NOTICE OF A REGULAR MEETING OF THE CALOPTIMA HEALTH BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

THURSDAY, JUNE 18, 2026
3:00 P.M.

505 CITY PARKWAY WEST, SUITE 108-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
José Mayorga, M.D., Chair
Maura Byron
Catherine Green

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	INTERIM CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	Ruby Nuñez

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors' Quality Assurance Committee, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Board of Directors' Quality Assurance Committee meeting agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org. Committee meeting audio is streamed live on the CalOptima Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us02web.zoom.us/webinar/register/WN_ogQkWEYJTN2qsytkzS4GRg
and Join the Meeting.
Webinar ID: **892 6725 3733**
Passcode: **122411** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

ADVISORY COMMITTEE UPDATES
1. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
2. Whole-Child Model Family Advisory Committee Update

PUBLIC COMMENTS
At this time, members of the public may address the Committee on matters not appearing on the agenda, but under the jurisdiction of the Board of Directors' Quality Assurance Committee. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the March 19, 2026, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

REPORTS/DISCUSSION ITEMS
4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Policy: GG.1611

5. Recommend that the Board of Directors Approve Reallocation of Remaining Non-monetary Gift Cards

INFORMATION ITEMS
6. Grant Management Activities and Updates

7. Quality Improvement Program Updates
   a. Quality Improvement Health Equity Transformation Program Quarterly Report
   b. Health Plan Accreditation Update
   c. Quality Improvement Strategies
   d. Member Grievances and Appeals Report

8. Utilization Management & Clinical Operations Updates

9. Whole Child Model Age Out Transition- PCP Incentive Pilot

10. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Health Equity Committee Report
    b. Program of All-Inclusive Care for the Elderly Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on June 18, 2026 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_ogQkWEYJTN2qsytkzS4GRg

Join from PC, Mac, iPad, or Android:
https://us02web.zoom.us/s/89267253733?pwd=j2Kc8kTzQXv139yWiwwIC9IxDIa4NG.1

Phone one-tap:
+16699006833,,89267253733#,,,,*122411# US (San Jose)
+16694449171,,89267253733#,,,,*122411# US

Join via audio:
+1 669 900 6833 US (San Jose)
+1 669 444 9171 US
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
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International numbers available: https://us02web.zoom.us/u/kdoFRpZzLd

Webinar ID: 829 3550 6992
Passcode: 587207
International numbers available: **https://us06web.zoom.us/u/keEKPetPJ4**

Board of Directors' Quality Assurance Committee Meeting
June 18, 2026

PACE Member Advisory Committee Update

Committee Overview
The PACE Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants.

March 11, 2026: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, transportation and scheduling. The Director welcomed new members who were joining us for the first time. Director reminded participants of the transition of our new EMR. Participants noted that they are not noticing any gaps with their care due to this transition. Director also shared news around our growth and mentioned that CalOptima Health PACE has initiated the process to the state for a potential second location. Participants also shared the continued challenges with transportation and outside appointments. Director reminded participants that at times the specialist connects directly with the participant or family member, and they are not notifying PACE of the scheduled visit. It is important that participants call PACE to confirm appointments.

Participants acknowledged that they need to call PACE to confirm appointments to ensure the visit is on our trip schedule and authorized by their provider. Participants expressed joy regarding PACE services expanding.

PMAC Member Forum

- Director will continue to support participants regarding external specialist visits and follow up at our next PMAC meeting to see how things are going.
- Participants expressed gratitude with the care and attention they receive while they are at PACE.

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Board of Directors'
Quality Assurance Committee Meeting
June 18, 2026

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Quality Assurance Committee

On May 19, 2026, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its quarterly meeting, which was conducted both in person and via Zoom Webinar.

Dr. Michelle Laba of California Children's Services provided an update, noting that the program served 11,000 clients in the general medical program and 1,650 in the medical therapy program so far in 2026. She noted that, looking ahead, 2027 marks the 100-year anniversary of California Children's Services, with expected celebratory activities. She also discussed that, operationally, staffing continues to be closely monitored due to ongoing state and federal underfunding, despite mandated workload requirements. They have recently hired one public health nurse and four office support staff for the general medical program, which has significantly helped address prior staffing shortages. The medical therapy program has also filled a supervising therapist position and is recruiting additional office support staff. These hires help offset earlier reductions of 40% in administrative staffing and 12% in the medical therapy program.

Hannah Kim, Director of Case Management, presented on the growing interest in home- and community-based programs and waivers. Ms. Kim reviewed the California Community Transitions (CCT) program, noting that although it was not technically a waiver, it worked closely with the Assisted Living Waiver (ALW) and the Home and Community-Based Alternatives (HCBA) waiver. These waivers are administered by the Department of Health Care Services (DHCS) through contracted community-based organizations. CCT's primary goal is to help members transition from institutional settings, such as hospitals or skilled nursing facilities, back into community-based care. To qualify, members must have been institutionalized for at least 60 consecutive days, excluding Medicare rehabilitation or acute care days, and must demonstrate both interest in and ability to return to the community. Transition Coordinators, similar to case managers, support members, their families, and providers throughout the process. The program has no age restrictions and offers physical and financial assistance to help individuals reintegrate into community living.

Ms. Kim's presentation also highlighted that transition plans often include returning to a member's home, a family member's home, a boarding care facility, or an assisted living facility. She noted that these plans mirror many community support benefits because DHCS modeled them after national

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programs and waivers, though California has applied its own naming conventions. There were many questions from the WCM FAC members.

Kelly Giardina, Executive Director, Medical Management and Clinical Operations, and Michael Gomez, Executive Director, Network Operations, jointly presented on a proposed Whole-Child Model (WCM) age-transition primary care physician incentive model. CalOptima Health is exploring a three-year, performance-based transition-incentive pilot to improve continuity of care for WCM members transitioning from CCS to the adult system. This work builds on prior discussions about the challenges partners and providers face, including fragmented adult systems, loss of long-standing pediatric relationships, limited provider expertise, capacity constraints, and gaps in readiness to manage highly complex youth. She noted that these issues have persisted for years, underscoring the need for focused, solution-driven approaches that strengthen coordination and reduce disruptions.

Ms. Giardina noted that CalOptima Health currently has 8,914 Whole-Child Model-eligible members, including 1,105 between ages 19 and 21 who are approaching the transition window. Rady's, formerly CHOC Health Alliance, has the largest group of transitioning youth, with 605 members, though all health networks face similar needs. The pilot aims to begin targeted engagement six months before a member turns 21, building on care management activities that already start at age 14. She noted that the pilot's design emphasizes early connection with adult providers, warm handoffs, ICT coordination, family involvement, and the use of a standardized transition playbook developed with stakeholder input.

She also discussed how the pilot would introduce performance-based payment enhancements, not changes to base capitation rates, to directly incentivize adult PCPs and specialists to perform essential transition activities. Once a willing adult PCP is identified, the pilot allows billing for designated codes tied to required coordination steps, ICT engagement, and the completion of specialist transition activities. These structured, codified processes reinforce accountability and provide adult providers with the financial support needed to deliver higher-touch, more coordinated care during this critical transition phase.

Michael Gomez discussed how CalOptima Health is developing a specialized provider network to support its transition-incentive pilot for Whole-Child Model members transitioning into the adult system. With more than 10,000 providers in its network, CalOptima Health aims to identify and engage primary care providers willing to participate in a focused "age-out" network. He noted that the pilot is designed to strengthen handoffs from pediatric to adult care, enhance provider reimbursement for transition-related activities, and improve overall continuity of care.

Mr. Gomez noted that the model would include enhanced payments for participating PCP offices, with up to $3 million allocated over three years. Expected outcomes include improved access, higher member satisfaction, reduced emergency department use and avoidable hospitalizations, and increased provider capacity. Training will also be provided to help PCP offices navigate transition-related codes and coordinate effectively with specialists.

Mr. Gomez also noted that the next steps would include building the specialty network, collaborating with delegated health networks, expanding the provider support infrastructure, and aligning incentives to reinforce quality and care coordination. He added that this proposal is expected to go to the Board in

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August, and he welcomed feedback from the WCM FAC as they refine the program. The WCM FAC members asked many questions and thanked CalOptima Health for bringing this vision forward to support the special needs population.

