and timely identification of eligible members, empowering outreach teams to act swiftly and effectively. Despite challenges such as data integrity issues, internal coordination hurdles and the complexities of implementing a new care management system, each barrier was addressed with thoughtful and sustainable solutions. Together, these efforts created a more agile, responsive and collaborative system, one that not only improved outcomes but also laid a strong foundation for continued progress. As the project progresses, ongoing monitoring and refinement will be crucial to sustaining these improvements and addressing persistent challenges, such as member responsiveness and provider availability.

4.25 Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	
Author(s): Melissa Morales	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Melissa Morales (Quality Improvement Specialist, Quality Analytics)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

CMS requires all Medicare Advantage plans and SNPs to conduct a Chronic Care Improvement Project (CCIP) as part of their required QI Program over a three-year period. The purpose of the CCIP is to promote effective chronic disease management and improve care and health outcomes for members with chronic conditions. For the three-year CCIP program, beginning in 2023 and ending in December 2025, CalOptima Health chose to focus on diabetes as the target condition, with a primary emphasis on improving diabetes management. The target population for the CCIP intervention is OneCare members identified as having diabetes (Type 1 and Type 2). CalOptima Health chose to focus on members who fall in the category of emerging risk. Emerging risk is defined as members who were previously controlled (<8.0% A1C) but had a recent A1C level of 8.0% to 9.0%. These members were chosen because targeting those with A1C levels between 8.0% and 9.0% is more likely to improve outcomes than targeting those above 9.0%

II. Data Sources and Methodology:

A two-year lookback period for members’ A1C results (2023–2024) and the current measurement year. Quality Analytics generated an A1C report and identified members who were below 8.0%, between 8.0% and 9.0%, and above 9.0%. Also included was whether the A1C result had decreased, increased, remained the same or no prior result was available. A QI specialist filtered the list to identify the target population. QI worked with the Diabetes Management Program to finalize the outreach list. The outreach included members who were part of the emerging risk category and the Diabetes Management stratification to keep the outreach list manageable. The health coaches outreached to emerging risk members, and their efforts were documented in the Jiva application. The emerging risk member list was refreshed quarterly.

III. Quantitative Analysis:

OneCare

Data	Emerging Risk List OneCare members	Outreach	Outreach Rate
MY 2025	175 members	155	88.57%

QI identified 175 members that met emerging risk criteria. According to Jiva reporting, there were 155 successful interactions, resulting in an outreach rate of 88.57%.

Successful interaction	A1C result	Outreach	Change of A1C
155	<8.0%	59	38.06%
	≥8.0%	36	23.23%
	No Result	60	38.71%

Of the 155 successful interactions identified, there were 59 members with a reported A1C result of <8.0% (as compared to the initial A1C reported measurement), 36 members with a reported A1C result that was ≥8.0% (as compared to the initial A1C reported measurement) and 60 members that had no A1C result update or reporting available (as compared to the initial A1C reported measure).

Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Telephonic outreach by health educators	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

IV. Qualitative Analysis:

Causal/Barrier Analysis:

- The outreach rate included any interaction outcome that was included in Jiva reporting and thus was not solely based on health coaching outreach.
- Refresh of the emerging risk list was impacted by the organization's transition to a new HEDIS engine.
- Data issues, e.g., missing A1C values, may have affected emerging risk assignment.
- The outreach list included members who were already assigned to CM, so they were not outreached (by a health educator).
- Unable to contact emerging risk category members.

V. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Planning	Develop intervention strategies and create new CCIP program.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	GSD, EED, KED, SPD, BPD

MC = Medi-Cal; OC= OneCare

VI. Conclusion:

This three-year CCIP has concluded. The program, which ran from 2023 to 2025, focused on improving diabetes management among OneCare members identified with Type 1 and Type 2 diabetes, particularly those in the emerging risk category (A1C levels 8.0%-9.0%). The interventions targeted members who had previously controlled A1C levels but recently exhibited levels between 8.0% and 9.0%, recognizing the high potential for improvement within this group. A new CCIP program will be created in MY 2026.

Section 5: Quality of Service

5.1 Improve Network Adequacy: Reducing Gaps in Provider Network

Author: Cathy dela Cruz

Department(s): Provider Data Operations

Responsible Party(ies): Quynh Nguyen (Director, Provider Data Operations); Cathy Dela Cruz (Manager, Provider Data Operations)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase provider network to meet regulatory access goals	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health routinely assesses the provider network for all programs, including Medi-Cal and OneCare, to ensure our members have appropriate access to care. This includes evaluating trends, identifying gaps in a particular HN or specific practitioner specialties, pinpointing opportunities for improvement, prioritizing those opportunities, and taking actions to enhance the network.

CalOptima Health established network adequacy in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services at both the plan and HN levels. Network adequacy applies to both Medi-Cal and OneCare, with mandatory provider types (MPTs) standards applicable only to the Medi-Cal Program.

II. Data Sources and Methodology

CalOptima Health conducted network adequacy gap analysis using the following methodology:

1. Time period was from January 1, 2025, through December 31, 2025
2. CalOptima Health used the 274 file as the provider network data for network adequacy gap analysis.
3. Provider network data is pulled quarterly to run an analysis for Medi-Cal for MPT, network capacity ratio (FTE), provider-to-member ratio (PMR) and compared with standards used to ensure members have the appropriate types of providers and an adequate number of practitioners in the network to access care. This analysis is used to determine whether CalOptima Health is compliant with the standards identified in CalOptima Health Access and Availability Policy: GG.1600.
4. For the OneCare plan, the minimum number of providers varies per provider type according to the CMS annual Health Service Delivery (HSD) reference table and specified in CalOptima Health Access and Availability Policy MA.7007.
5. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in CalOptima Health Access and Availability Policies referenced. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations.
 - a. Medi-Cal 99% compliance with time and distance standards for primary and specialty care
 - b. OneCare: 90% compliance with time and distance standards for primary care and specialty care

III. Program Results and Quantitative Analysis:

Medi-Cal: Key Performance Indicators

Medi-Cal LOB *unless otherwise noted*	Goal	Data Source	Q1	Q2	Q3	Q4
Network Adequacy						
Time/Distance <u>Primary Care</u> (Adult and Ped) 10 miles OR 30 minutes from any member or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance <u>Core Specialty Care</u> (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance <u>OB/GYN</u> (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance <u>Hospitals</u> (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Mandatory Provider Types for FQHCs: Minimum Number of Providers: 1	Min 1 (100%)	274 File	100%	100%	100%	100%
Mandatory Provider Types for Certified Nurse Midwives (CNM): Minimum Number of Providers: 1	Min 1 (100%)	274 File	100%	100%	100%	100%
Network Capacity and Ratios (FTE) — <u>Primary Care Practitioner to Members</u> : 1:2,000	1:2,000 (100%)	274 File	100%	100%	100%	100%
Network Capacity and Ratios (FTE) — Physician to Members: 1:1,200	1:2,000 (100%)	274 File	100%	100%	100%	100%

Medi-Cal: Provider to Member Ratios by Specialty Type

Indicator/Goal(s)

A. PCP: 1:2,000 or better

B. Specialists:

1. OB/GYN is 1:2,000 or better

2. Nephrology, pulmonology and psychiatry is 1:10,000 or better

3. All other specialist to member is 1:5,000 or better

Provider Type	Quarter in 2024	Q1		Q2		Q3		Q4	
	Medi-Cal Specialty	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
PCP	General/Family Medicine	1:1767	Met	1:1745	Met	1:1798	Met	1:1731	Met
PCP	Internal Medicine	1:1915	Not Met	1:1921	Met	1:2016	Not Met	1:1968	Met
PCP	Pediatric	1:883	Met	1:874	Met	1:869	Met	1:858	Met
PCP	Total PCP	1:770	Met	1:761	Met	1:784	Met	1:766	Met
Specialist	Cardiology/Interventional Cardiology	1:2776	Met	1:2672	Met	1:2651	Met	1:2259	Met
Specialist	Gastroenterology	1:4985	Met	1:4692	Met	1:4680	Met	1:4078	Met
Specialist	General Surgery	1:2038	Met	1:919	Met	1:1850	Met	1:1692	Met
Specialist	Hematology/Oncology	1:2708	Met	1:2491	Met	1:2340	Met	1:2073	Met

Specialist	Nephrology	1:6577	Met	1:5920	Met	1:5549	Met	1:5098	Met
Specialist	Neurology	1:3933	Met	1:3927	Met	1:4004	Met	1:3461	Met
Specialist	OB/GYN	1:1064	Met	1:1049	Met	1:1045	Met	1:971	Met
Specialist	Ophthalmology	1:4301	Met	1:4275	Met	1:3963	Met	1:3526	Met
Specialist	Orthopedic Surgery	1:6115	Not Met	1:5744	Not Met	1:5754	Not Met	1:4518	Met
Specialist	Pulmonology	1:5218	Met	1:5063	Met	1:5044	Met	1:4775	Met
Specialist	Urology	1:7906	Not Met	1:7620	Not Met	1:7193	Not Met	1:6859	Not Met

Quantitative Analysis:

Medi-Cal

- CalOptima Health was compliant with the following standards:
 - Network capacity ratio (FTE) for primary care and all physicians
 - Time or distance for primary care, OB/Gyn, specialty care and hospitals
 - MPT (FQHC, CNM and Licensed Midwife [LM])
- PMR
 - Internal medicine did not meet standards in Q3 but the gap was remediated in Q4 and now meets the standard
 - Total primary physician aggregate type was not affected by the Q3 gap in internal medicine, consistently meeting the standards all year.
 - Specialty type of orthopedic surgery did not meet standards in Q1, showed significant improvement in Q2, then increased slightly in Q3, finally closing the gap in Q4
 - Specialty type urology does not meet standards since being added in Q1; however, quarter after quarter data shows the gap is improving and trending downward.
 - Most ratios are trending downward, showing fewer members per provider except for general medicine, internal medicine, neurology and orthopedic surgery.

OneCare: Key Performance Indicators

OneCare LOB	MPL	Data Source	Q1	Q2	Q3	Q4
Network Adequacy (New for 2024)						
Time/Distance Primary Care Five miles AND 10 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Allergy and Immunology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Cardiology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Chiropractor 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Dermatology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Endocrinology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance ENT/Otolaryngology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%

Time/Distance Gastroenterology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance General Surgery 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Gynecology, OB/GYN 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Infectious Diseases 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Nephrology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Neurology 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.4%	96.8%	96.8%	96.8%
Time/Distance Neurosurgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Oncology - Medical, Surgical 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%
Time/Distance Oncology - Radiation/Radiation Oncology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Ophthalmology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	99.8%	99.8%	99.8%
Time/Distance Orthopedic Surgery 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.4%	98.4%	98.4%	98.4%
Time/Distance Physiatry, Rehabilitative Medicine 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Plastic Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	97.9%	97.9%	97.9%	97.9%
Time/Distance Podiatry 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Psychiatry 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.8%	98.8%	98.8%	98.8%
Time/Distance Pulmonology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.7%	99.7%	99.7%	99.7%
Time/Distance Rheumatology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Urology 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.3%	98.3%	98.3%	98.3%
Time/Distance Vascular Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	98.4%	98.4%	98.4%	98.4%
Time/Distance Cardiothoracic Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Clinical Psychology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Clinical Licensed Social Work 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	99.8%	99.8%
Time/Distance Acute Inpatient Hospitals 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.5%	98.5%	98.5%	98.5%
Time/Distance Cardiac Surgery Program 15 miles AND 30 minutes from any member's residence	90%	FACETS	98.0%	98.0%	98.0%	98.0%
Time/Distance Cardiac Catheterization Services 15 miles AND 30 minutes from any member's residence	90%	FACETS	99.3%	99.3%	99.3%	99.3%
Time/Distance Critical Care Services – Intensive Care Units (ICU) 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%
Time/Distance Surgical Services (Outpatient or ASC) 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.7%	98.7%	98.7%	98.7%

Time/Distance Skilled Nursing Facilities 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.8%	99.8%	96.3%	96.3%
Time/Distance Diagnostic Radiology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	98.6%	98.6%	98.6%
Time/Distance Mammography 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Physical Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Occupational Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	85.9%	100.0%	100.0%	100.0%
Time/Distance Speech Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.0%	98.0%	99.8%	99.8%
Time/Distance Inpatient Psychiatric Facility Services 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Outpatient Infusion/Chemotherapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%

Year-over-Year Trending of Time AND Distance Compliance for Specialty and Facility Contracted Providers

Count of Noncompliant Specialty Contracted Provider for Time AND Distance								
	Q1 Specialties		Q2 Specialties		Q3 Specialties		Q4 Specialties	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2025	0	Met	0	Met	0	Met	0	Met
2024	0	Met	0	Met	0	Met	0	Met

Count of Noncompliant Facility Contracted Provider for Time AND Distance								
	Q1 Facilities		Q2 Facilities		Q3 Facilities		Q4 Facilities	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2025	1	Not Met	0	Met	0	Met	0	Met
2024	0	Met	0	Met	0	Met	0	Met

Quantitative Analysis:

OneCare

- Provider count data show OneCare consistently meeting standards. Quarterly data shows an upward trend overall, indicating that the provider network is expanding. Primary care, ophthalmology and psychiatry are the top specialties that experienced the highest increase in provider count from Q1 to Q4. Neurology, podiatry and cardiothoracic surgery, however, showed the most significant decrease by four providers.
- Time and distance standards for the specialty type were met consistently quarter over quarter
- Time and distance standards for facility type were met except for occupational therapy in Q1. The occupational therapy gap was closed in Q2, resulting in a 100% success rate.
- 2025 showed one quarter with a time and distance gap in comparison to 2024; however, the gap was immediately closed the following quarter.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
• Recruitment outreach to address gaps in urology	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Provider network review and recruitment outreach to increase occupational therapy providers	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Issued and monitored CAP to health networks with time or distance and provider-to-member ratio gaps for closure	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Recruitment outreach to address the gap in orthopedic surgery	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Network Adequacy Workgroup moved forward with expanding specialty care access via telehealth and partnered with other departments to expand the TeleMed2U contract.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Establish orthopedic subspecialty and area of focus to help with orthopedic surgery access gaps	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

CalOptima Health deployed interventions to address and close identified gaps in network adequacy. Below is the analysis of the effectiveness of the interventions.

1. Recruitment intervention for urology did not yield enough contracts to close the gap. However, in combination with the CAP issued to health networks with gaps in urology, the efforts CalOptima Health and the health networks combined were effective in decreasing the gap, as shown by the downward trend of the PMR ratio from Q1 to Q4.
2. The recruitment efforts to close the occupational therapy gap for OneCare did not yield an increase in the provider network and were not successful. However, PDO audited the providers' full scope of specialties and identified additional occupational therapy facilities that were not previously counted. This effort successfully closed the gap.
3. The CAP issued to health networks helped to improve and lessen the gap in orthopedic surgery from Q1 to Q4 in general. CalOptima Health's recruitment outreach is in progress, with results to be evaluated in Q1 2026.
4. Expansion of the TeleMed2U contract to include specialty care services that would cover urology and orthopedic surgery (nonsurgical appointments only) is in progress, to be implemented first in the OneCare LOB. The effectiveness will be determined after implementation in Medi-Cal, the date of which will be determined at a later time.

5. Establishing the orthopedic surgery subspecialty and area of focus is currently ongoing; we will not know the effectiveness of this intervention until it is deployed in 2026.

VI. Qualitative Analysis

Qualitative Analysis was conducted by the Provider Network Operations senior director, Provider Data Operations director, Provider Relations director, executive director Medicare Programs, Contracting director, medical director, Care Management director, Provider Data Operations senior manager, Analytics, Provider Relations manager Provider Data Operations manager to identify barriers to closing the gaps through interventions deployed.

Causal/Barrier Analysis:

- CalOptima Health continues to meet time or distance standards, but South County remains an area where time or distance gaps and access challenges continue to occur due to the low count of providers practicing in this region of Orange County.
- CalOptima Health's recruitment outreach for urology, led by the Provider Relations director, Provider Relations manager, Provider Data Operations director and Provider Data Operations manager, trended on providers either not interested or no longer at the location listed per DHCS FFS database. The DHCS FFS database is where all providers are listed that are Medi-Cal approved.
- CalOptima Health has implemented ways to help speed up the contracting process at each step of the way, but this remains a multistep (contracting, credentialing) process, which will always take a minimum of a couple of months to add a provider to the network to help close a gap.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Better collaboration between Credentialing, Contracting and Provider Data Operations regarding providers approaching recredentialing deadlines	Reimagine a new timeline for receiving data on providers with expiring credentialing to avoid termination of providers that belong to specialties experiencing network adequacy gaps	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Provider termination network adequacy assessment	Create a new network assessment process to determine if terming providers will affect overall network adequacy compliance	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Continue to find new ways to address gaps in network adequacy	Continue to conduct gap analysis, implement efforts to reduce gaps, and examine the effectiveness of the intervention to find new solutions	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L

VIII. Conclusion:

CalOptima Health conducted a gap analysis of our network to identify opportunities with providers and expand our network. It conducted multiple outreach efforts and implemented recruiting initiatives to address network gaps and increase access to care for our members. It has been successful at closing gaps in the OneCare program, as well as improving upon the gaps identified in the Medi-Cal program. Partnering closely with our health networks has been key to improving and expanding our provider network, while also addressing identified gaps in the provider-to-member ratio.

Establishing the Network Adequacy Workgroup as a forum to discuss gaps cross-functionally has helped the organization operate collaboratively, with better visibility on the what and why for gaps, leading to more thoughtful solutions with better visibility to outcomes and barriers.

CalOptima Health will continue to monitor ongoing interventions and conduct network adequacy gap assessments to evaluate the effectiveness of these interventions, as well as ensure the plan meets all network adequacy components under Medi-Cal and OneCare. CalOptima Health will continue to implement various strategies to address network gaps and increase access for its members.

5.2 Improve Timely Access: Appointment Availability/Telephone Access	
Author: Karen Jenkins	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Helen Syn (Manager, Quality Analytics); Karen Jenkins (Project Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Improve Timely Access compliance with Appointment Wait Times to meet 70% MPL	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health engaged a professional health care survey vendor to conduct its annual appointment access survey for MY 2024. The primary objective of this survey was to ensure that members have timely access to appointments and care. Additionally, it aimed to verify that all contracted providers comply with access to care standards mandated by contract, and in alignment with regulations from the DMHC, DHCS and the CMS.

The survey encompassed both Medi-Cal and OneCare lines of business and was conducted from October 15 to December 5, 2024. Utilizing a direct survey methodology, callers identified themselves as representatives of CalOptima Health. The survey universe included contracted providers across various provider types, including primary care (FQHCs and community clinics), specialty care, behavioral health, and ancillary care groups.

II. Data Sources and Methodology

The Timely Access Survey is fielded annually. For the 2024 survey results, the survey monitoring process changed from a three-year escalation cycle to a one-year cycle to support the timelier issuance of CAPs and noncompliance notices to providers. Noncompliance notices were issued for deficiency with one appointment standard, and CAPs were issued for deficiency with two or more appointment standards. Additionally, CalOptima Health adjusted the MPL threshold from 80% to 70% to align with the DHCS-recommended guidelines.

The survey data collection methodology included both census and sampling data. Census data was utilized for provider types with universes of less than 100 providers, while sampling was applied for provider types with universes of 100 or more providers. Providers were not contacted on weekends or holidays, and each contact attempt was limited to a maximum of three attempts to reach a live person.

The survey employed a direct script methodology to gather appointment times, with callers adhering strictly to the script. The surveyor collected the availability of other providers at the same location who could potentially see the patient sooner. Notably, from 2023 to 2024, the follow-up criteria for Medi-Cal Non-physician BH changed from 20 calendar days to 10 business days.

In 2025, after an in-depth analysis, it was determined that telephone measures are not a regulatory requirement. Consequently, the CalOptima Health Timely Access Workgroup decided not to hold providers accountable for compliance purposes and will not issue notices of noncompliance. However, the workgroup agreed to continue surveying, monitoring and educating providers on the importance of the "instruct caller to ER or dial 911 in case of emergency" telephone measure, as it is considered best practice.

A new survey question regarding PCP after-hours availability was added to the survey script in 2024 for NCQA purposes. The survey question asks, "Does the office have an on-call provider or answering service available for after-hours calls 24 hours, seven days a week?" Since this is not a DHCS nor DMHC requirement, individual providers will not be monitored for compliance. At this time, results will be used for NCQA purposes only.

Appointment Standards

2024 Medi-Cal	2024 OneCare
Primary Care Nonurgent – 10 business days Primary Care Urgent – 48 Hours	Primary Care - Services Not Emergent or Urgently Needed but Require Medical Attention – 7 business days Primary Care Routine and Preventive Care (Physical Exam) – 30 business days
Specialists Nonurgent – 15 business days Specialists Urgent with Prior Authorization – 96 hours OB/Gyn Nonurgent – 15 business days OB/Gyn Urgent – 48 hours Psychiatrists Nonurgent – 15 business days Psychiatrists Urgent – 48 hours	 Psychiatrist Routine and Preventive Care – 30 business days

Psychiatrists Follow-up Care – 30 calendar days	
Nonphysician BH Nonurgent –10 business days Nonphysician BH Urgent – 48 hours Nonphysician Follow-up Care – 10 business days	Nonphysician BH Routine and Preventive Care – 30 business days
Ancillary Nonurgent – 15 business days	Not Applicable

Telephone Standards

Description	Standard
Telephone access after/during business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room in case of an emergency
After-hours access	A PCP or designee will be available 24/7 to respond to after-hours member calls or to a hospital emergency room practitioner

III. Program Results and Quantitative Analysis:

The following tables include Timely Access results for both Medi-Cal and OneCare from 2021 to 2024. Starting in 2023, multiple appointment times were collected; however, when determining compliance, CalOptima Health selects the highest rate. To simplify the data in the tables, only the highest rate for 2023 is shown.

Medi-Cal

Appointment Types	2021	2022	2023	2024 Individual Provider	2024 Another Office Provider	Met MPL	Difference*
Primary Care Nonurgent (10 business days)	72%	61%	88%	82%	97%	Met	+9
Primary Care Urgent (48 hours)	63%	59%	75%	67%	85%	Met	+10
Specialists Nonurgent	59%	49%	74%	64%	86%	Met	+12
Specialists Urgent (96 hours)	64%	55%	59%	64%	80%	Met	+21
OB/GYN Nonurgent (15 business days)	81%	81%	74%	73%	89%	Met	+15
OB/GYN Urgent (48 hours)	76%	70%	64%	44%	75%	Met	+11
Psychiatrist Nonurgent (15 business days)	54%	59%	89%	73%	100%	Met	+11

Psychiatrists Urgent (48 hours)	24%	86%	47%	29%	55%	Not Met	+8
Psychiatrists Follow-Up (30 calendar days)	59%	32%	85%	56%	33%	Not Met	-29
Nonphysician BH Nonurgent (10 business days)	75%	67%	83%	83%	100%	Met	+17
Nonphysician BH Urgent (48 hours)	57%	69%	70%	62%	76%	Met	+6
Nonphysician BH Follow-Up (2024: 10 business days) (2021-23: 20 calendar days)	71%	67%	81%	70%	72%	Met	-9
Ancillary Nonurgent (15 business days)	85%	73%	64%	97%	100%	Met	+36

*2023 versus highest rate for 2024

OneCare

Appointment Types	2023	2024 Individual Provider	2024 Another Office Provider	Met MPL (Highest rate for 2024)	Difference*
Primary Care - Services Not Emergent or Urgently Needed but Require Medical Attention (seven business days)	79.6%	70%	90%	Met	+10
Primary Care Routine and Preventive Care - Physical Exam (30 business days)	92.8%	86%	97%	Met	+4
Psychiatrist Routine and Preventive Care (30 business days)	96.8%	92%	100%	Met	+3
Nonphysician BH Routine and Preventive Care (30 business days)	94.7%	96%	100%	Met	+5

*2023 versus highest rate for 2024

Telephone – Medi-Cal and OneCare

Telephone Call Type	2021	2022	2023	2024	Met MPL	Difference*
Instructs Caller to ER/911	20.8%	19.7%	62.1%	56%	Not Met	-6
After-Hours Care 24/7	n/a	n/a	n/a	76.2%	Met	n/a

*2023 versus highest rate for 2024

Quantitative Analysis

Starting in 2023, CalOptima Health’s survey methodology takes into account the appointment availability of other providers who can see the patient sooner at the same location. Therefore, to determine compliance, the highest rate is selected between the provider who was selected to participate in the survey and the availability of the other provider. To simplify the analysis for 2023, the data table includes only the highest compliance rates.

Medi-Cal

There are 13 appointment standards CalOptima Health monitors providers on to ensure our members have appropriate and timely access to care. The 2024 compliance rates for another office provider were the highest, ranging from 72% to 100%, with the exception of the Follow-up Appointment for Psychiatrist. In addition, Follow-up Appointments for Psychiatrist and Psychiatrist Urgent did not meet the 70% MPL threshold. When analyzing the data for trends between 2023 and 2024, it is evident that there has been a significant improvement, as most standards showed an increase ranging from 8 to 36 percentage points. However, follow-up appointments for both psychiatrist and non-physician BH decreased by 29 and 9 percentage points, respectively.

OneCare

The analysis for 2024 reflects impressive performance outcomes across various indicators. All performance standards exceeded the 70% MPL. Compliance rates for another office provider were the highest, ranging from 90% to 100%. This indicates a positive trend and consistent improvement compared to the previous year, where the rates were marginally lower. The 100% target achievement showcases the effectiveness of the implemented strategies and the commitment to maintaining high standards of care.

Telephone – Medi-Cal and OneCare

The measure “Instruct caller to ER or dial 911 in case of emergency,” did not meet the 70% MPL threshold. This trend is consistent with the performance of prior years. The compliance rate decreased, dropping from 62.1% in 2023 to 56% in 2024, marking a decline of more than six percentage points.

In 2024, the availability of after-hours care among PCPs successfully met the 70% MPL threshold. However, since this question was newly introduced in the 2024 survey, no trend analysis is available at this time.