Yunkyung Kim, Chief Operating Officer, noted that CalOptima Health currently serves 8,900 Whole-Child Model children, a number that has declined over the past 18 months and has now stabilized. About 6,000 of these members are cared for by CHOC/CHOC Health Alliance, underscoring how transition challenges are compounded by limited continuity between pediatric and adult systems. Approximately 300 children have unsatisfactory immigration status, a key factor because state policy changes may affect their eligibility and services differently than for other families.

The Governor's May budget revision includes several proposals that could affect these families. Major items include: restoring the lower asset limit for older adults to federal SSI levels; shifting Medi-Cal members with unsatisfactory immigration status back to Fee-for-Service, where benefits differ significantly from managed care, especially for CalAIM services; and tightening eligibility and utilization rules for Enhanced Care Management, Community Supports, ABA therapy, and transportation services. These proposals have prompted significant concern, and state budget negotiations are ongoing through the summer.

CalOptima Health is proceeding with its 2026–27 budget, anticipating continued membership decline and adjusting for utilization and cost trends. The budget includes targeted investments to improve access: raising hospital outpatient rates from 140% to 170% of Medicare and increasing specialist physician rates from 156% to 200% of Medi-Cal, partially closing gaps in pediatric and adult specialty reimbursement. These rate increases, estimated at roughly $170 million per year, will require drawing on reserves for the next 2.5 years.

Effective July 1, new Medi-Cal members will be assigned a PCP and health network on day one, with the option to change at any time. This change aims to reduce ER use caused by delays in selecting a provider. CalOptima Health is also moving toward becoming a Covered California health plan in January 2027, primarily to provide existing members who temporarily lose Medi-Cal with an affordable way to maintain their providers and continuity of care. The plan is designed to remain competitively priced while expanding the provider network to support additional commercial members.

The discussion closed with reminders to help families stay vigilant during eligibility renewals, since paperwork errors and system inconsistencies can lead to the inappropriate loss of benefits. Committee members appreciated the updates, asked clarifying questions about PCP assignment and transition processes, and emphasized the need to maintain access for medically complex children as broader system changes unfold.

The WCM FAC appreciates and thanks CalOptima Health's Board of Directors' Quality Assurance Committee for the opportunity to provide input and updates on its current activities.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 19, 2026

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Quality Assurance Committee (Committee) was held on March 19, 2026, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar, as allowed under the Brown Act, as amended by Senate Bill 707 (2025). The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Jose Mayorga called the meeting to order at 3:06 p.m., and Director Maura Byron led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Jose Mayorga, M.D. Chair; Maura Byron; Catherine Green, R.N.
(All Committee members in attendance participated in person.)

Members Absent: None.

Others Present: Linda Lee, Executive Director, Quality Improvement; Kelly Giardina, Executive Director, Clinical Operations; Dr. Kelly Bruno-Nelson, Executive Director, CalAIM; Yunkyung Kim, Chief Operating Officer; Veronica Carpenter, Chief Administrative Officer; Sharon Dwiers, Clerk of the Board; Ruby Nunez, Executive Assistant

The Clerk announced at the top of the meeting that the presentation for agenda item eight had been unintentionally omitted and would be added to the archive materials after the meeting.

ADVISORY COMMITTEE UPDATES

1. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Monica Macias-Garcia, Director, CalOptima Health PACE, provided a brief update on the PACE Member Advisory Committee (PMAC) activities. She reported ongoing changes related to the transition to the Electronic Medical Record (EMR) system and noted that the EMR migration was underway, explaining that the goal was to ensure participants understood that the transition was intended to improve efficiency. Ms. Macias-Garcia also noted that continuous transportation check-ins have led participants to report an overall improvement compared to previous concerns. Ms. Macias-Garcia further stated that participants raised an issue with the phone system at the last PMAC meeting, as callers were unable to reach staff due to a lag in the queue. Ms. Macias-Garcia stated that

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the issue was identified and resolved. She noted that the matter would be revisited at the next quarterly meeting to confirm improvement.

2. Whole-Child Model Family Advisory Committee (WCM FAC) Updates

Lori Sato, Chair of the WCM FAC, provided highlights from the February 24, 2026, meeting. She reported that the committee received a detailed presentation from Rady Children's Health, including remarks from Remy Sims and Dr. Michael Weiss on the Adolescent-to-Adult Bridge Program. Ms. Sato noted that parents actively discussed the challenges of transitioning children from pediatric to adult care. Ms. Sato noted that additional presentations included an overview of CalOptima Health's transition playbook by Jennifer Claros and Alice Cheng, outlining preparation for the upcoming age-out of California Children's Services. She also noted that Andrew Kilgas presented a CalAIM transitional rent overview, noting the program's focus on supporting permanent housing for members experiencing or at risk of homelessness. Ms. Sato noted that Dr. Richard Pitts also provided an update on measles as a continuing public health concern and responded to questions about the pediatric system's readiness for a major outbreak.

Chair Mayorga thanked Ms. Sato for her valuable participation and contributions to the WCM FAC, emphasizing the importance of hearing from families and parents. Vice Chair Byron expressed appreciation for Ms. Sato's advocacy and underscored that these challenges have long been raised by families in the Whole Child Model. She emphasized the need for greater provider availability and system support and affirmed that bringing these issues forward to leadership remains a priority. Yunkyung Kim, Chief Operating Officer, confirmed that the challenges raised have been an ongoing focus for the WCM FAC. She noted that information on this topic will be brought to the full Board, and further discussions were planned for future meetings.

PUBLIC COMMENTS

None received

CONSENT CALENDAR

3. Minutes

a. Approve the Minutes of the October 8, 2025, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

b. Approve the Minutes of the November 13, 2025, Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Green, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

REPORTS/DISCUSSION ITEMS

4. Recommend that the Board of Directors Receive and File the 2025 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation and Approve the 2026 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Linda Lee, Executive Director of Quality Improvement, presented the evaluation of the prior year's Quality Improvement and Health Equity Transformation Program and provided an overview of the framework guiding CalOptima Health's policies and systems to ensure delivery of high-quality care and services. Ms. Lee began by summarizing major accomplishments achieved throughout the year,

including the Orange County Board of Supervisors' January 2025 approval authorizing CalOptima Health's participation in Covered California. She noted that in March 2025, the Board approved expanding the Street Medicine Program to Santa Ana. Additionally, several back-to-school events were held in August 2025, and in October 2025, the Board approved approximately $20 million to expand efforts to help vulnerable residents maintain health care coverage. Ms. Lee reported that Providence was added as CalOptima Health's tenth health network in November 2025, and in December 2025, CalOptima Health achieved its first-ever National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation.

Ms. Lee then reviewed performance on priority goals. She stated that, despite improvements in well-child visit measures, the program fell approximately 2 percentage points short of its targeted 50% reduction in disparities. The maternity care disparity goal, however, was met, and all child preventive care measures exceeded the 50th percentile. She identified two behavioral health measures – follow-up after mental health services and follow-up after substance use disorder treatment – that did not meet their goals, though both demonstrated consistent month-over-month improvement. She also reported that OneCare improved to three stars under the Centers for Medicare & Medicaid Services (CMS) rating system but did not reach the four-star goal.

Ms. Lee provided an overview of the Health Equity Committee's activities and noted that CalOptima Health earned four stars in Prevention and Equity and three stars in Treatment. She stated that the organization met 15 of the 18 California Department of Health Care Services (DHCS) quality withhold requirements, with no downstream impacts on health networks. She explained that member experience remains an area for improvement, though performance has strengthened over time, including OneCare's improvement from one to three stars. Ms. Lee then outlined several new initiatives for 2026, including expanding at-home visit programs, broadening health disparity analyses through enhanced demographic data, improving data exchange in alignment with NCQA's transition to full electronic reporting, and preparing quality programs for Covered California implementation beginning January 1, 2027.

During the discussion, Director Byron inquired about the primary drivers of lower member-experience scores. Ms. Lee explained that "getting needed care" and "getting care quickly" remain the principal challenges and noted that initiatives are underway to improve timely access, streamline referral processes, and strengthen coordination with health network partners. Director Green asked whether CalOptima Health provides services to members with veteran or military health care needs. Ms. Lee clarified that veterans and Native American members may choose to access Medi-Cal services or utilize alternative services available to their respective groups.