IV. **Actions/Interventions Implemented in 2025:**

Interventions	Product	Quarter	Type	Status
- Contracted with a new survey vendor in July 2025 and streamlined the survey process to be completed within a year from annual survey to annual survey a. Follows Provider Appointment Availability Survey (PAAS) methodology b. Inclusive of vendor education to noncompliant providers	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

c. Survey process includes five distinct phases, and noncompliant providers are given up to three opportunities to resurvey d. Continued noncompliance to be escalated to the Compliance Committee for further review and potential disciplinary action				
Engaged in quarterly health network patient experience meetings to collaborate on processes, opportunities, and interventions including CAHPS, Access and Customer Service	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- Offered Access webinar trainings and Q & A sessions a. Appointment Access- The Song that Never Ends b. CHCN Network Lunch and Learn c. Community Health Centers Monthly Forum	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
- Issued noncompliance letters to: a. Providers: i. CAPs: 73 ii. Noncompliance: 184 b. Health Networks: 4 CAPs	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
- CAP Follow-up Outreach a. Health networks were assigned certain providers for outreach to confirm receipt of CAP, provide guidance for thorough root cause analysis and ensure the response is returned to CalOptima Health b. The Quality Analytics team conducted outreach through multiple modalities to collect outstanding CAP responses, including phone, fax and email.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
MPL has been adjusted from 80% to 70% to align with the recommended guidelines provided by DHCS	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other (Plan Level)	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The effectiveness of the first three interventions cannot be determined yet because the 2025 access survey results have not been received. This survey is conducted annually, and the interventions began implementation in the third quarter.

Adjusting the MPL from 80% to 70%, as recommended by DHCS guidelines, has significantly improved compliance for CalOptima Health and its individual health networks. In 2023, CalOptima Health met only five out of 13 standards for the Medi-Cal LOB. However, in 2024, 11 standards were met. Similarly, for the OneCare LOB, three out of four standards were met in 2023, and all standards were met in 2024.

The changes in requirements for issuing CAPs and noncompliance notices, along with the removal of monitoring telephone measures for compliance, have significantly reduced the number of noncompliance notices issued to providers for MY 2024.

VI. Qualitative Analysis

Appointment Access:

Initial analysis of the access survey results was conducted by the Quality Analytics project manager and the manager. The data was presented at Timely Access Workgroup meetings for review, development of interventions and determination of next steps. The workgroup met five times in 2025 and includes representation from the following departments: Medical Management, Provider Relations, Health Network Relations, Behavioral Health, Quality Analytics, Provider Data Operations and Quality Improvement.

Appointment Standard:

CalOptima Health met the MPL threshold for all standards with the OneCare LOB. For Medi-Cal, most standards were met except for two BH standards:

- Psychiatrist Urgent Appointment: 55%, which is 15 percentage points below the threshold.
- Psychiatrists Follow-up Appointment: 56%, which is 14 percentage points below the threshold.

These compliance rates were notably lower compared to the 2023 rates. The decrease in performance may be attributed to a smaller size surveyed in 2024.

Overall, when compared year-to-year, the steady increase in performance rates suggests an adequate system of care delivery, except for certain specialties. This consistent rise can be attributed to enhanced training, improved resource allocation and more effective patient engagement strategies.

Moving forward, it's essential to continue monitoring these trends to ensure sustained high performance. Identifying areas of opportunity and potential challenges early on will enable proactive measures, thereby maintaining the momentum of positive outcomes.

Telephone Standards:

In 2024, CalOptima Health's compliance rate for the telephone measure "Instruct caller to ER or dial 911, in case of emergency" was 56%, 14 percentage points below the MPL. Additionally, the compliance rate trended downward from 2023 to 2024, which could be due to the smaller pool of providers surveyed in 2024.

Findings show that PCP after-hours care successfully met the 70% MPL threshold.

Overall Causal/Barrier Analysis:

- Providers may not be familiar with the access standards, leading to noncompliance.
- Providers and others may not realize that participation in the survey is a federal and state requirement, resulting in nonparticipation when called upon.
- Providers were not notified of their noncompliance status until months later, after they were surveyed.
- Providers do not submit a response to the CAP in a timely manner.

- Provider offices have limited appointment availability due to a lack of staffing.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Educate providers on the importance of the Access Survey	• Issue a notice of noncompliance within four to five weeks after being surveyed • Vendor to educate noncompliant providers on standards • Include updates on the new survey process in CalOptima Health's Provider Update communication • Offering appointment access, webinars and trainings in collaboration with the SullivanLuallin Group • Encourage health networks to take action with noncompliant providers	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Issue noncompliance notices via the CalOptima Health Provider Portal	• Incorporate noncompliance survey results and CAPs into CalOptima Health's Provider Portal to enhance tracking and follow-up communication	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☐ M ☒ L
3. Provider offices to maximize the office schedule	• Offer extended office hours at least once a week • Schedule appointments so there is availability for walk-in/same-day appointments • Expand office capacity by hiring additional staff, including nonphysician medical practitioners	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
4. Change the fielding period to a more practical time of year for provider offices	• Survey scheduled for Q3	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L
5. Expansion of specialist and behavioral health provider network through telehealth options.	• Telehealth efforts to increase provider accessibility, especially for key specialties	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC= OneCare

VIII. Conclusion:

The 2024 survey findings indicate that the interventions implemented have proven effective, as evidenced by the increase in rates for both Medi-Cal and OneCare standards. However, it is important to note that exceptions were observed in the areas of Psychiatrist Urgent and Psychiatrist Follow-up Appointments, and this area will remain on the work plan for 2026.

Despite these improvements, significant work remains as we continue to implement and monitor the new 2025 survey process. Ongoing efforts will focus on addressing the areas where standards have not yet been met, including the "Instruct caller to the ER or dial 911 in case of an emergency" telephone

measure, and ensuring that the positive trends observed in other areas are maintained and further enhanced.

5.3 Network Adequacy Regulatory Submission and Audits	
Author: Cathy dela Cruz	Department(s): Provider Data Operations
Responsible Party(ies): Quynh Nguyen (Director, Provider Data Operations); Cathy Dela Cruz (Manager, Provider Data Operations)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

DHCS APL 21-006 and 23-001: Network Certification Requirements, established network adequacy standards, the Annual Network Certification (ANC) process, which assesses and certifies CalOptima Health for network adequacy at least annually, to ensure CalOptima Health’s provider network meets state and federal network adequacy and access requirements.

DHCS APL 23-001: Delegation and Subcontractor Network Certification (SNC) added additional network adequacy requirements, requiring CalOptima Health to undergo a separate and distinct certification process from the ANC, to provide the state with assurances that each subcontractor’s and downstream subcontractor’s provider network meets state and federal network adequacy and access requirements.

In addition to the annual schedule, CalOptima Health must undergo a separate SNC if CalOptima Health’s network experiences a change that substantially affects how it services members or enters into a new subcontractor agreement.

II. Data Sources and Methodology

CalOptima Health’s ANC, SNC and Network Adequacy Validation (NAV) Audit covers the time period from January 1, 2025, through December 31, 2025. The monthly 274 file comprises the provider data used for ANC, SNC certifications and the NAV audit. CalOptima Health conducts quarterly monitoring of its plan’s provider network against anticipated membership for all of Orange County. CalOptima Health conducts quarterly monitoring and reporting of its subcontracted networks or health networks against the health network’s assigned membership.

A. CalOptima Health complies with the following ANC requirements:

1. Mandatory provider type (including cancer center)
2. Network Capacity (FTE)
 - a. PCP: 1:2,000 ratio
 - b. Physician: 1:1,200 ratio

3. Time or distance

- a. Starting in Plan Year 2024, DHCS changed the compliance rate to 99%

- B. For SNC, CalOptima Health uses the November 274 and November member data for the health network to run the analyses for each health network. These analyses are used to determine whether the health network complies with the network adequacy standard, as outlined in policy GG.1600: Access and Availability. The results are then used for CalOptima Health’s annual SNC submission in accordance with policy GA.7111 Health Network Certification.
- C. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in the CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area at the plan level and of the members covered at the health network level, according to the standards mentioned in sections A and B.

III. Program Results and Quantitative Analysis:

Indicator/Goals: Comply with regulatory requirements for ANC, SNC, NAV Audit

Actions Completed	
Quarter 1	- CalOptima Health issued 2024 SNC CAPs to HNs that did not meet requirements - Quarterly monitoring of ANC requirement and gap analysis - Quarterly monitoring of HNs for SNC requirement and gap analyses - Completed 2024 ANC and Alternative Access Standards (AAS) submission in March 2024 - Worked on posting approved 2023 AAS from DHCS on the website
Quarter 2	- Quarterly monitoring of ANC requirement and gap analysis - Quarterly monitoring of HNs for SNC requirement and gap analyses - CalOptima Health submitted NAV Audit ISCAT questionnaire and all required supporting documents - CalOptima Health authorized the use of Telehealth and Alternative Access Standard to close remaining HN 2024 SNC Gaps
Quarter 3	- Quarterly monitoring of ANC requirements and gap analysis - Quarterly monitoring of HNs for SNC requirement and gap analyses - Closed all 2024 SNC CAPs issued to HNs and certified all HNs for RY 2024 SNC. - Completed RY 2024 NAV Virtual Audit with HSAG, including additional document submission requested at the end of the audit.
Quarter 4	- Completed 2025 SNC Landscape Analysis submission to DHCS - Quarterly monitoring of ANC requirements and gap analysis - Quarterly monitoring of HNs for SNC requirement and gap analyses - Annual in-depth analysis of HN compliance with requirements will be conducted in December to determine whether the HN has met SNC requirements for certification or will need to be issued a CAP for Reporting Year 2025.

Results:

- DHCS 2024 ANC assessment in Q1 found CalOptima Health in full compliance with the following requirements:
 - MPT — Hospital, Cancer Treatment Validation

- MPT, LTSS, OB/Gyn PCPs
- Network Capacity Ratio (PCP, Total Physician, Outpatient NSMHS)
- DHCS 2024 ANC assessment found CalOptima Health did not meet time and distance requirements for 21 zip codes; therefore, CalOptima Health completed the required ANC submission, which includes recruitment efforts and Alternative Access Standards Request, which was approved by DHCS in Q4.
- CalOptima Health completed the NAV Virtual Audit with HSAG in Q3 and received confirmation in Q4 that the audit is fully closed. The final plan-specific validation rating determination will be shared in January 2026.
- CalOptima Health completed the 2025 SNC Landscape Analysis submission to DHCS with a correction that TeleMed2U is not exempt from the next step, which is the annual SNC submission, due to mental health services having network adequacy standards. CalOptima Health will include TeleMed2U in the upcoming 2025 SNC submission, in February 2026.
- CalOptima Health 2025 SNC Assessment found Health Networks non-compliant with Time or Distance and Provider-to-Member Ratio standards, all other components were met. Those found non-compliant will be issued a CAP in January 2026. The assessment showed one health network without deficiency, which is Providence.
- DHCS completed the 2025 ANC and found CalOptima Health in compliance with Time or Distance Standards.

SNC Components	Directory Review	Network Capacity/Ratio (FTE)	Provider to Member Ratio (PMR)	Time or Distance	Whole-Child Model Program
Subcontracted Health Network	Q3	Q4	Q4	Q4	Q4
AltaMed Health Services	Met	Met	Not Met	Not Met	Met
AMVI Care Health Network	Met	Met	Not Met	Not Met	Met
CHOC Physicians Network	Met	Met	Met	Not Met	Met
Family Choice Health Services	Met	Met	Not Met	Not Met	Met
Heritage Provider Network	Met	Met	Met	Not Met	Met
Nobel Mid-Orange County	Met	Met	Met	Not Met	Met
Optum	Met	Met	Not Met	Not Met	Met
Prospect	Met	Met	Not Met	Not Met	Met
Providence*	N/A	Met	Met	Met	Met
United Care Medical Group	Met	Met	Not Met	Not Met	Met

IV. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: CalOptima Health must ensure that its subcontractors or health networks meet network adequacy standards at both the state and federal levels through the SNC process.

- All health networks meet the required Network Capacity Ratio for PCP (1:2000) and All Physician (1:1200) in Q4. This has been a consistent result throughout 2025.
- All health networks meet the Directory Review requirements as applicable
- Providence, a new health network effective November 1, 2025, met time or distance standards. The rest of the health networks did not meet time or distance standards in Q4.
- In 2025, the aggregate health network time or distance gaps decreased from Q1 to Q4, due largely to CalOptima Health's SNC process, which requires contracting and recruiting efforts to close gaps. Due to the lengthy nature of the recruiting process, we are now seeing the results of the health networks' efforts that began in Q1.
- 2025 Q4 gaps are also less compared to 2024 Q4 time or distance aggregate gap count.
- Data results for Q4-PMR are not yet available

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. PDO and PR performed recruitment outreach to address the time or distance gaps identified in the 2024 ANC package received from DHCS	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Issued CAPs to HNs who did not meet SNC standards for Time or Distance and PMR	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. PDO created a NAV Workplan to facilitate the completion of the NAV submission elements from multiple departments	☐ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Changed the department owner for recruitment outreach from PR to Contracting to help expedite the contracting process.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

CalOptima Health implemented interventions throughout the year to address the network adequacy gaps identified in 2025. Below is the analysis of the effectiveness of each intervention deployed.

1. The recruitment outreach intervention deployed to close gaps identified in DHCS's ANC time or distance analysis of CalOptima Health's provider network was not successful in closing the gaps in time for submission. This is because the information on the DHCS FFS website for providers

that can close the gaps proved to be outdated. Most providers are no longer practicing at the indicated location, having retired or lost interest. This is why the AAS request had to be submitted.

2. Issuing CAPs to health networks not meeting SNC standards was effective at decreasing the gaps of the health networks via contracting efforts, and in turn expanding CalOptima Health's plan-level provider network.
3. Creating a NAV Workplan to execute the collection of over 30 supporting documents and completing the ISCAT questionnaire was effective in being able to provide an in-depth and complete submission. This paved the way for a smooth Virtual Audit, with no follow-up questions or additional new documentation requested after the audit.
4. The process change for recruitment outreach was recently implemented in Q4, and the effectiveness cannot be measured until the end of Q1 2026.

VII. Qualitative Analysis

DHCS's 2024 ANC Assessment showed CalOptima Health did not meet time or distance standards. CalOptima Health deployed interventions to address the identified gaps and completed the required submission to ensure regulatory compliance with the ANC.

Qualitative Analysis was conducted by the Provider Data Operations director, Provider Data Operations Analytics senior manager, Provider Data Operations manager, Provider Relations director, Provider Relations manager, and Contracting director to drill down and identify barriers that prevented CalOptima Health's interventions from being successful at closing the time or distance gaps.

Causal/Barrier Analysis Results:

1. CalOptima Health used the DHCS Fee-for-Service database to find providers to close ANC gaps. The outreach results were unsuccessful in closing gaps due to a significant number of providers with inaccurate practice locations, invalid contact information or who were not interested in contracting.
2. DHCS and CalOptima Health do not use the same geomapping methodology, leading to different assessment results between CalOptima Health's plan monitoring and DHCS assessment. DHCS does not require CalOptima Health to switch geomapping vendors, but this means we may not know about a gap until DHCS completes its assessment, despite our own monitoring efforts.
3. It takes months to recruit and contract providers, which means gaps may continue to remain open for multiple months.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. CalOptima Health is exploring ways to have a geomapping methodology that is closer to DHCS	The Provider Data Operations team is requesting a software upgrade to Quest QES Cloud product that offers more detailed geomapping features	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. CalOptima Health will explore how to prevent our provider network from losing providers through terminations, given the length of the process to recruit new ones	Provider Data Operations will work with Credentialing, Contracting and Provider Relations to create a process to assess network adequacy impact early to prevent providers from terming due to recredentialing nonsubmission	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Provide support to the health networks to help them better understand and address network adequacy requirements and gaps	Revise the current health network certification policy to provide more information to health networks about the SNC process	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
4. Improve the SNC process for health networks	Review and revise the process and materials as needed to better align with DHCS's processes for uniformity and to shorten the length of time to complete the certification.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

CalOptima Health continues to fulfill its goal of meeting regulatory submission requirements for ANC, SNC and the NAV Audit. It successfully completed the NAV Virtual Audit with HSAG, requiring no additional documentation requests or questions.

For ANC regulatory requirements, CalOptima Health successfully completed all required monitoring and submission requirements throughout the year, while also meeting most of the standards. As for time or distance, CalOptima Health will not be able to fully replicate DHCS's time or distance analysis results when conducting monitoring activities due to different software, but it has a software upgrade planned for 2026, which will help improve our analyses and intervention efforts.

Nevertheless, CalOptima Health meeting 2025 ANC time or distance standards shows that consistent work monitoring its own network as whole and its health networks, can be an effective way to ensure that CalOptima has an adequate network to serve our members, without having to use a different software.

Regarding SNC regulatory requirements, CalOptima Health has successfully completed all 2025 SNC Landscape Analysis submissions and is poised to meet the 2025 SNC submission timeline and data requirements provided by DHCS. Furthermore, CalOptima Health continues to look to DHCS as a guide on how to better provide guidance, education and further support to all health networks during its own SNC process, so that the health networks continue to have a provider network that is adequate to meet the needs of its assigned members.

Moving forward, CalOptima Health will continue its monitoring activities and review its processes and procedures to provide clear guidance and support to health networks, while also exploring other ways to support the overall expansion of the plan provider network. This will enable the continued meeting of network adequacy regulatory requirements.

5.4 Increase Primary Care Utilization - Initial Health Appointment	
Author: Stefanie Johnson	Department(s): Case Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Stefanie Johnson (Program Manager, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025. To support this goal, CalOptima Health continued its efforts to promote primary care utilization and preventive screenings for unengaged members. This initiative aligns with CalOptima Health's broader commitment to strengthening primary care and advancing prevention and wellness for all members. In accordance with DHCS guidance, primary care visits and screenings continue to serve as proxy measures for IHA completion. To operationalize this objective, CalOptima Health focused on the following priority areas: 1. Member Education and Engagement Enhance methods of informing new members about the importance of completing their IHA and participating in preventive screenings through multimodal outreach (e.g., IVR calls, newsletters, new member packets, and staff scripts). 2. Health Network Compliance and Oversight Collaborate with delegation oversight to improve IHA compliance across Health Networks. This includes regular performance monitoring, feedback loops, and support to meet the 50% benchmark. 3. Provider and Health Network Training Deliver targeted education to providers and Health Networks to support timely IHA completion and ensure new member screening for Social Determinants of Health (SDOH) within 120 days of enrollment.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

DHCS requires that all newly enrolled Medi-Cal members be offered and provided access to an IHA within 120 days of their enrollment date. The IHA is a comprehensive assessment conducted during the members' first visit with their assigned or selected PCP and must be delivered in a culturally and linguistically appropriate manner.

For members under age 21, the IHA must be offered within 120 days of enrollment or in accordance with the Bright Futures periodicity schedule established by the AAP—whichever is sooner.

The IHA includes a review of the member's physical and behavioral health history, identification of health risks, assessment of preventive care needs and the development of a treatment plan for any identified

conditions. In 2023, DHCS clarified that primary care visits and screenings may serve as proxy measures for IHA completion, reinforcing the importance of early engagement in primary care.

This program supports CalOptima Health's broader commitment to prevention, wellness and health equity by ensuring that new members are connected to care early and comprehensively.

II. Data Sources and Methodology

CalOptima Health utilizes a combination of claims and encounter data, along with quality performance measures, to monitor IHA completion and track progress toward the 2025 goal.

1. Claims and Encounters for IHA Completion

The IHA Performance Report continuously extracts and processes claims data to identify completed IHAs for eligible members. This report aligns claims with member enrollment dates and filters for specific billing codes to confirm IHA completion. Data is aggregated monthly and integrated into the Delegation Oversight Committee (DOC) Dashboard, which is used to monitor IHA completion rates across health networks.

In 2025, CalOptima Health maintained the IHA KPI benchmark at 50% for all health networks, reinforcing accountability and alignment with DHCS expectations. The Delegation Oversight Dashboard (Medi-Cal DOC by health network and month) also serves as a feedback tool, enabling health networks to track their performance and identify areas for improvement.

2. Quality Measures as Proxy for IHA Completion

CalOptima Health leverages MCAS and HEDIS quality measures as proxy indicators for IHA completion, particularly for preventive care and primary care utilization. The MY 2025 Prospective Rate Report, produced by the Quality Analytics team, is shared monthly with each health network and CHCN to track performance on these measures.

Key measures used as IHA proxies include:

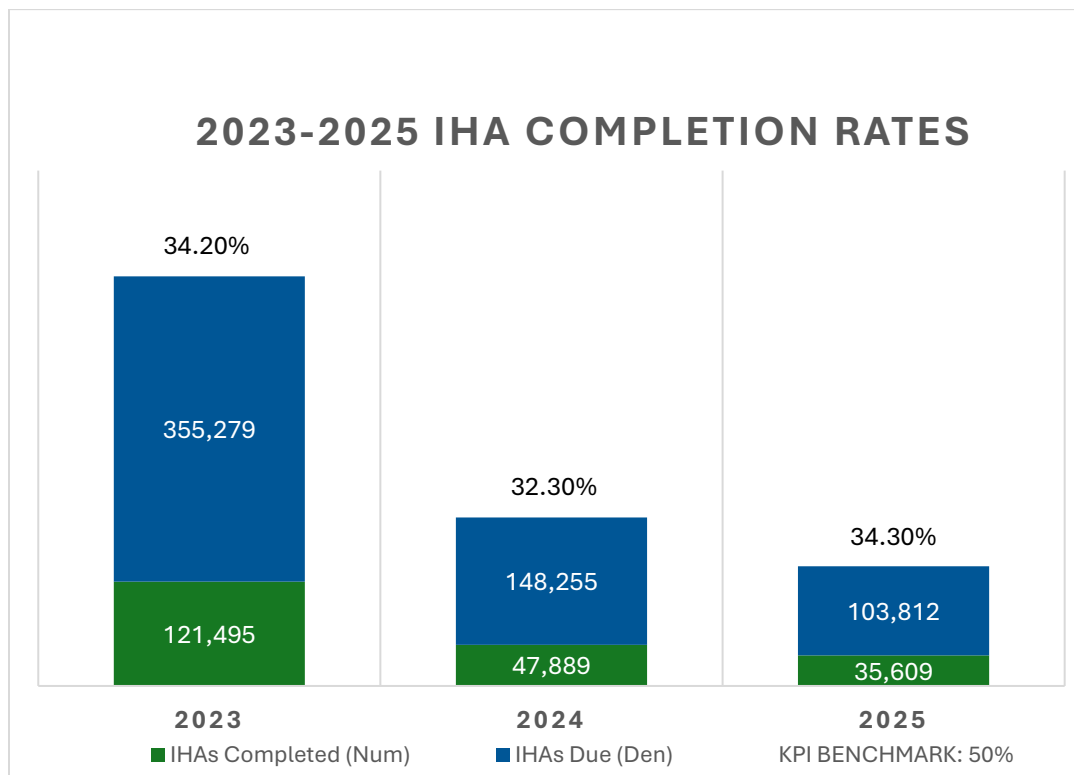
- Depression Screening and Follow-Up for Adolescents and Adults
- Child and Adolescent Well-Care Visits
- Childhood Immunization Status – Combination 10
- Developmental Screening in the First Three Years of Life
- Immunizations for Adolescents – Combination 2
- Lead Screening in Children
- Topical Fluoride for Children
- Well-Child Visits in the First 30 Months of Life (0–15 Months and 15–30 Months)
- Chlamydia Screening in Women
- Breast Cancer Screening
- Cervical Cancer Screening

- Adults' Access to Preventive/Ambulatory Health Services

These measures are primarily reviewed during scheduled Joint Operations Meetings (JOMs) and bimonthly Quality Update Meetings with health networks to support continuous improvement and alignment with IHA-related goals.

III. Program Results and Quantitative Analysis:

Chart A: 2023–2025 IHA Completion Rates: Three Consecutive Annual Trends of IHA Compliance Rates



* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for 2025 is preliminary.

Table A: 2025 IHA Completion Performance: Quarterly Rates for All Ages Versus Members ≤18 Months Compared to 50% KPI Benchmark

2025 IHA Performance												
	Num	Den	Qtr. 1	Num	Den	Qtr. 2	Num	Den	Qtr. 3	Num	Den	Qtr. 4
All Ages	10,863	31,482	34.51%	19,657	74,289	26.46%	9,487	28,119	33.74%	10,018	25,903	38.68%
≤18 Months	2,079	3,080	67.50%	1,701	2,053	82.58%	2,136	3,020	70.73%	1,881	2,628	71.58%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for Q4 2025 is preliminary.												

Table B: 2023-2025 Annual Rates for IHA Completion Over Three Consecutive Years

2023–2025 IHA Completion Rates			
	2023	2024	2025
IHAs Completed (Num)	121,495	47,889	35,609
IHAs Due (Den)	355,279	148,255	103,812
IHA Completion Rate	34.20%	32.30%	34.30%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for 2025 is preliminary.			

Table C: 2025 IHA Completion Rates by Health Network: Quarterly Performance Against 50% KPI Benchmark

2025 IHA Performance				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHCN	47.48%	51.36%	49.13%	51.32%
COD	63.29%	71.91%	82.84%	86.11%
AltaMed	23.83%	22.84%	23.48%	24.13%
AMVI	27.09%	21.43%	20.91%	21.03%
CHOC	57.21%	60.87%	63.25%	64.42%
Family Choice	30.98%	23.44%	22.64%	23.64%
HPN-Regal	20.61%	19.98%	16.11%	16.01%
Noble	21.92%	21.09%	20.44%	19.79%
Optum	29.84%	28.24%	27.53%	27.24%
Prospect	23.53%	23.00%	21.81%	24.83%
United Care	34.51%	26.90%	24.41%	29.32%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for Q4 2025 is preliminary.				

IV. Quantitative Analysis and Performance Trends:

Indicator/Goals: 50% IHA Completion Rate

Quantitative Analysis

Quantitative Analysis

A collective review of IHA performance, including completion and compliance rates, provides a comprehensive view of the quantity of IHAs due and completed, validated through claims data. This analysis reflects CalOptima Health’s efforts to improve member engagement, as well as health network and provider compliance with IHA requirements.