Ms. Lee concluded her report with the presentation of the 2026 Quality Improvement (QI) Program, highlighting goals for the current calendar year. The goals include achieving a 4.5-star Medi-Cal health plan rating, maintaining accreditation for both the health plan and health outcomes, achieving a four-star rating for OneCare, and ensuring operational readiness for Covered California. She noted that all committee structures and program descriptions had been updated, including the addition of the Behavioral Health Integration Pay-for-Value Program to the Quality Improvement framework. She also stated that the Population Health Management Program had been discontinued, with its responsibilities reassigned to the Utilization Management (UM) Committee and the Quality Improvement Health Equity Committee. Ms. Lee highlighted that additional staffing had been allocated to support the QI program and that several initiatives had successfully concluded and will

sunset. She further noted that high-priority areas continue to include Medicare measures that score 2 stars or lower. Ms. Lee concluded by providing updates on Cozeva implementation progress and the continued expansion of at-home services, including home visits by nurse practitioners and physician assistants and the at-home laboratory testing program.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: 1.) Receive and file the 2025 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation; and 2.) Approve the 2026 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan. (Motion carried 3-0-0)***

5. Recommend that the Board of Directors Receive and File the 2025 CalOptima Health Utilization Management Program Evaluation and Approve the 2026 CalOptima Health Utilization Management and Case Management Integrated Program Description

Kelly Giardina, Executive Director of Clinical Operations, presented the 2025 UM Program Evaluation, outlining recent accomplishments, identified opportunities, and strategic direction for the upcoming year. She highlighted several key achievements, including strengthened inventory management and oversight, enhancements in outcomes reporting, and extensive monitoring of the post-stabilization authorization process to better support hospital partners during after-hours admission decisions. Ms. Giardina also reported on the establishment of a dedicated pediatric clinical review team supported by two pediatricians within Medical Management to expand the department's pediatric utilization review expertise. Additional advancements included expanded provider portal automation enabling real-time treatment authorization decisions; initiation of a standardized prior authorization project, scheduled for full implementation by the end of 2026; expansion of transplant services to include Loma Linda; and removal of preventive screening prior-authorization requirements for OneCare to improve access. She further noted enhancements to Transitional Care Services through the assignment of a dedicated medical director, the launch of a skilled nursing facility workgroup to improve transitions to lower levels of care and support complex hospital discharges, and the implementation of new transitional-care communication strategies, such as text-based outreach.

Ms. Giardina reviewed member satisfaction survey findings, noting improvement in three of the four UM-related measures. She acknowledged that the remaining measure did not show improvement, consistent with previously discussed challenges, particularly around pediatric specialty access. She emphasized that this issue remains a cross-functional organizational priority, with multiple departments collaborating to develop strategies to expand access for pediatric members. She then invited Dr. Robin Hatam to present the UM-specific utilization data.

Dr. Hatam presented utilization trends across CalOptima Health's major populations. He explained that, beginning in March 2025, several adult Medi-Cal aid categories were consolidated into a single reporting group due to limitations in historical utilization data for the expansion population. As a result, baseline goals were set using projected estimates. He reported that utilization levels were higher than anticipated and noted that multiple interventions are underway, including improvements to transitional care processes and ongoing efforts of the Emergency Room Utilization Workgroup. Dr. Hatam observed similar trends in the pediatric population, with higher early-year admissions; however, he emphasized that pediatric readmission rates remained low and emergency room

utilization for the seniors and persons with disabilities population was lower than expected. For the long-term care population, Dr. Hatam described typical seasonal fluctuations, with higher utilization in the fourth quarter of 2024 and first quarter of 2025 due to respiratory illnesses, followed by improvements throughout the remainder of the year. He further noted that within the Whole Child Model population, utilization was elevated in the first quarter of 2025, driven by RSV and other seasonal illnesses, but decreased as the year progressed, including reductions in emergency department use. Dr. Hatam concluded by reporting that the OneCare population met its utilization goals by year-end, with readmission rates declining from 18.6% to 13.7%, and admissions and bed-day metrics closing the year within target.

Director Mayorga requested clarification regarding the blended utilization data and asked whether the Temporary Assistance for Needy Families and expanded populations could be reported separately. He stated that distinguishing these populations would help the Committee better understand potential differences in health-status trends, particularly given the increased utilization reflected in the combined data. He also inquired about the availability of data for the unsatisfactory immigration status population and questioned the absence of utilization goals for the Whole Child Model. Ms. Giardina explained that the Clinical Advisory Committee had recommended setting only one goal for that year but committed to revisiting the matter within the committee structure and returning with updated recommendations.

Ms. Giardina continued by summarizing the extensive work completed by the Prior Authorization Team over the past year. She reported that 428,260 treatment authorizations were processed across routine, urgent, and retrospective categories. She described the various referral submission methods, including fax, the provider portal, automated authorization through clinical rule sets and direct provider outreach and noted that all turnaround times remained fully compliant. She further reported that pharmacy utilization goals were met across all three adherence measures, supported by comprehensive interventions such as provider faxes, patient education materials, targeted outreach campaigns, interactive voice response and text message engagements, and coordinated pharmacy-led initiatives. Additionally, inter-rater reliability assessments were completed across all departments participating in UM, including physical and behavioral health, pharmacy, CalAIM services, long-term services and supports, Community-Based Adult Services centers, Multipurpose Senior Services Program, and the medical director team.

Ms. Giardina concluded by reviewing the UM Program's overarching goals and initiatives, emphasizing continued focus on timely and efficient treatment authorizations, enhanced coordination and continuity of care, oversight of access and timeliness, and improved member and provider satisfaction. She noted ongoing collaboration with Network Management, Health Network Relations, and Provider Relations Teams to address patterns of over- and under-utilization, while also promoting health literacy, preventive health practices, and overall improvement in member outcomes.

Ms. Giardina then reviewed the structural framework of the UM Program, noting that the Pharmacy and Therapeutics Committee and the Benefit Management Subcommittee both report to the UM Committee. She explained that the Pharmacy and Therapeutics Committee is responsible for reviewing pharmaceutical care for CalOptima Health members, including policy review, regulatory compliance, pharmacy outcome updates, alignment with quality measures, and integration with disease management and case management programs. The Benefit Management Subcommittee evaluates specific benefit categories, including clinical interpretation standards, authorization

requirements, and updates to benefit review processes, with input from all medical directors to ensure regulatory compliance, including adherence to All-Plan Letters and the Medi-Cal Provider Manual.

Ms. Giardina also highlighted the UM Program's specialized sub-workgroups, which support oversight of utilization across key areas. She noted that the High-Risk Management Workgroup focuses on emergency department utilization, inpatient hospitalizations, long lengths of stay, opportunities to prevent readmissions, and monitoring under- and over-utilization trends, as well as gender-affirming care. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Workgroup ensures compliance with EPSDT requirements across clinical programs and supports pediatric members with complex health needs by reviewing cases and confirming appropriate coverage pathways. She further described Enhanced Care Management clinical oversight activities, noting ongoing collaboration with CalAIM Operations to support and monitor protocols, review complex cases, and address emerging utilization patterns. Finally, she reported that the Skilled Nursing Facility Workgroup continues to focus on inpatient review processes, early discharge planning, and support for facilities managing complex admissions requiring services such as bedside dialysis, isolation accommodations, or bariatric care.

Dr. Hatam concluded the presentation by summarizing updates to the 2026 utilization goals. He explained that, because several aid categories had been consolidated in prior reporting periods, additional data was required to refine targets. Based on updated information, adjustments were made to the 2026 goals to better reflect current utilization trends.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: 1.) Receive and file the 2025 CalOptima Health Utilization Management Program Evaluation, and 2.) Approve the 2026 CalOptima Health Utilization Management and Case Management Integrated Program Description. (Motion Carried 3-0-0)***

6. Recommend that the Board of Directors Receive and File the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Approve the 2026 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Ms. Macias-Garcia introduced the presentation on the 2025 Quality Work Plan Evaluation and the proposed Quality Work Plan for 2026, noting that she and Dr. Donna Frisch would present both the clinical and non-clinical elements. Ms. Macias-Garcia began with an overview of program enrollment, highlighting that PACE, which opened in 2013 with only seven participants, ended in 2025 with a census of 543 members. She reported continued growth into 2026, noting that enrollment reached 559 members as of March. She shared that participants in the PMAC have expressed enthusiasm for the program's expansion and frequently inquire about the possibility of a second location, noting that growth strategies are currently under discussion.