Annual Performance Trends:

In 2025, the overall IHA completion rate was 34.3%, reflecting a modest gain over 2024’s 32.3%, despite a

decrease in absolute volume compared to the prior year. The number of IHAs completed totaled 35,609, while the number of IHAs due was 103,812, indicating stabilization after the surge in Medi-Cal enrollment in 2024. This improvement in rate, despite lower volumes, suggests that the operational strategies implemented in 2025 — such as enhanced outreach and provider education — helped offset the challenges from the prior year's expansion.

Quarterly Performance:

Table A shows quarterly trends for 2025. Q2 reflected the largest denominator compared to other quarters, driven by a surge in new member enrollments early in the year. This increase in IHAs due placed additional operational demands on health networks and providers, contributing to lower completion rates during that period. Despite this challenge, subsequent quarters showed recovery as outreach and provider engagement strategies were reinforced.

Health Network Performance:

Table C highlights variation across health networks. Top performers included COD and CHOC, which consistently exceeded 50% in multiple quarters. CHCN demonstrated steady improvement, achieving near-benchmark performance by Q4. Other networks, such as AltaMed and Optum, remained below target but exhibited incremental gains compared to 2024.

Key Observations:

- **Stabilization Post-Expansion:** Unlike 2024, when Medi-Cal expansion drove a sharp increase in IHAs due, 2025 reflected normalized enrollment patterns, reducing operational strain.
- **Incremental Rate Improvement:** Despite fewer IHAs completed in absolute terms compared to 2024, the completion rate improved slightly, indicating better efficiency and engagement.
- **Persistent Outreach Challenges:** For IHAs not completed, documentation of outreach attempts remained inconsistent, highlighting opportunities for improvement in member engagement and provider follow-up.

Summary Against Goals:

In 2025, the overall IHA completion rate was 34.3%, reflecting a modest gain over 2024’s 32.3%, despite a lower volume of IHAs completed. Quarter-to-quarter trends showed recovery following a Q2 dip, and three health networks — COD, CHOC and CHCN — demonstrated strong or improving performance, with COD and CHOC consistently exceeding the 50% benchmark. However, most networks remained below target, indicating that while progress has been made, further interventions are needed to achieve additional improvements.

V. **Actions/Interventions Implemented in 2025:**

Interventions	Product	Qtr.	Type	Status
• CHCN Virtual Learn Meeting: Ongoing quarterly presentations are provided to CHCN contracted providers to offer IHA updates, performance and reminders. Presentation at Q1 CHCN Virtual Learn Meeting held on March 24, 2025.	☒ MC ☐ OC	☒ Q1 ☐ Q2	☐ Mem ☒ Prov	☐ Completed ☐ Ongoing ☐ Incomplete

IHA Reference Guide for PCPs: A guide for PCPs to complete the IHA within 120 days from the member's enrollment date with CalOptima Health. This document is shared on the www.caloptima.org website and provided as a resource during trainings.		☐ Q3 ☐ Q4	☐ HN ☐ Comm ☐ Data ☐ Other	
- QIHEC Meeting: Meeting with CalOptima Health leaders to provide direction and oversight of quality improvement processes related to regulatory requirements. IHA updates shared on January 14, 2025, and March 11, 2025. - PHMC Meeting: Quarterly meeting to provide overall direction for continuous process improvement and oversight of the PHM Program, ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities, and monitor compliance with regulatory requirements. IHA updates presented February 20, 2025. - DOC Meeting: Monthly oversight meetings focused on monitoring health network compliance with key performance indicators KPIs, including IHA completion rates. These meetings provide a forum for reviewing performance dashboards, discussing corrective actions, and sharing updates on regulatory requirements and quality initiatives. IHA updates were provided at the March meeting.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Member Interactive Voice Response (IVR) Calls: Automated phone calls are sent twice a month, tailored to new members enrolled in CalOptima Health, designed to welcome them and inform them about the next steps to take after enrollment.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- JOM: Ongoing monthly presentations are provided to all health networks to offer IHA updates, performance rates and reminders. IHA was presented at three JOMs in Quarter 2. - Health Network Quality Update Meeting: Bimonthly quality presentations are delivered to all health networks to provide IHA updates, performance rates, and reminders. IHA was presented at six meetings in May.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
- DOC Meeting: IHA updates were provided at the May and June meetings. - QIHEC Meeting: IHA updates shared on April 8, 2025, May 13, 2025, and June 10, 2025. - PHMC: IHA updates shared at meeting held on May 16, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
- CHCN Virtual Learn Meeting: Presentation at Q2 CHCN Virtual Learn Meeting held on June 25, 2025. - Provider Update: Monthly CalOptima Health updates to providers. IHA updates are shared in the March Provider Update. - Provider Onboarding: Training is provided to all new CHCN-contracted providers. Training was reviewed and updated in the overall presentation given to newly contracted CHCN providers. This training was updated in April and uploaded to the Provider section of www.caloptima.org. - Provider Annual Training: Yearly training for CHCN contracted providers to discuss updates and ongoing education. This training was updated in April and uploaded to the Provider section of www.caloptima.org.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
- Member Interactive Voice Response (IVR) Calls: Automated phone calls are sent twice monthly - Implementation of the New Member Welcome – Two-way texting campaign, designed to guide new CalOptima Health Medi-Cal members through essential onboarding steps to help them get started with their health care.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete

- Health Network Newsletter: Weekly newsletter sent out to all health networks with important updates and upcoming events from CalOptima Health. Notification on IHA updates sent in Health Network Weekly Newsletter for the week of August 5-9, 2025. - Health Network Delegation Oversight Meeting: Oversight meetings focused on health network compliance and performance. The IHA discussion on completion rates was presented at eight meetings in September. - JOM: IHA was presented at six JOMs in Quarter 3.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
- DOC Meeting: IHA updates were provided at the August and September meetings. - QIHEC Meeting: IHA updates shared on July 8, 2025, August 12, 2025, and September 9, 2025. - PHMC: IHA updates shared at meeting held on August 21, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
- Continuing Medical Education: An annual webinar for medical professionals to learn more about the IHA requirements and best practices to complete the IHA with their patients. The webinar was held on August 6, 2025. - CHCN Virtual Learn Meeting: Presentation at Q3 CHCN Virtual Learn Meeting held on September 25, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
- DOC Meeting: IHA updates were provided at the October and November meetings. - QIHEC Meeting: IHA updates are planned for December 9, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
JOM: IHA was presented at three JOMs in Quarter 3.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Throughout 2025, CalOptima Health implemented a series of interventions to improve IHA completion rates, including enhanced member outreach, provider education, and regular performance monitoring through DOC and JOM meetings. To evaluate the effectiveness of these efforts, Q1 2025 was used as a baseline and compared to Q4 2025 performance for the general Medi-Cal population (all ages).

Key Findings:

- Overall Improvement: The IHA completion rate for all ages increased from 34.51% in Q1 to 38.68% in Q4, indicating a modest but positive trend over the course of the year.
- Top Performing Networks:
 - CHOC improved from 57.21% in Q1 to 64.42% in Q4, consistently exceeding the 50% benchmark, largely attributed to their pediatric population.
 - CHCN increased from 47.48% in Q1 to 51.32% in Q4, crossing the benchmark by yearend.

- **Limited Gains in Other Networks:** Most other health networks remained below the 50% benchmark throughout the year, with minimal quarter-over-quarter improvement. For example, AltaMed's rate increased from 23.83% to 24.13%, and Optum's rate decreased from 29.84% to 27.24%, suggesting that interventions had varying levels of impact across networks.

Considerations:

While outreach and engagement strategies were emphasized throughout the year, it is important to note that member outreach attempts are not currently captured through claims data and, therefore, cannot be used as a proxy for IHA completion. As such, the effectiveness of outreach-specific interventions may be underrepresented in this analysis.

Conclusion:

The 2025 interventions were associated with measurable improvements in IHA completion rates among a subset of health networks. However, the overall systemwide rate remains below the 50% benchmark, and performance varied significantly across networks. IHA will remain on the work plan for 2026 and continued monitoring and refinement of strategies will be important to support broader improvement in 2026.

VII. Qualitative Analysis

This analysis was conducted by the Case Management team based on 2025 IHA performance data, internal reporting and feedback received through oversight activities. The purpose was to identify barriers that contributed to underperformance against the 50% IHA completion benchmark and to inform future improvement strategies.

Causal/Barrier Analysis:

Operational Barriers

- **Enrollment Surge in Early 2025:** A spike in new Medi-Cal enrollments in Q2 increased the volume of IHAs due, placing strain on operational capacity.
- **Outdated Member Contact Information:** Difficulty reaching members due to incorrect or missing contact details continues to be a barrier.
- **Outreach Documentation Gaps:** While outreach is encouraged and often conducted, these efforts are not captured through claims data and therefore cannot be reflected in IHA completion metrics.

Health Network Barriers

- **Inconsistent Accountability Structures:** Some health networks lack clearly defined roles or escalation pathways for IHA oversight and follow-up.
- **Staffing:** Without a designated point person responsible for IHA performance, follow-through on improvement plans may be inconsistent or delayed. Furthermore, ongoing turnover within health networks has led to gaps in training and continuity of IHA processes.

- **Competing Priorities:** Health networks may be balancing multiple regulatory or operational demands, which can deprioritize IHA completion efforts — especially if not tied to financial incentives or contractual penalties.
- **Delays in Member Assignment:** The current auto-assignment process delays the timeframe in which new members are assigned to a health network, reducing the window available to complete the IHA within the required 120-day period.

Provider Barriers

- **Awareness and Access Issues:** Some providers remain unaware of how to access or interpret IHA performance reports.
- **Clinic Staffing Constraints:** Staffing shortages continue to impact the ability of clinics to prioritize and complete IHAs.
- **Variability in Data Submission:** Differences in how clinics submit chart review records or encounter data can affect the accuracy and timeliness of reporting.
- **Lack of Integration Between EHR and Reporting Systems:** In some clinics, EHR systems may not be configured to flag IHA-eligible patients or capture the necessary data elements for reporting, leading to missed or delayed documentation.
- **No Mechanism to Report Outreach Attempts:** Providers currently have no way to report outreach attempts through claims when they are unable to reach a member. As a result, these efforts, though encouraged, are not reflected in IHA completion metrics.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
IHA rate only captures completed visits via claims/encounters and does not incorporate health network or provider efforts to reach out to members.	Evaluate the feasibility of capturing outreach attempts for future reporting and incorporation into IHA performance reporting.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☒ H ☐ M ☐ L
Health networks' performance is consistently below the goal for members of all ages.	Re-evaluate the 50% IHA benchmark Evaluate whether the current benchmark is realistic and aligned with those of peer health plans.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☒ H ☐ M ☐ L
Short timeframe for member outreach once the member is assigned to the health network.	Evaluate opportunities to reduce the timeframe for members to be assigned to a health network	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

In 2025, CalOptima Health continued its efforts to improve IHA completion rates through targeted outreach, provider education and performance monitoring. While the overall IHA completion rate (34.3%)

remained below the 50% benchmark, it reflected a modest improvement from 2024 and a return to 2023 levels. A few health networks, most notably CHOC and CHCN, demonstrated meaningful progress, with CHCN crossing the benchmark by Q4.

Despite these gains, the majority of health networks remained below target, and performance varied significantly across the system. Barriers, including staffing constraints, competing priorities, delayed member assignment and limited mechanisms for capturing outreach efforts, continue to impact IHA completion. These challenges underscore the need for ongoing evaluation of operational processes and performance expectations.

Looking ahead, CalOptima Health will continue to assess the feasibility of capturing outreach activity, review the auto-assignment process to reduce delays in member attribution and reevaluate appropriate benchmarks to ensure they are realistic and aligned with quality measures and regulatory expectations. These efforts will support more equitable and achievable performance goals as we work toward improving early engagement in primary care for Medi-Cal members.

5.5 Improve Member Experience/CAHPS	
Author(s): Carol Matthews	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Carol Matthews (Project Manager, Quality Analytics); Helen Syn (Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase CAHPS performance to meet goal of OC: One Star Improvement MC: One Star Improvement	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health is committed to annually monitoring member experience and identifying areas for improvement for all lines of business. By actively seeking feedback from members, CalOptima Health assesses the current state of member satisfaction and experiences and identifies specific areas for improvement. Collecting valid data ensures that the insights gained are reliable, which allows for the development and implementation of evidence-based interventions. The goal is to improve the overall member experience by more effectively meeting our members’ needs.

II. Data Sources and Methodology:

CalOptima Health utilizes the CAHPS survey to measure member experience. The CAHPS program is overseen by the United States Department of Health and Human Services, and the surveys are a nationally recognized tool developed by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS process has standardized tools, questionnaires and data collection protocols. CalOptima Health

submits CAHPS rates to NCQA for accreditation and to CMS as part of the CMS's Five-Star Quality Rating System.

III. Quantitative Analysis:

Medi-Cal: Adult

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	51.61	55.67	55.21	57.32	☐ Y ☒ N
RPD	Rating of Personal Doctor	61.71	69.88	66.30	70.89	☐ Y ☒ N
RS	Rating of Specialist	62.50	63.70	69.67	66.34	☒ Y ☐ N
RHP	Rating of Health Plan	52.34	57.22	60.22	62.18	☐ Y ☒ N
GNC	Getting Needed Care	79.72	76.26	81.39	80.82	☒ Y ☐ N
GCQ	Getting Care Quickly	76.04	75.35	77.93	80.23	☐ Y ☒ N
CS	Customer Service	87.05	87.89	82.38	89.41	☐ Y ☒ N
CC	Coordination of Care	79.55	79.53	NA	84.78	☐ Y ☐ N
HWDC	How Well Doctors Communicate	88.10	90.80	91.09	92.57	☐ Y ☒ N

Analysis Against Goals and Year-Over-Year Trends

The analysis of the Medi-Cal Adult measures for MY 2022, MY 2023 and MY 2024 indicates a mixed performance against the established goals.

RHC: There was a slight improvement from 51.61 in MY 2022 to 55.67 in MY 2023, followed by a marginal decline to 55.21 in MY 2024. Despite these gains, the rate did not meet the NCQA Quality Compass (QC) 50th percentile goal.

RPD: Significant improvement was observed from 61.71 in MY 2022 to 69.88 in MY 2023, though a decrease to 66.30 was noted in MY 2024. The measure fell short of reaching the QC 50th percentile goal.

RS: There was a notable year-over-year increase, from 62.50 in MY 2022 to 63.70 in MY 2023, and a further rise to 69.67 in MY 2024. This measure surpassed the QC 33rd percentile goal.

RHP: The rate increased steadily from 52.34 in MY 2022 to 57.22 in MY 2023, and then to 60.22 in MY 2024, achieving the QC 33rd percentile goal.

GNC: Despite a slight dip from 79.72 in MY 2022 to 76.26 in MY 2023, the rate improved to 81.39 in MY 2024, meeting the QC 33rd percentile goal.

GCQ: This measure remained relatively stable, with 76.04 in MY 2022 and 75.35 in MY 2023, followed by an increase to 77.93 in MY 2024. However, it did not meet the QC 33rd percentile goal.

CS: There was a consistent performance with a slight improvement from 87.05 in MY 2022 to 87.89 in MY 2023, though a decline to 82.38 in MY 2024. The measure still achieved the QC 50th percentile goal.

CC: The rates remained steady at 79.55 in MY 2022 and 79.53 in MY 2023, with no available data for MY 2024. The measure did not meet any goals.

HWDC: This measure saw a positive trend, increasing from 88.10 in MY 2022 to 90.80 in MY 2023 and 91.09 in MY 2024. Despite this improvement, it did not meet the QC 33rd percentile goal.

Overall, while several measures have shown improvement over the years, there are still areas that require focused interventions to meet and surpass the set goals.

Medi-Cal: Child

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	64.20	67.94	68.67	71.07	☐ Y ☒ N
RPD	Rating of Personal Doctor	72.27	67.34	69.97	76.52	☐ Y ☒ N
RS	Rating of Specialist	NA	NA	71.43	70.49	☒ Y ☐ N
RHP	Rating of Health Plan	66.51	63.61	66.01	69.91	☐ Y ☒ N
GNC	Getting Needed Care	77.80	75.18	75.08	82.32	☐ Y ☒ N
GCQ	Getting Care Quickly	82.29	77.81	79.65	85.02	☐ Y ☒ N
CS	Customer Service	88.08	85.17	88.76	87.16	☒ Y ☐ N
CC	Coordination of Care	76.42	77.97	75.68	83.09	☐ Y ☒ N
HWDC	How Well Doctors Communicate	93.99	91.34	92.97	92.91	☒ Y ☐ N

Analysis Against Goals and Year-Over-Year Trends for Medi-Cal Child

RHC: The RHC measure increased from 64.20 in MY 2022 to 67.94 in MY 2023 and then rose slightly to 68.67 in MY 2024. Despite this improvement, it did not meet the QC 50th percentile goal. This indicates a positive upward trend, although efforts are needed to reach the set benchmark.

RPD: There was a decrease from 72.27 in MY 2022 to 67.34 in MY 2023, followed by a slight improvement to 69.97 in MY 2024. The measure did not meet the QC 33rd percentile goal. The downward trend in the earlier years requires focused intervention to ensure consistent improvement.

RS: Data for MY 2022 and MY 2023 is not available. However, in MY 2024, the RS measure was recorded at 71.43, surpassing the QC 33rd percentile goal.

RHP: The RHP measure declined from 66.51 in MY 2022 to 63.61 in MY 2023, but recovered to 66.01 in MY 2024. Despite the recovery, it did not meet the QC 33rd percentile goal, pointing to the need for sustained improvements in health plan ratings.

GNC: The GNC measure decreased from 77.80 in MY 2022 to 75.18 in MY 2023, and slightly declined further to 75.08 in MY 2024. It did not meet the QC 33rd percentile goal, indicating consistent challenges in accessing needed care.

GCQ: This measure decreased from 82.29 in MY 2022 to 77.81 in MY 2023, but rose to 79.65 in MY 2024. Despite the improvement, it fell short of the QC 33rd percentile goal, suggesting the need for enhancements in the timeliness of care.

CS: The CS measure declined from 88.08 in MY 2022 to 85.17 in MY 2023, then improved to 88.76 in MY 2024, meeting the QC 33rd percentile goal. This fluctuation underscores the importance of maintaining high standards in customer service.

CC: The CC measure saw a slight improvement from 76.42 in MY 2022 to 77.97 in MY 2023, but it dropped to 75.68 in MY 2024, failing to meet the QC 33rd percentile goal. Continuous efforts are needed to enhance care coordination.

HWDC: There was a slight decline from 93.99 in MY 2022 to 91.34 in MY 2023, but it improved to 92.97 in MY 2024. This measure met the QC 33rd percentile goal, indicating strong performance in doctor-patient communication.

Overall, the analysis reveals varied performance across different measures, with some areas showing positive trends while others require focused efforts to meet and surpass the set goals.

OneCare

Acronym	Measure	MY 2022 OneCare Rate/	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	86	83	84	84 - 85	☒ Y ☐ N
RHP	Rating of Health Plan	86	84	86	85 - 86	☒ Y ☐ N
GNC	Getting Needed Care	75	75	75	78 - 79	☐ Y ☒ N
GCQ	Getting Appointments and Care Quickly	73	76	77	80 - 81	☐ Y ☒ N
CS	Customer Service	87	86	85	88	☐ Y ☒ N
CC	Coordination of Care	80	83	82	85	☐ Y ☒ N
GNPD	Getting Needed Prescription Drugs	88	86	86	87	☐ Y ☒ N
RDP	Rating of Drug Plan	88	85	87	86 - 87	☒ Y ☐ N

Flu	Annual Flu Vaccine	68	68	71	86 - 72	☒ Y ☐ N
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Analysis Against Goals and Year-Over-Year Trends for OneCare

RHC: The RHC measure declined from 86 in MY 2022 to 83 in MY 2023, followed by a slight increase to 84 in MY 2024. The goal was met.

RHP: The RHP measure decreased from 86 in MY 2022 to 84 in MY 2023, then returned to 86 in MY 2024, regaining its previous performance level. The goal was met.

GNC: The GNC measure remained constant across all three years, maintaining a steady level of 75 from MY 2022 through MY 2024. The goal was not met.

GACQ: The GACQ measure improved from 73 in MY 2022 to 76 in MY 2023, and continued to rise to 77 in MY 2024, showing a consistent upward trend. The goal was not met.

CS: The CS measure experienced a gradual decline, dropping from 87 in MY 2022 to 86 in MY 2023, and further to 85 in MY 2024. The goal was not met.

COC: The COC measure increased from 80 in MY 2022 to 83 in MY 2023, followed by a slight decrease to 82 in MY 2024. The goal was not met.

GNPD: The GNPD measure declined from 88 in MY 2022 to 86 in MY 2023, and remained stable at 86 in MY 2024. The goal was not met.

RDP: The RDP measure dropped from 88 in MY 2022 to 85 in MY 2023, then rose to 87 in MY 2024, nearly returning to its original level. The goal was met.

AFV: The AFV measure held steady at 68 in both MY 2022 and MY 2023, then increased to 71 in MY 2024, indicating a modest improvement. The goal was met.

Across the nine reported measures, performance exhibited a mixed trend, with areas of improvement, stability and a slight decline. GNC is a measure that has consistently maintained the same performance level for the past three years.

IV. Data Stratification Data Source and Methodology for Race, Ethnicity and Gender:

CalOptima Health's survey vendor uses collected CAHPS data and conducts analysis of selected demographic categories for the CAHPS overall ratings and composites to better understand differences in member experience. The categories are gender, age (18-44 and 45+), education (low education: through high school graduate or GED), ethnicity (Hispanic or Latino and not Hispanic or Latino), the language the survey was fielded in (English or Spanish), and race (White, Black, or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander and Other). The

variables are coded for performance: scores equal to or higher than 85%, scores less than 85% but equal to or higher than 75%, and scores less than 75%.

Adult CAHPS Survey Overall Ratings and Composites by Race, Ethnicity and Gender

Ratings	Aggregate Rate	White	Black	Asian	Hawaiian	American Indian	Other Race	Male	Female	Hispanic or Latino	Not Hispanic or Latino
Rating of all health care	76.7	77.3	100*	67.5	100*	100*	71.4	76.8	76.6	85.9	66.2
Rating of personal doctor	87	86.3	100*	86.7	100*	100*	87.5	90.1	85	88.9	85.9
Rating of specialist talked to most often	82.8	90.4	100*	67.9	-	100*	75.9	89.6	78.4	88.7	76.7
Rating of health plan	75.5	80.2	50*	59.1	100*	100*	80	79.1	73	84.1	66.7
Composites	Aggregate Rate	White	Black	Asian	Hawaiian	American Indian	Other Race	Male	Female	Hispanic or Latino	Not Hispanic or Latino
Getting needed care	81.4	85.2	100*	64.3	100*	83.3*	87.8	80.1	82.1	89.1	72.9
Getting care quickly	77.9	77.4	100*	54.3	50*	100*	82.5	69.8	82.7	88.8	64.5
How well doctors communicate	91.9	88.1	-	91.2	100*	100*	92.6	90.1	91.7	90.7	91.4
Customer service	82.4	87.7	-	56.5	-	100*	93.9	81.3	83	90.4	71.3
Coordination of care	84.7	83.3	-	81.8	100*	100*	84.6	83.3	85.5	83.7	85.7

Bold <75%; *Score based on < 11 cases; -no respondents met the criteria

Analysis of the Medi-Cal adult survey results, stratified by race, ethnicity and gender, showed that members of Asian descent scored lower on many measures. For this population, overall rating of personal doctor and how well doctors communicate performed above 85%, coordination of care performed above 75% but below 85%, and the following six overall ratings and composites performed below 75%: rating of all health care, rating of specialist talked to most often, rating of health plan, getting needed care, getting care quickly and customer service.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
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Conduct outreach to members in advance of 2025 CAHPS survey.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Launch eight listening post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Launch a recurring meeting series with health network partners dedicated to member experience improvement strategy.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Propose mapping of member responses to CAHPS categories in support of the organization adopting a voice of member reporting system.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☒ Incomplete	All
Train member-facing roles on the Decision Point Insights platform to review and address CAHPS risk during member discussions.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☒ Incomplete	All

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

The various interventions enabled CalOptima Health to develop better member feedback mechanisms for improving CAHPS scores. These interventions have been effective in providing member-level feedback to teams, enabling them to develop strategies.

VII. Qualitative Analysis:

Initial analysis of the CAHPS survey results was conducted by the CAHPS project manager. Data was presented at CalOptima Health's Member Experience Committee meetings for review. The committee is an executive team whose purpose is to improve the member experience and drive initiatives that achieve member experience goals. It is responsible for identifying barriers and recommending solutions. The committee met four times in 2025 and included representation from the following departments: Medical Management, Provider Relations, Health Network Relations, Behavioral Health, Quality Analytics, Quality Improvement, Customer Service, Provider Data Operations, Grievance and Appeals, Medicare Operations, Equity and Community Health, Utilization Management and Quality Improvement.