Additionally, Ms. Macias-Garcia reported on the results of the 2025 PACE Participant Satisfaction Survey, which evaluates performance across 13 domains, including transportation, center-based services, home care, medical care, general service delivery, and overall satisfaction. She stated that the program improved its 2024 performance across multiple categories and increased overall satisfaction from 90% to 93%. She further noted that PACE programs statewide continue to expand,

with 27 programs operating in California, up from 22 the prior year. She emphasized that CalOptima Health's PACE performed above both state and national benchmarks, with the national PACE average for overall satisfaction at 87.9% and the CalPACE average at 89%, compared to CalOptima Health's overall satisfaction rate of 93 to 94%.

Turning to the 2026 Quality Work Plan, Ms. Macias-Garcia stated that detailed descriptions of all proposed initiatives were included in the Committee packet. She highlighted several key focus areas, including continued strategic growth supported by community partnerships and expanded use of alternative care sites, with a goal of increasing utilization from 10% to 12%. She emphasized the importance of reducing enrollment processing time so that prospective participants complete the required level-of-care nursing assessment and state approval process within 45 days.

Lastly, Ms. Macias-Garcia stated that the program will continue to prioritize transportation services, meal services, home care, and overall participant satisfaction. She reaffirmed the program's ongoing commitment to increasing the percentage of participants with an Advance Health Care Directive, aiming to achieve completion rates of 55% or higher. She also noted continued efforts to improve dental satisfaction, with a target of one or fewer valid dental grievances per quarter, and emphasized that transportation will remain a monitored metric, with a goal of three or fewer valid transportation grievances per quarter. She reported that this target was met in the fourth quarter of 2025, with only one valid grievance, and stated that oversight will continue in collaboration with the PACE Center Manager and Transportation Manager to ensure quality and timeliness of services.

Ms. Macias-Garcia turned it over to Dr. Donna Frisch, PACE Medical Director.

Dr. Frisch provided an overview of the clinical quality measures for PACE, noting that the team continues to work diligently to improve the quality of care delivered to participants. She reported strong performance across several key indicators, including an influenza vaccination rate of 84%, a pneumococcal vaccination rate of 93%, and a 94% completion rate for diabetic eye exams. Dr. Frisch highlighted that these outcomes are particularly noteworthy given the ongoing challenges of vaccine fatigue. She stated that the program met its goals for blood pressure control among participants with hypertension and/or diabetes and emphasized the success of the diabetic initiative, which reduced the percentage of participants with hemoglobin A1c below 9%, surpassing the goal of remaining below 12%.

Dr. Frisch also reported that breast cancer screening reached 84%, and osteoporosis monitoring consistently met targets; these measures will continue to be monitored but will no longer be reported annually. She noted that only one participant remained on a high-dose opioid regimen, and while monitoring will continue, this measure will also be removed from the annual report. She explained that long-term custodial care needs remain rare among PACE participants, typically ranging from 1 to 2%, and that the program will continue to monitor this metric. She stated that immunization rates, colorectal cancer screening, breast cancer screening, blood pressure control, diabetic eye exams, and blood sugar control will remain ongoing areas of focus as the program seeks continuous improvement.

In response to a question from Director Mayorga, Dr. Frisch clarified that the diabetes goal was to have fewer than 12% of participants with a hemoglobin A1c greater than nine, which the program

exceeded by achieving 9% by year-end. For hypertension, she noted that approximately 80% of participants achieved blood pressure control defined as below 140/90 mmHg.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: 1.) Receive and File the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation, and 2.) Approve the 2026 Program of All-Inclusive Care for the Elderly Quality Improvement Plan. (Motion carried; 3-0-0)***

7. Recommend that the Board of Directors Approve the Modifications to the Quality Improvement Policies

Ms. Lee provided a summary of the recent Quality Improvement policy updates. She explained that revisions to Policy GG.1650: Credentialing and Recredentialing of Practitioners, and Policy GG.1651: Assessment and Reassessment of Organizational Providers were made to ensure alignment with Covered California standards and the California Department of Managed Health Care (DMHC) credentialing requirements. She further noted that the updated policies now expressly exclude practitioners who operate exclusively at Federally Qualified Health Center Look-Alike clinics from CalOptima Health's credentialing requirements, consistent with the applicable regulatory guidance.

Action: ***On motion of Byron, seconded and carried, the Committee recommended that the Board of Directors approve modifications to the following CalOptima Health policies pursuant to Covered California requirements: 1.) GG.1650: Credentialing and Recredentialing of Practitioners; and 1.) GG.1651: Assessment and Re-Assessment of Organizational Providers. (Motion carried; 3-0-0)***

8. Recommend that the Board of Directors Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program for Measurement Period 2026-27

Chair Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and passed the gavel to Director Byron as he left the room during the discussion and vote.

Carmen Katsarov, Executive Director, Behavioral Health Integration, provided an overview of the Applied Behavioral Analysis (ABA) and the Behavioral Health Pay-for-Value (P4V) Programs. She noted that the Board approved the ABA P4V Program on May 2, 2024, with implementation beginning July 1, 2024, and approved the Behavioral Health Provider P4V Program on November 7, 2024, with implementation beginning January 1, 2025. Ms. Katsarov explained that contracted providers participating in these programs may qualify for incentives of up to 10% applied to adjudicated claims during the payout period, representing a shift from traditional retrospective models to a more prospective payment design. She acknowledged the leadership of CalOptima Health's Medical Director for Behavioral Health, Dr. Natalie Do, in co-designing and guiding these programs.

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Ms. Katsarov reviewed the ABA P4V Program framework, noting that measurement periods occur semi-annually and rely primarily on claims and encounter data. She stated that the program originally included eight metrics but was refined to five equally weighted metrics after determining that three provider-reported and survey-based metrics lacked statistical validity due to low response rates and high provider and member burden. She emphasized that caregiver and member feedback continues to be collected through the Consumer Assessment of Health Care Providers and Systems and CalOptima Health's annual member surveys, even though these elements were removed from the incentive structure. She further explained the rationale for the prospective payout model, describing how payouts follow a continuous cycle based on performance in the prior measurement period while incentivizing ongoing service delivery and quality improvement.

Ms. Katsarov presented current performance results for the ABA P4V Program, reporting that 81% of ABA providers met one or more metrics in the initial measurement period, with 74% meeting one or more metrics in the subsequent period. She explained that incentive payout figures continue to evolve due to the Medi-Cal claims submission timeline.

Ms. Katsarov then summarized the Behavioral Health P4V Program, which includes measures tied to Healthcare Effectiveness Data and Information Set standards, DMHC timely-access requirements, and clinical best practices. She highlighted key priorities, including timely follow-up after mental health and substance use disorder visits, continuity of care following initial assessments, capacity and panel growth to strengthen network adequacy, essential laboratory monitoring, functional status evaluation using evidence-based tools, and member experience. Ms. Katsarov noted that some metrics were initially marked as "not available" due to dependencies on new provider-portal functionality, which has since been implemented. She reported that, to date, 81% of behavioral health providers have met one or more metrics in the current payout period.

Ms. Katsarov concluded by requesting approval to continue the ABA P4V Program based on demonstrated progress and the ongoing statewide provider shortage. She noted that the incentives serve as an important mechanism to support provider recruitment, training, and service quality. She stated that she would return to the Committee in 2026 to present updates and request continued approval for the Behavioral Health P4V Program.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program for the measurement periods between July 1, 2026, through June 30, 2027. (Motion carried; 2-0-0; Chair Mayorga Recused)***

9. Recommend that the Board of Directors Approve a Modification to CalOptima Health's Calendar Year 2026 Postpartum Member Health Reward

Ms. Giardina provided background on the Member Health Rewards initiative approved for Calendar Year 2026, noting that the program was developed to strengthen primary care relationships and promote preventive care. She explained that, in late 2025, the Maternal Health Team was integrated into Clinical Operations within the Case Management structure to better align clinical functions and enhance oversight of the Maternal Health Program across disciplines. This integration allowed for a detailed review of processes, program enhancements, and performance data, which identified a significant performance gap: in 2024, CalOptima Health ranked last among California managed care

plans in postpartum follow-up visit compliance, with a rate of 81%, compared to the state average of 87%. Ms. Giardina emphasized the clinical importance of timely postpartum visits, which support physical recovery, depression screening, evaluation of complications, breastfeeding support, and regulatory compliance.