Causal/Barrier Analysis:

- Response rates continue to decline, or remain stagnant, for CAHPS surveys.
- Appointment timeliness and availability:

- Members are unable to obtain timely appointments for routine, specialty and urgent care.
 - There is a lack of providers who offer extended office hours for urgent appointments.
 - Provider offices do not employ mid-level providers to increase appointment availability.
 - Specialist appointments may be delayed for months due to referral submission delays and the need to coordinate with PCPs.
 - Delay in authorization requests.
- Member visits with their doctor: Members experienced challenges due to:
 - Long office wait times
 - Feeling rushed in their visits with their provider
 - Providers do not fully address the members' health concerns
 - Results of tests not being provided at office visits
- Provider efficiency: Members expressed not being able to reach providers for a variety of reasons, including:
 - Provider not seeing new patients
 - Provider cancelled appointment
 - Phone calls not being answered
 - Unable to reach the provider due to outdated contact information
- Referrals: Expired because patients could not get an appointment, or the provider canceled/changed the appointment.
- Specialists: There are not enough specialists in the CalOptima Health network for rheumatology, neurology, endocrinology and urology, delaying access for members.
 - Members do not receive referrals to specialty care due to the limited number of specialists and/or access in certain geographic areas for additional specialties.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Improve specialty access	Complete the contract and begin implementation to expand access via telemedicine for neurology, rheumatology, endocrinology and urology.	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	RS
Identification of positive and negative member cohorts for outreach via phone and mailing to improve CAHPS performance.	Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	All
Improvement in CAHPS measures	Launch additional listening post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	All

Complete member education and outreach related to specialty care	A specialist referral strategy educates members via email and SMS with a flyer on the referral/prior authorization process, and provides support throughout the process to facilitate access to care.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L	RS
Improve access to primary care/education re: how to get care	A high-risk access outreach campaign is an email and SMS campaign that includes a flyer targeting members at high risk for access issues, directing them to where they can find appropriate care.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L	RPD
Outreach to members who are at high risk for dissatisfaction and disenrollment to improve satisfaction and retention	Pre-Annual Enrollment Period AEP outreach in collaboration with Customer Service.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	All
Improve health network CAHPS performance	Launch a recurring meeting series with health network partners dedicated to member experience improvement strategy.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	All
Improvement in CAHPS measures through year-round member feedback and monitoring	Mapping of member responses to CAHPS categories in support of the organization adopting a voice of member reporting system.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	All
Improvement in CAHPS measures	Train member-facing roles on the Decision Point Insights platform to review and address CAHPS risk during member discussions. Share Decision Points Insights with health network partners.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	All

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

CalOptima Health has adopted a structured, multipronged strategy to improve CAHPS scores, with varied results across different domains. The organization has implemented a range of systems and processes, emphasizing that sustained improvement requires collaboration across all departments. Internal education efforts have reinforced the message that achieving strong CAHPS outcomes is a shared responsibility, with each area playing a critical role in driving success. Success can be measured in terms of operational readiness, and CalOptima Health is moving in a positive direction. CalOptima Health's goal was a one-star improvement for both Medicare Stars and a one-star improvement for the NCQA Health Plan Rating for Medi-Cal. Unfortunately, neither goal was achieved, highlighting the continued need to prioritize member experience

5.6 Grievance and Appeals Resolutions Services

Author: Heather Sedillo– Director, Grievance & Appeals

Department(s): Grievance and Appeals Resolutions Services (GARS)

Responsible Party(ies): Heather Sedillo (Director, Grievance & Appeals); Ismael Bustamante (Manager, Grievance & Appeals)

Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

GARS handles all members and provider complaints and appeals for Medi-Cal and OneCare LOB. GARS data helps achieve improved care and access to services for our members, while also monitoring provider satisfaction by identifying and addressing provider-related concerns and reporting on remediation efforts.

II. Data Sources and Methodology

All member and provider appeals and grievances received in 2025.

III. Program Results and Quantitative Analysis:

Medi-Cal Grievances

	MC GRIEVANCES				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	2,702	2,485	2,337	2,917	3,261
Quality of Care	586	480	364	518	213
Access	882	875	821	899	851
Billing	217	178	153	172	222
TOTAL	4,387	4,018	3,675	4,506	4,547

OneCare Grievances

	OneCare Grievances				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	371	334	302	444	507
Quality of Care	51	22	25	39	20
Access	49	49	33	57	54
Billing	15	14	11	10	3
TOTAL	486	419	371	550	584

Indicator/Goals: Report key findings, analyze barriers and trends.

Medi-Cal and OneCare Appeals

Both Medi-Cal and OneCare saw significant decreases in quality of care (QOC) grievances, which is an outcome of our process improvements.

The overall grievance volume increased in 2025 for OneCare and remained consistent in 2025 for Medi-Cal.

Consistent reporting of trends during quarterly GARS Committee meetings has played a pivotal role in guiding targeted interventions and driving measurable performance outcomes when patterns and opportunities for improvement are identified.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Implementation of nurse triage for identification of QOC grievances.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete
Jiva system enhancements to improve tracking and trending of appeals and grievances.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Implementation of nurse triage for identification of QOC grievances assisted in earlier identification, action and resolution, which increased overall member satisfaction.

Jiva system enhancements to improve tracking and trending of appeals and grievances contributed to the production of more meaningful data for reporting and interventions.

VI. Qualitative Analysis

The analysis was conducted by the GARS department director, managers and senior data analyst. These individuals remain responsible for identifying and addressing GARS QIHE goals.

VII. Conclusion:

The data indicates that the program is making overall improvements, particularly in the areas of QOC and billing, and has met its goal. These outcomes affirm that GARS department remediations were successful in improving both member and provider experiences while supporting continuous quality improvement.

5.7 Customer Service Call Center	
Author: Andrew Tse	Department(s): Customer Service
Responsible Party(ies): Andrew Tse (Director, Customer Service); Mike Erbe (Manager, Customer Service)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: The telephonic wait time shall not exceed ten minutes for members to speak with a customer service representative.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

The Customer Service department provides telephonic assistance to CalOptima Health members.

II. Data Sources and Methodology

Inbound call data from the contact center system

III. Program Results and Quantitative Analysis:

KPI Goal: The telephonic wait time will not exceed 10 minutes for members to speak with a customer service representative.

Q1 2025	Q2 2025	Q3 2025	Q4 2025
2:56	1:34	0:38	4:35

The average speed of answering threshold, not exceeding ten minutes, is consistently achieved.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Hire additional staff to help with the inbound call volume	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Leverage the callback offering for those who do not want to wait in the queue.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Partner with various departments to stagger their member engagement campaigns	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

By hiring additional call center staff to support inbound calls, continuing to ensure the contact center callback feature is enabled and partnering with various departments to stagger their member engagement campaigns, the call center has achieved an average speed of answering threshold — not exceeding 10 minutes — throughout each quarter.

VI. Qualitative Analysis

There are no barriers, and the analysis was conducted by the Customer Service call center director and managers, who remain responsible for identifying and addressing call center KPI goals.

VII. Conclusion:

On a quarterly basis, the average speed of answer threshold has not exceeded 10 minutes.

Section 6: Safety of Clinical Care

6.1 Plan All Cause Readmission	
Author: Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr Director, Utilization Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

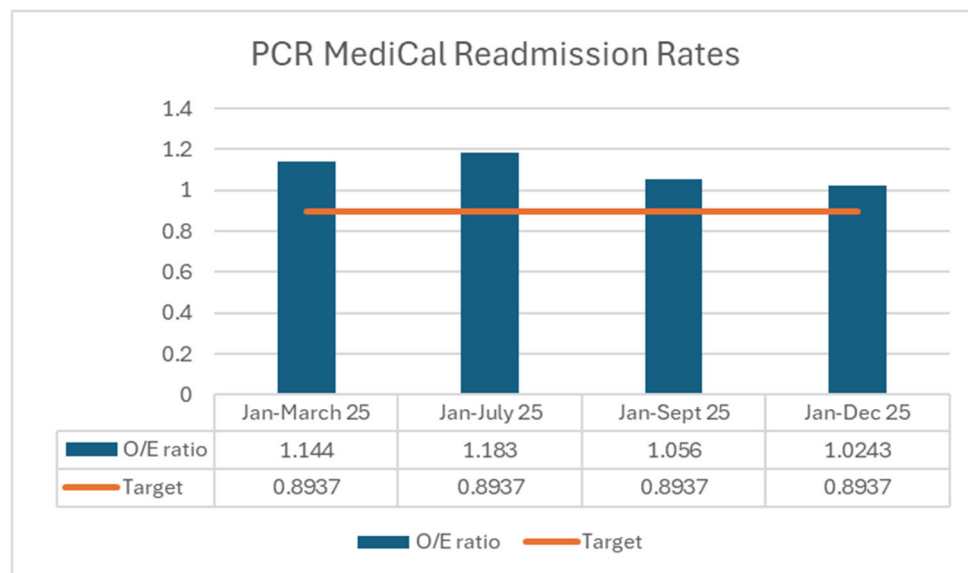
Prioritizing readmission reduction not only enhances patient outcomes but also optimizes resource utilization and elevates the overall quality of care for members.

II. Data Sources and Methodology

The data source is administrative HEDIS data for MY 2024 and MY 2025, which is trended quarterly for both OneCare and Medi-Cal LOB for readmission rates.

III. Program Results and Quantitative Analysis:

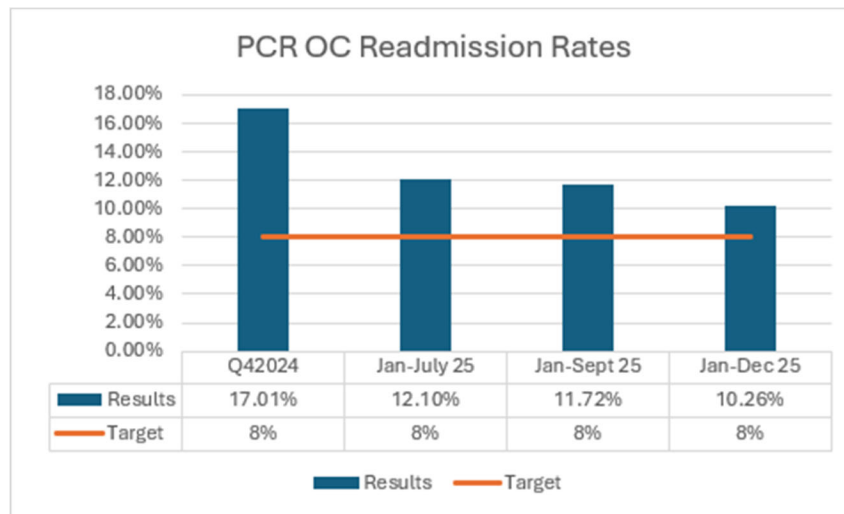
Medi-Cal



Indicator/Goals: Target was readmission rate of 0.8937 by December 31, 2025

Overall, readmissions are trending downward. We did not meet the goal at the end of the fourth quarter for both LOBs.

OneCare



Indicator/Goals: Target was readmission rate of 8% by December 31, 2025.

While we continued to trend downward in both LOBs, we did not meet the goal for Medi-Cal or OneCare across all-plan readmission rates.

IV. Actions/Interventions Implemented in 2025:

To support improvement efforts, extensive education was provided to providers and health networks during JOMs, focusing on:

- Transitional Care Management (TCM) services (CPT Codes 99495 & 99496).
- Post-discharge ambulatory follow-up rates within seven days for both health network and facility JOMs.
- Readmission rate transparency, with data shared regularly with health networks and facilities.
- Best practices for reducing readmissions, discussed and reinforced during sessions.
- Usher text campaign for admissions (MC) — provides TCS number for support
- Member resources created:
 - Services to support your care
 - CalOptima Health Behavioral Health line
 - Transportation
 - ECM and Community Supports
 - Get the care you need
 - How to use primary care, urgent care, emergency services and CalOptima Health Nurse Advice Line
 - Doctor visit form
 - Readmission review during high-risk subgroup
 - ED diversion program focuses on high utilizers

- Implemented maternal health and multiple payor TCS workflows for high-risk members in 2025.

V. Effectiveness of Interventions: Medi-Cal: Comparing program results from Q4 2024 shows a significant downward trend; will validate Q3 2025 data for accuracy due to a large disparity. For Q3; the O/E ratio was inadvertently reported as 0.0933, the correct O/E ratio 1.0566 reflected in chart. Both MC and OC show a downward trend. Q4 2025 performance reflects end of year goal not met, continued improvement efforts planned for 2026.

VI. Qualitative Analysis:

Barriers to meeting readmission goals include:

- A lack of insight into readmission strategies from health network and facility partners, despite data sharing.
- A lack of member engagement or a decline in transitional care services.
- Members are unable to reach for post-discharge outreach and support.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. During HN JOMs, seek out readmission strategies HN are using to support this measure	Staff will attend HN JOMs and request readmission strategies HN are using to support readmission reduction.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Continue to share readmission rates at the facility and HN JOMs for transparency and opportunities.	Each quarter will share readmission rates at the facility and HN JOMs.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Continue to share post-discharge ambulatory follow-up rates within seven days of discharge for HN and facility Continue TCS activities and program enhancements supporting member outreach and engagement	Post-discharge ambulatory follow-up rates within seven days will be shared quarterly with HN and facility JOMs. Continue TCS activities supporting member engagement, and PCP follow-up after discharge.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

While successes demonstrated year-over-year improvement in readmission rates, PCR will remain on the work plan for 2026. Staff implemented a broad range of interventions and improved awareness from external stakeholders (health networks and hospital partners). Challenges continue to persist despite shared data and strategies to increase member engagement for TCS services. Although the numerical target was not met, the program demonstrated meaningful progress and laid a foundation for future

success. The implemented strategies showed a downward trend in readmissions, resulting in a partially successful program.

6.2 Emergency Department Member Support	
Author: Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr Director, Utilization Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

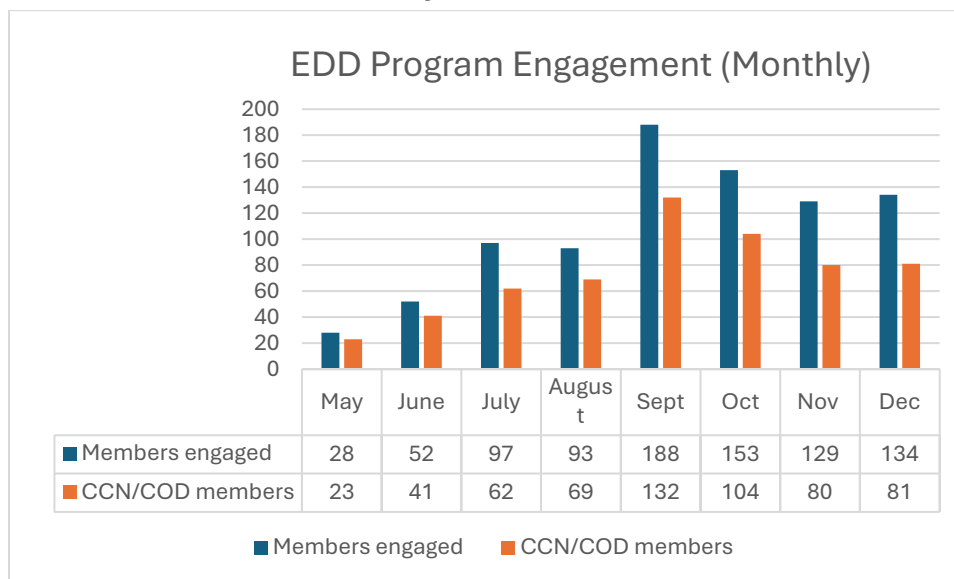
I. Purpose or Background:

Launch the ED Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers and improvement efforts.

II. Data Sources and Methodology

The data source is manual tracking, utilizing an Excel spreadsheet within a tracking tool. Jiva ED assessment was created for use with member outreach.

III. Program Results and Quantitative Analysis:



Indicator/Goals: Increased month-over-month member engagement since program inception.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Program implementation and onboarding of staff	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue onsite activities 2. Weekly workgroup: Identify trends/opportunities/barriers 3. Continue real-time member recommendations during weekly meetings 4. Program enhancements supporting increased member engagement 5. Warm handoff to delegated HN/CM/TCS/ECM providers 6. Member resources and referrals (CalAIM, housing, TCS, CM, etc.)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue onsite activities 2. Added BH to the weekly workgroup: Identify trends/opportunities/barriers, real-time follow-up on member recommendations 3. Evaluate Jiva assessment as a reporting enhancement and consistent documentation practice 4. Continue refining workflows and processes	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

V. Effectiveness of Interventions:

The month-over-month increase in member engagement reflects the effectiveness of outreach, real-time coordination and post-discharge member outreach. The integration of BH enhances the program's ability to address complex member needs. The Jiva ED assessment tool improved consistency in member assessment. Warm handoffs to health network, TCS and CM staff help streamline communication. SNF placements help streamline transitions and reduce ED boarding times and unnecessary admissions. Referral pathways ensure members are connected to appropriate support services.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Limited engagement from ED facility staff reduced opportunities for collaborative, on-site intervention
- Reliance on real-time identification of CalOptima Health members for outreach limited proactive engagement, as support was often initiated by the program rather than by ED staff
- Challenges in member engagement, including frequent declination of services and difficulty reaching members post-ED visit, hindered the effectiveness of follow-up efforts

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
- Enhance member engagement strategies to increase participation and satisfaction - Strengthen resource support and referral processes during member interactions to ensure timely access to services. - Maintain real-time member-focused recommendations through consistent weekly workgroup meetings and follow-up actions - Create automated reporting capabilities to reduce manual tracking of program interventions and improve data accuracy	- Maintain weekly workgroup meetings and follow up on real-time interventions and recommendations - Continuously refine workgroup processes to improve efficiency and outcomes - Proactively engage members during ED visits to support care coordination - Provide proactive post-ED engagement with members as needed to ensure continuity of care - Monitor and adjust outreach strategies based on performance and member needs - Collaborate and communicate with member engagement teams and delegated HN/CM/TCS/ECM providers to strengthen care continuity and member support - Facilitate member resources and referrals (e.g., CalAIM, housing, TCS, CM) during member interactions to address social and clinical needs - Create automated reporting capabilities to reduce manual tracking of program interventions and improve data accuracy	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
- Start scheduling ED post-discharge follow-up appointments for OneCare members to ensure continuity of care - Develop a standardized process for identifying eligible OC members immediately after ED discharge	- Implement a standardized process for identifying OC members for ED post-discharge follow-up appointments - Establish and continuously refine workflows to support this process - Monitor and optimize member outreach activities to improve engagement - Track and analyze outreach success rates to ensure effectiveness - Monitor and report on PCP appointment completion following ED discharge	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Expand onsite staff presence into additional emergency departments to strengthen program impact and improve member engagement	- Identify opportunities for program expansion into additional emergency departments - Select target emergency departments for program implementation and develop a standardized onboarding process - Continuously refine processes and onsite activities to ensure ongoing improvement and efficiency	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The program is meeting member engagement goals and has established a strong operational foundation since its inception. The program will continue to refine and enhance workflows, opportunities to engage members with needed services and support.

6.3 Transitional Care Services (TCS)	
Author: Mimi Cheung and Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr. Director, Utilization Management); Mimi Cheung (Project Manager, Medical Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31, 2025. [New goal will be established Q1 2025]	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Beginning January 1, 2023, CalOptima Health has implemented TCS to ensure members receive support from discharge through connection to necessary services, including medication reconciliation at discharge and follow-up care. The goal is to reduce medication errors and ensure continuity of care across all settings. CalOptima Health's QI Work Plan includes a KPI from the CalAIM PHM policy: the percentage of high-risk member transitions with at least one care manager interaction within seven days post-discharge.

CalOptima Health goal is to improve care coordination by increasing successful interactions for TCS high-risk members within seven days of their discharge by 10% (66.77%) from baseline, by the end of December 31, 2025.

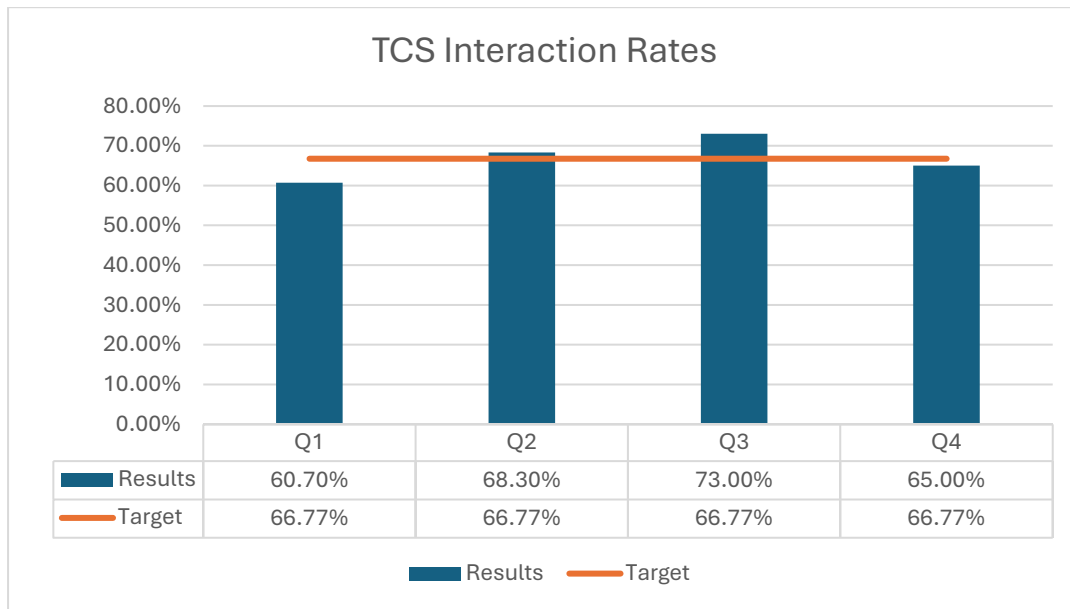
II. Data Sources and Methodology

Jiva was the data source used to track TCS-eligible members. Data is tracked quarterly using Jiva to monitor progress and ensure timely follow-up care.

A random sample of 30 members was selected monthly to assess the rate of interactions between the care manager and members within seven days of discharge.

III. Program Results and Quantitative Analysis:

Medi-Cal: Transitional Care Services



2025	Rate	Percentage Point Change (from baseline)	Percentage change (from baseline)	Goal Met (from baseline)
Quarter 1	60.7%	---	---	---
Quarter 2	68.3%	+7.6 pp	12.52%	Yes
Quarter 3	73.0%	+12.3 pp	20.28%	Yes
Quarter 4	65.0%	+4.3 pp	7.08%	No

Indicator/Goals: The goal is to increase this rate by 10% from baseline (60.7% to 66.77%) by the end of Quarter 4, 2025. Based on the random sampling audit, there was a 4.3 percentage point increase from Quarter 1 (60.7%) to Quarter 4 (65.0%) of 2025, representing a 7.08% percentage change. CalOptima achieved the 10% improvement target during Quarters 2 and 3.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Continue TCS texting campaign 2. Established TCS phone audit log to capture any missed opportunities to outreach to members 3. Designated staff for TCS maternal health outreach 4. Promotion TCS services at facility/hospital JOMs and SNF quarterly meetings 5. IT support for Jiva Report	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue TCS Texting campaign. 2. Established TCS phone audit log to capture any missed opportunities to outreach to members 3. Designated staff for TCS maternal health outreach 4. Promotion TCS services at facility/hospital JOMs and SNF quarterly meetings. 5. IT support for Jiva Report updates	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

Interventions	Product	Quarter	Type	Status
1. DHCS TCS report restarted again (July 2025 - pending final tech/specs) 2. Moved to three staff covering mental health TCS activities (end of July) 3. Moved to member outreach daily for the first seven days post-discharge, mid-August	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The interventions conducted by CalOptima Health this year have shown improvements from Quarter 1 to Quarter 4. Continued focus on real-time outreach, identification and follow-up on missed opportunities (phone audit log), and targeted staffing (for BH population) has supported successful member interactions quarter over quarter.

1. Texting campaigns:
 - a. Continued throughout the year, supporting member engagement and contact number for support post-discharge.
2. TCS phone audit log:
 - a. Helped to identify and address missed outreach opportunities
 - b. Strengthened program accountability and follow-through
3. Promotion of TCS services at facility/hospital JOMs and SNF quarterly meetings:
 - a. Increased awareness of TCS services among provider partners
 - b. Reinforced program visibility and alignment with care partners
4. IT support for Jiva Report updates:
 - a. Provides continuous monitoring of the interaction with members.
5. Daily outreach conducted for the first seven days post-discharge:
 - a. Shifted to daily member contact within the first seven days post-discharge
 - b. Strengthened early intervention and care continuity

VI. Qualitative Analysis

Strengths and Positive Impact:

- Expansion of Outreach: The shift to daily member outreach within the first seven days post-discharge (starting mid-August) reflects a proactive approach to care continuity.
- Targeted Staffing Enhancements: Assigning dedicated staff for maternal health outreach and expanding TCS coverage to three team members by July improved the program's ability to address high-risk populations with specialized needs.
- Operational Infrastructure Improvements: The creation of a TCS phone audit log and IT support for Jiva report updates enhanced internal tracking, accountability and data accuracy — critical for identifying missed opportunities and refining workflows. Jiva report continues to be in development.

- Collaborative Promotion: Regular promotion of TCS services at facility/hospital JOMs and SNF quarterly meetings helped increase awareness and fostered alignment with external partners.
- Cross-Functional Coordination: The inclusion of BH in the weekly workgroup and the reactivation of the DHCS TCS report (pending final specs) demonstrate a commitment to integrated care and long-term sustainability.

Causal/Barrier Analysis:

- Although improvements were observed, continued refinement of data collection tools (e.g., Jiva reports) and audit processes (currently manual) will be essential to maintain momentum and validate outcomes.
- Member Engagement Barriers:
 - Many members lacked access to a working phone or had disconnected numbers.
 - A significant number of members did not return calls or declined outreach efforts.
 - Declined TCS services

VII. Opportunities for Improvement:

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Reporting dashboard	• Create and implement a reporting dashboard for DHCS reporting requirements with IS. • Implement a real-time dashboard to identify opportunities for member outreach within seven days of discharge. • Automate ECM reporting for successful interaction.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Continue workflow enhancements and efficiencies	• Continue TCS activities and program/workflow enhancements, increasing member engagement opportunities. • Reduce manual processes through system integration and automation. • Support member engagement and PCP follow-up. • Maintain TCS activities focused on connecting members with PCP after discharge.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
3. Jiva enhancements that support automation of TCS activities instead of manual creation	• Jiva enhancements to include creation of TCS activity with creation of an Inpatient episode	☐ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
4. Implement readmission strategies for the MC and OC Plan All-Cause readmissions	• Collaborating on Readmission Strategies: Attend Health Network (HN) Joint Operating Meetings (JOMs). • Share Readmission Rates for Transparency: Provide quarterly updates on facility-level and HN readmission rates during JOMs.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

	• Implement post discharge program with Papa and share with all health networks. • PointClickCare discharge sharing (implemented 9/18/2025) • PointClickCare admission notifications (live 12/15/2025) • Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025) • Assisting OneCare members discharged from ED with their PCP after discharges. • UM notification to PCP of all admissions and discharges.			
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MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the program demonstrated strong performance and meaningful progress toward the goal of successful interaction, achieving the targeted 10% improvement in Quarters 2 and 3. From Quarter 1 to Quarter 4, performance increased by 7.08%. While the measure met goal, it is still below the 66th percentile and will remain on the work plan for 2026. Moving forward, the program will continue to invest in member contact strategies, technology enhancements, and partner collaboration to further strengthen member engagement.