To improve performance, Ms. Giardina stated that increasing the postpartum visit incentive to $50 is expected to enhance engagement and compliance among at-risk members. She outlined the implementation strategy, which includes coordinated care management, integrating reminders into late-pregnancy and post-delivery touchpoints, and aligning these practices across CalOptima Health's direct network and contracted health networks. She described a multimodal engagement approach comprising direct member outreach, digital communication, community engagement, and provider education. Additionally, she emphasized the importance of synchronizing phone reminders, mailed incentive forms, text messaging campaigns, and follow-up calls to support appointment scheduling and address barriers to postpartum care. Ms. Giardina requested the Committee's support to advance this proposal to the April Board agenda for funding approval.

Director Mayorga asked for the approximate number of women affected by the proposed change and the criteria for measuring success. Staff indicated that the approximate number was 250, and Ms. Giardina stated that she did not have the exact figures available but would provide them later, noting that additional questions were anticipated at the upcoming Board meeting.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: Approve a modification to Calendar Year 2026 Member Health Rewards for Medi-Cal to increase the postpartum check-up provider attestation reward from $25 to $50, effective July 1, 2026. (Motion carried; 3-0-0)***

INFORMATION ITEMS

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Ms. Lee provided an overview of several key Quality Improvement and Health Equity activities, noting that she would highlight selected program areas for time constraints. She reported significant improvement in adherence to antipsychotic medications for individuals with schizophrenia across both Medi-Cal and OneCare populations. Ms. Lee also noted substantial progress achieved through the Student Behavioral Health Incentive Program, including a 38% increase in behavioral health staffing, expanded access to telehealth services for more than 260,000 students through Hazel Health, the opening of ten wellness spaces in Children's Hospital of Orange County (CHOC)-affiliated schools, the launch of specialized autism care, and expanded on-demand training accessed by 65% of school districts.

Ms. Lee highlighted results from the Language Services Experience Survey, which indicated that 90% of members who accessed interpretation or translation services reported satisfaction. She also reported improvements in Health Risk Assessment performance for OneCare members, with 77% of newly enrolled members completing an assessment within 90 days and 95% of members having a care plan completed within the prior year. She summarized several recommendations from the Quality Improvement Committee, including developing a Transitional Care Services informational

flyer for members, strategies to increase participation in home glucose screening, and clarifying that timely access surveys include telehealth providers.

b. Health Equity Accreditation Update

Ms. Lee announced that CalOptima Health achieved 100% compliance in its first-ever NCQA Health Outcomes Survey accreditation, earning a three-year accreditation period from December 16, 2025, through December 16, 2028. She emphasized that this achievement reflects organization-wide collaboration to ensure alignment with cultural and linguistic needs, network demographics, and targeted health equity initiatives. She noted that this work will continue into 2026 and will incorporate Covered California requirements beginning in 2027.

c. Hospital Quality Program Update

Ms. Lee also provided an update on the Hospital Quality Program, initiated in December 2022 to align hospital incentive efforts with other provider-based quality programs. She explained that the program is structured as a five-year incentive model based on publicly reported CMS and Leapfrog measures within three domains: quality, patient experience, and hospital safety. Incentives are awarded beginning at a three-star rating for quality and patient experience and at a grade of "C" for hospital safety, with domains weighted at 40% each for quality and patient experience and 20% for safety. She noted that pediatric hospitals that do not report to CMS are evaluated using equivalent Leapfrog quality measures. The annual incentive pool totals $30 million; for the 2024 performance year (paid in Q1 2026), $16.7 million was earned and $13 million was forfeited. Ms. Lee reviewed hospital performance and noted that participation levels varied, with some hospitals improving year-over-year while others declined. She also identified hospitals eligible for participation grants of $150,000 should they elect to begin public reporting.

d. Quality Improvement Strategies

In closing, Ms. Lee outlined several Quality Improvement strategies underway to support performance across Medi-Cal and OneCare measures. These include expanded in-home services, outreach to members overdue for primary care visits, direct scheduling assistance for mammograms and colorectal screenings, and enhanced at-home quality programs. She reported high utilization of the home-visit vendor between January and February, with 323 completed visits and 93% of members tested for diabetes achieving an A1c value under nine. She also presented improved response rates for at-home colorectal screening kits, noting uptake of 16% among Medicare members compared to an average of 9.8%. Ms. Lee outlined operational lessons learned, including the need to confirm addresses immediately before kit mail-outs and the importance of wrap-around communication – such as priming texts, instructions, and follow-up reminders – to support test completion. She concluded with a summary of additional outreach efforts, noting that in 2025 staff contacted more than 300 members, achieving a 12% successful appointment-completion rate for outstanding preventive services

11. Grant Management Activities and Updates

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, provided a brief update on the activities of the Grant Management Department, noting that the department was established in April 2025 to provide consistent oversight and administration of CalOptima Health's grantmaking portfolio. She presented a high-level synopsis of the overall grant program, explaining that grants are monitored using a green-yellow-red status model to indicate performance. A green status signifies that a grant is on track, yellow indicates delays or the need for adjustments, and red denotes grants

requiring performance improvement plans. Ms. Bruno-Nelson reported that the current portfolio includes 235 grants, of which 162 are active, with only 2 in yellow status and 1 in red status. She further explained that portfolio categories represent the total number of grants and funding allocated to each area, and that closed portfolios are excluded from reporting.

Ms. Bruno-Nelson provided an update on the Quality Improvement Grant Program referenced earlier in the meeting. She stated that oversight of this portfolio began in April and includes 37 grants totaling $4.6 million awarded to 15 unique organizations – several of which received multiple grants. She noted that most of these grants are nearing closure, with approximately 13 expected to receive no-cost extensions. She also reported that a second round of Quality Improvement grants was released in the first quarter of 2026, limited to health networks and restricted to measures not addressed in the previous round. Applicants were permitted to request up to $125,000 for a 5% improvement in up to two measures. Ms. Bruno-Nelson stated that the department initially anticipated 11 applications but expects to process approximately eight due to in-progress no-cost extensions, which preclude applicants from applying for the same measures until their existing grants are complete. She concluded by offering to answer additional questions.

12. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

The report was accepted as presented during the Quarterly Reports to the Quality Assurance Committee agenda item. No additional report was presented.

b. Member Grievances and Appeals Report

Heather Sedillo, Director of Grievance and Appeals Resolution Services, provided an overview of key trends observed in the third quarter of 2025. She reported that transportation-related grievances continued to be a significant issue across both lines of business, ranking as the second-highest category under Quality of Service and trending similarly within OneCare. Ms. Sedillo explained that these grievances increased following ModivCare's removal of a transportation provider in late quarter two of 2025; however, CalOptima Health identified the trend promptly and began remediation efforts in quarter 3 of 2025 She noted that grievances declined substantially in quarter 4 of 2025 after new transportation providers were onboarded and member support efforts were intensified.

Ms. Sedillo then reviewed appeal trends, including those related to CalAIM services, durable medical equipment (DME), and orthotics and prosthetics. For CalAIM, the highest volume of appeals involved personal care hours, and 35 of 106 appeals were upheld on policy grounds. She reported that eight of 24 appeals involving day habilitation services were overturned after additional information, including updated Individual Care Plans, was provided. Regarding housing transitions and navigation, six of 14 appeals were overturned after previously missing documentation was provided. For DME, she noted 26 total appeals, covering items such as wheelchairs, custom power chairs, ultra-lightweight chairs, cranial helmets, Cubby beds, and hospital beds; seven of the 26 appeals were overturned. In orthotics and prosthetics, the most common requests involved custom foot molds and inserts. Ms. Sedillo also confirmed that two appeals were submitted for Whole Child Model members in quarter 3 if 2025 – one Cubby bed appeal, which was upheld with no hearing requested, and one stroller appeal, which was overturned.

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She concluded by noting that additional details were included in the Committee materials and offered to answer any remaining questions.

COMMITTEE MEMBER COMMENTS

The Committee thanked staff for the depth of information and the ease with which the reports were understood, highlighting the importance of transparency and communication.

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 4:51 p.m.

/s/ Ruby Nunez
Ruby Nunez
Interim Clerk of the Board

Approved: 6/18/2026

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 18, 2026
Regular Meeting of the CalOptima Health Quality Assurance Committee

Report Item

4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Policy: GG.1611

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Marsha Choo, Director, Quality Improvement, (714) 246-8670

Recommended Action

Recommend that the Board of Directors approve modifications to CalOptima Health Policy GG.1611: Potential Quality Issue Review Process in connection with CalOptima Health's regular review process and consistent with regulatory requirements.

Background/Discussion

CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima Health operations.

Below are the proposed modifications to Policy GG.1611:

Policy Section	Proposed Changes
II.E. and III.C.1.	Clarifies that reporting under section 805.01 is included when submitting actions to state licensing boards.
II.J.	Adds criteria directing when letters must be issued based on the Medical Director or Credentialing and Peer Review Committee's (CPRC) recommendations: • Contracted CalOptima Health Community Network (CCN) providers receive a letter summarizing investigation findings. • Providers not contracted with CCN but contracted with a CalOptima Health Network receive a letter; a copy may also be sent to their Health Network requesting case review and a response to CPRC after investigation. • For non-contracted providers, a non-805-reportable letter may be sent to the state licensing board requesting review of the identified issue.
III.B.3.	Extends the target potential quality issue (PQI) case closure timeline from 90 days to 120 days to align with turnaround times used by other Medi-Cal health plans.
III.B.3.c.	Clarifies that two QI Nurse RNs must jointly close Quality-of-Service PQI cases.
Attachment A	Removes the Provider Resolution Letter attachment from the policy and procedure.

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Fiscal Impact
The recommended action is operational nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation
To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Board of Directors approve and adopt the presented CalOptima policy and procedure. The updated policy and procedure will supersede prior versions.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy GG.1611: Potential Quality Issue Review Process
2. Quality Policy Updates Presentation

/s/ Michael Hunn *06/08/2026*
Authorized Signature **Date**

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Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	~~Medical Management~~Quality Improvement
Section:	~~Quality Improvement~~Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department for any Provider servicing Members.

II. POLICY

A. CalOptima Health departments, Health Networks and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation.

B. The QI Department shall log a PQI in CalOptima Health's care management system and appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.

C. The QI Department shall conduct an investigation on the PQI and obtain pertinent documentation as needed to conduct the investigation.

D. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health Credentialing and Peer Review Committee (CPRC) for evaluation and action, pursuant to the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP).

E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

2. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.

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G. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.

H. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.

I. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws.

J. PQI Cases Given a Severity Level 3 Shall Send a Letter Per the Following Criteria as the Recommendation of the Medical Director or CPRC:

1. The Pproviders contracted with CCN shall receive a letter outlining the findings of the investigation.

2. The Pproviders who are not contracted with CCN, but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.

3. For non-contracted Pproviders, a non-805-reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.

III. PROCEDURE

A. Case Referral and Identification

1. In addition to PQI referrals to CalOptima Health by Providers and Health Networks, a PQI may also be identified and referred to the QI Department from multiple internal sources. Internal sources, include but are not limited to CalOptima Health departments, QIHEC and subcommittees, and QOC related activities such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.

3. Supporting documentation (*e.g.*, correspondence, Grievances, claims data, case management notes) shall accompany the referral.

   a. Any entity referring a PQI case shall specify whether the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases shall be opened by the CalOptima Health QI Department PQI team to review QOC issues, system issues, and/or administrative issues. PQI cases shall be documented in CalOptima Health's care management system.

   a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the care management system.

b. The QI Nurse shall request pertinent medical records and a response to the PQI from the appropriate Provider(s) and/or Health Network that rendered medical services or were involved in rendering medical service(s) related to the PQI.

i. Medical records and a response may or may not be able to be obtained for confidential cases to maintain the Member's anonymity.

ii. If a Provider or Health Network fails to respond:

a) CalOptima Health's QI Department, in consultation with a CalOptima Health Medical Director, may take any and all reasonable actions it deems to be in the best interest of the Member, including the issuance of a corrective action plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

iii. Data may also be collected from surveys, incident reports, and other sources to assess QOC and performance.

2. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and obtain medical records.

3. CalOptima Health's QI Department shall analyze medical records and other data, and will target case closure within ~~ninety~~ one hundred and twenty (~~90~~120) calendar days of receipt of the PQI. The case will be considered closed when it is given an outcome score.

a. QI Nurses may close cases when the following is determined:

i. The case is deemed service-related only; and/or

ii. No QOC or Quality of Service (QOS) issue is identified.

b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.

c. If the QI Nurse RN does not identify a QOC issue, the case will be reviewed by a second QI Nurse RN, and if the QI Nurse RN concurs, given an outcome score, and designated with the Action of "N~~n~~o F~~f~~urther A~~a~~ction Required" and/or "Track and Trend" ~~regarding the PQI review shall occur~~and the case will be closed..

4. If the QI Nurse identifies a QOC issue, the case shall be referred to and reviewed by the CalOptima Health Medical Director, who must address service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services ~~meets~~meet professionally recognized standards of practice. Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).

a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.

b. Other cases may be presented to CPRC upon CalOptima Health Medical Director's discretion.

Outcome Score	Description of Outcome Score
0	No Quality-of-Care or Quality-of-Service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

6. CalOptima Health shall utilize an external review entity when the following occurs:

   a. A specific specialty is required for PQI review and the specialty is not represented by a CalOptima Health Medical Director.

   b. A second opinion is determined to be needed.

7. A CalOptima Health Medical Director or CPRC may recommend and approve further action, including but not limited to:

   ~~J.~~K. A corrective action, which may require the Provider to attend a course, provide training to their staff, and/or update policies and procedures;

   ~~K.~~L. An educational or best practice letter, which may reference an ~~all plan~~all-plan letter or other regulatory requirement, a CalOptima Health policy, and/or national standard of practice;

   ~~L.~~M. An on-site audit of the facility and/or medical records;

   ~~M.~~N. Medical records review;

   ~~N.~~O. Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;

   ~~O.~~P. Referral to a regulatory Agency, including but not limited to a state licensing Agency, the California Department of Public Health, and/or The Joint Commission.

   Q. Require other appropriate action(s) as recommended by the CPRC, up to and including the recommendation for administrative or for cause termination per CalOptima Health Policy GG.1616: Fair Hearing Process.

   ~~P. The QI Nurse shall send p aThe QI Nurse shall send pThe QI Nurse shall send n~~

8. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

9. Once the PQI review process is completed, a resolution letter will be sent to the Provider or Health Network.

    a. If the case was a confidential case, the Member information will be blinded in the Provider/ Health Network resolution letter.

    b. If the Provider/Health Network disagrees with the determination, the Provider/Health Network may notify CalOptima Health by contacting the QI Department and/or by filing a complaint pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

C. Reporting Requirements and Follow-up Actions

1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant agency within fifteen (15) days after the effective date on which any of the following occurs as a result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network:

    a. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

    b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

    c. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12)-month period, for a medical disciplinary cause or reason.

2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

3. The QI Department shall use statistical methods and quality improvement models to identify trends, gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

4. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

5. The QI Department shall submit a report to CPRC of all QOC Practitioner-specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.

6. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to ~~the CalOptima Health~~ CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

7. The QI Department shall follow-up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.

8. The CalOptima Health QIHEC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.

9. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

10. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

11. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

Not Applicable~~Peer Review Conclusion Letter~~

V. REFERENCE(S)

A. California Business and Professions Code, §805 and 1000
B. California Health and Safety Code § 1370
C. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan
~~B.~~D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
~~D.~~F. CalOptima Health Contract with Covered California
~~E.~~G. Covered California Physician Group Services Contract
~~F.~~H. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
~~G.~~I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
~~H.~~J. CalOptima Health Policy GG.1616: Fair Hearing Process
~~I.~~K. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
~~J.~~L. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
~~K.~~M. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
~~L.~~N. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
~~M.~~O. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
~~N.~~P. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
~~O.A. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan~~
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
~~Q.A. California Health and Safety Code § 1370~~
R. Peer Review Conclusion Letter
~~R.~~S. Title 22, California Code of Regulations (C.C.R.), § 51051
~~S.~~T. Title 28, California Code of Regulations (C.C.R.), ~~C.C.R.~~ §§ 1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
~~T.~~ Title 42, Code of Federal Regulations (C.F.R), § 422.152 and
U. ~~42 C.F.R. §~~ 438.330

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
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Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
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Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

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Term	Definition
	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or 2837.104. Licentiate also includes a person authorized to practice medicine pursuant to BPC §§ 2113 or 2168.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of

Term	Definition
	Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all

Term	Definition
	care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

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Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department for any Provider servicing Members.

II. POLICY

A. CalOptima Health departments, Health Networks and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation.

B. The QI Department shall log a PQI in CalOptima Health's care management system and appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.

C. The QI Department shall conduct an investigation on the PQI and obtain pertinent documentation as needed to conduct the investigation.

D. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health Credentialing and Peer Review Committee (CPRC) for evaluation and action, pursuant to the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP).

E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

2. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.

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G. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.

H. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.

I. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws.

a. PQI Cases Given a Severity Level 3 Shall Send a Letter Per the Following Criteria as the Recommendation of the Medical Director or CPRC:

1. The Providers contracted with CCN shall receive a letter outlining the findings of the investigation.

2. The Providers who are not contracted with CCN, but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.

3. For non-contracted Providers, a non-805-reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.

III. PROCEDURE

A. Case Referral and Identification

1. In addition to PQI referrals to CalOptima Health by Providers and Health Networks, a PQI may also be identified and referred to the QI Department from multiple internal sources. Internal sources, include but are not limited to CalOptima Health departments, QIHEC and subcommittees, and QOC related activities such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.

3. Supporting documentation (*e.g.*, correspondence, Grievances, claims data, case management notes) shall accompany the referral.

a. Any entity referring a PQI case shall specify whether the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases shall be opened by the CalOptima Health QI Department PQI team to review QOC issues, system issues, and/or administrative issues. PQI cases shall be documented in CalOptima Health's care management system.

a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the care management system.

b. The QI Nurse shall request pertinent medical records and a response to the PQI from the appropriate Provider(s) and/or Health Network that rendered medical services or were involved in rendering medical service(s) related to the PQI.

i. Medical records and a response may or may not be able to be obtained for confidential cases to maintain the Member's anonymity.

ii. If a Provider or Health Network fails to respond:

a) CalOptima Health's QI Department, in consultation with a CalOptima Health Medical Director, may take any and all reasonable actions it deems to be in the best interest of the Member, including the issuance of a corrective action plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

iii. Data may also be collected from surveys, incident reports, and other sources to assess QOC and performance.

2. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and obtain medical records.

3. CalOptima Health's QI Department shall analyze medical records and other data and will target case closure within one hundred and twenty (120) calendar days of receipt of the PQI. The case will be considered closed when it is given an outcome score.

a. QI Nurses may close cases when the following is determined:

i. The case is deemed service-related only; and/or

ii. No QOC or Quality of Service (QOS) issue is identified.

b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.

c. If the QI Nurse RN does not identify a QOC issue, the case will be reviewed by a second QI Nurse RN, and if the QI Nurse RN concurs, given an outcome score, and designated with the Action of "No Further Action Required" and/or "Track and Trend" and the case will be closed..

4. If the QI Nurse identifies a QOC issue, the case shall be referred to and reviewed by the CalOptima Health Medical Director, who must address service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice. Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).

a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.

b. Other cases may be presented to CPRC upon CalOptima Health Medical Director's discretion.

Outcome Score	Description of Outcome Score
0	No Quality-of-Care or Quality-of-Service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

6. CalOptima Health shall utilize an external review entity when the following occurs:

   a. A specific specialty is required for PQI review and the specialty is not represented by a CalOptima Health Medical Director.

   b. A second opinion is determined to be needed.

7. A CalOptima Health Medical Director or CPRC may recommend and approve further action, including but not limited to:

   a. A corrective action, which may require the Provider to attend a course, provide training to their staff, and/or update policies and procedures;

   b. An educational or best practice letter, which may reference an all-plan letter or other regulatory requirement, a CalOptima Health policy, and/or national standard of practice;

   c. An on-site audit of the facility and/or medical records;

   d. Medical records review;

   e. Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;

   f. Referral to a regulatory Agency, including but not limited to a state licensing Agency, the California Department of Public Health, and/or The Joint Commission.

   g. Require other appropriate action(s) as recommended by the CPRC, up to and including the recommendation for administrative or for cause termination per CalOptima Health Policy GG.1616: Fair Hearing Process.

8. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

9. Once the PQI review process is completed, a resolution letter will be sent to the Provider or Health Network.

a. If the case was a confidential case, the Member information will be blinded in the Provider/ Health Network resolution letter.

b. If the Provider/Health Network disagrees with the determination, the Provider/Health Network may notify CalOptima Health by contacting the QI Department and/or by filing a complaint pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

C. Reporting Requirements and Follow-up Actions

1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant agency within fifteen (15) days after the effective date on which any of the following occurs as a result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network:

   a. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

   b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

   c. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12)-month period, for a medical disciplinary cause or reason.

2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

3. The QI Department shall use statistical methods and quality improvement models to identify trends, gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

4. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

5. The QI Department shall submit a report to CPRC of all QOC Practitioner-specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.

6. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

7. The QI Department shall follow up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.

8. The CalOptima Health QIHEC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.

9. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

10. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

11. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §805 and 1000
B. California Health and Safety Code § 1370
C. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
F. CalOptima Health Contract with Covered California
G. Covered California Physician Group Services Contract
H. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
J. CalOptima Health Policy GG.1616: Fair Hearing Process
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Date	Regulatory Agency	Response
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VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

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Term	Definition
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Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

Term	Definition
	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or 2837.104. Licentiate also includes a person authorized to practice medicine pursuant to BPC §§ 2113 or 2168.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of

Term	Definition
	Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all

Term	Definition
	care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

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CalOptima Health

Quality Policy Updates

Quality Assurance Committee

June 18, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

Annual Policy Review of GG.1611: Potential Quality Issue (PQI) Review Process

- Summary of key updates:
  - Expanded language to clarify policy covers “805.01,” reporting, ensuring alignment with regulatory requirements for reporting and oversight
  - Target PQI case closure timeframe extended from 90 days to 120 days.
  - Clarified that Quality of Service (QOS) cases closed by QI Nurses undergo review by two RNs prior to closure
  - Updated contact from a named individual to a centralized inbox: qualityofcare@caloptima.org

CalOptima Health

Annual Policy Review of GG.1611: Potential Quality Issue Review Process Continued

- Summary of key updates continued:
  - For Severity Level 3 potential quality issues, notification processes were clarified:
    - Contracted CHCN providers: Receive a formal letter outlining investigation findings.
    - Non-CHCN providers contracted with a CalOptima Health network: Receive a letter, and their network is formally requested to review the case and respond to the Credentialing and Peer Review Committee (CPRC) upon completion.
    - Non-contracted providers: A non-805-reportable letter is submitted to the appropriate State Licensing Board requesting review of the concern

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 18, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

5. Recommend that the Board of Directors Approve Reallocation of Remaining Non-monetary Gift Cards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

Recommend that the Board of Directors:

1. Approve the reallocation of the remaining non-monetary gift cards totaling $16,425 from the Medi-Cal COVID-19 Member Vaccination Incentive Program to the Calendar Year 2026 Medi-Cal Member Health Rewards Program.
2. Approve the reallocation of the remaining non-monetary gift cards totaling $2,750 from the OneCare COVID-19 Member Vaccination Incentive Program and $65,600 from the OneCare Calendar Year 2024 Member Health Rewards Program to the Calendar Year 2026 OneCare Member Health Rewards Program.

Background

On November 3, 2022, the Board of Directors (Board) approved extending CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Medi-Cal, OneCare (OC) and OneCare Connect (OCC), and authorized expenditures for additional $25 non-monetary gift cards for the program. The program ended on December 31, 2023. An inventory of $25 gift cards remains unused from the program as follows:

- 657 gift cards totaling $16,425 for Medi-Cal; and
- 110 gift cards totaling $2,750 for OC.

On November 2, 2023, the Board approved CalOptima Health's Calendar Year (CY) 2024 Member Health Rewards (MHR) for Medi-Cal and OC. The OC MHR Program included rewards for annual wellness visit (AWV), breast cancer screening, colorectal cancer screening, diabetes A1c test, diabetes eye exam, osteoporosis management, and Health Risk Assessment.

For CY 2024, the OC MHR Program utilized physical gift cards to incentivize member participation. In 2024, the AWV MHR was based on passive identification, meaning members who completed the AWV were automatically recognized and qualified for the reward through claim and encounter data. In Quarter 4 of 2024, staff were notified of data enhancements that could increase the number of eligible members, prompting the purchase of additional gift card inventory in anticipation of higher participation. This measure was taken to ensure that the OC MHR Program maintained adequate inventory to reward all eligible and participating members in a timely manner. An inventory of 2,624 gift cards totaling $65,600 remains unused from the program.

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On August 1, 2024, the Board approved CalOptima Health's CY 2025 MHR for Medi-Cal and OC, which maintained the same OC rewards as CY 2024. For CY 2025, efforts were made to transition the OC MHR Program to a flex card model to minimize the turnaround time for rewarding members.

On November 6, 2025, the Board approved the CY 2026 MHR for Medi-Cal and OC, which continued the OC rewards from the year prior with minor revisions to expand qualifying criteria and enhance ease of participation for members. The flex card reward model adopted in CY 2025 remains the primary reward mechanism in CY 2026.

Discussion

Staff recommends the Board approve the following:

- Medi-Cal: Staff requests reallocation of the remaining Medi-Cal COVID-19 VIP non-monetary gift card inventory to the CY 2026 Medi-Cal MHR Program, approved by the Board on November 6, 2025.
- OneCare: Staff requests reallocation of the remaining non-monetary gift card inventory from the OC COVID-19 VIP program and the CY 2024 OC MHR Program to the CY 2026 OC MHR Program.

The gift cards will be utilized by staff and/or vendor partners to provide member incentives pursuant to the type and amount of the member health rewards in the Board-approved CY 2026 Medi-Cal and OC MHR Program. These member incentives include completion of plan-approved quality services and screenings, such as completion of an AWV, completion of a Health Risk Assessment, or completion of a quality care gap, such as a breast cancer screening mammogram, blood lead test, diabetes A1c test and eye exam, cervical cancer screening, colorectal cancer screening, osteoporosis screening, and postpartum checkup.

Staff will oversee the gift card inventory and monitor program activity and completion, ensuring all cards issued for these services are closely tracked and reconciled.

Table 3. Release and Distribution

From:	To:	Number of Gift Cards	Total
Medi-Cal COVID-19 VIP Program	CY 2026 Medi-Cal MHR Program	657	$16,425
	Medi-Cal Subtotal	***657***	***$16,425***
OC COVID-19 VIP Program	CY 2026 OC MHR Program	110	$2,750
CY 2024 OC MHR Program	CY 2026 OC MHR Program	2,624	$65,600
	OC Subtotal	**2,734**	***$68,350***

Fiscal Impact

The reallocation of the remaining Medi-Cal and OC non-monetary gift card inventory will have no net fiscal impact on CalOptima Health Operating Budgets.

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Rationale for Recommendation

The non-monetary gift cards were previously designated for programs that have since concluded. To maximize organizational resources and enhance member engagement, staff recommends that the remaining gift card inventory be repurposed for the current, Board-approved MHR Program. This strategic realignment will directly support efforts to improve member experience, strengthen the primary care provider-patient relationship, and improve the quality of care delivered to CalOptima Health members. By incentivizing preventive care, early detection, chronic disease management, and facilitating opportunities to coordinate care through AWV, this approach aligns with CalOptima Health's commitment to delivering comprehensive, high-quality healthcare.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program
2. Approve CalOptima Health's CY 2024 Member Health Rewards
3. Approve CalOptima Health's CY 2025 Member Health Rewards
4. Approve CalOptima Health's CY 2026 Member Health Rewards

Prior Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for CY 2021	CY 2021	$20 million
March 4, 2021	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to COVID-19 Member VIP + fiscal impact	CY 2022	$695,974
December 20, 2021	Consider Authorizing an Extension of CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for CY 2022	CY 2022	Original funding level of $35 million
November 3, 2022	Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program	CY 2023	$550,000
November 2, 2023	Approve CalOptima Health's Calendar Year 2024 Member Health Rewards for Medi-Cal and OneCare.	CY 2024	Medi-Cal: $4.76 million, OneCare: $550,000

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August 1, 2024	Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.	CY 2025	Medi-Cal: $4.87 million, OneCare: $660,000
November 6, 2025	Approve CalOptima Health's CY 2026 Member Health Rewards for Medi-Cal and OneCare	CY 2026	Medi-Cal: $6.3 million, OneCare: $1.0 million

/s/ Michael Hunn *06/08/2026*

Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591
Katie Balderas, Director, Population Health Management, (657) 235-6907

Recommended Actions

1. Authorize extending CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Medi-Cal, One Care (OC) and One Care Connect (OCC) members through end of the fiscal year, June 30, 2023;
2. Authorize modification to CalOptima Health's COVID-19 Member VIP to provide up to four (4) $25 non-monetary gift cards to eligible Medi-Cal, OC, and OCC members for receiving up to four (4) required doses of the COVID-19 vaccine; and;
3. Authorize unbudgeted expenditures in an amount up to $550,000 from existing reserves for the COVID-19 Member VIP for eligible OC and OCC members.

Background

On January 7, 2021, the CalOptima Health Board of Directors allocated $35 million in IGT 10 funds for CalOptima Health's COVID-19 VIP. The program included member health rewards for eligible members to receive a $25 gift card per vaccine, for a maximum of $50 per member. On March 4, 2021, the Board authorized unbudgeted expenditures in an amount up to $695,974 from existing reserves to include OC and OCC members in the COVID-19 VIP.

On December 20, 2021, the Board extended the COVID-19 VIP through calendar year (CY) 2022 and included provisions for $25 non-monetary gift cards for members receiving the two required doses of the COVID-19 vaccine (one gift card per shot) and receiving a single COVID-19 booster shot.

The Food and Drug Administration (FDA) has continued to authorize the COVID-19 vaccine to include additional age groups:

- In June 2022, the FDA approved a primary three dose series of the Pfizer vaccine for children six months to four years old.
- In August 2022, the FDA approved one dose of the bivalent booster for ages 12 years and older.

Discussion

Since the COVID-19 vaccine approval in 2021, CalOptima Health has engaged in multi-faceted outreach strategies to close vaccination gaps for members. Activities to engage and motivate members have included outbound calls to targeted populations and homebound members, hosting vaccination clinics in collaboration with Orange County Health Care Agency (OCHCA), social media, direct mail, texting campaigns, and partnering with trusted messengers to address vaccine hesitancy. The non-monetary gift cards have promoted vaccine adherence and motivated members to participate in

vaccination clinics. Although the CalOptima Health has made great strides in vaccination, staff believes that CalOptima Health must continue outreach to the community to increase awareness and encourage vaccination.

CalOptima Health members are currently eligible for a maximum of two $25 non-monetary gift cards and a booster (one gift card per shot) based on current Board approvals. However, that does not include an additional $25 non-monetary gift card for the third primary dose approved for children 6 months to 4 years and bivalent booster. Staff recommends the approval of up to four gift cards per eligible member and extending the COVID-19 VIP until the end of the fiscal year, June 30, 2023. A CalOptima Health member who receives a primary COVID-19 vaccine dose on or before June 30, 2023, will be eligible to receive $25 non-monetary incentives for COVID-19 vaccine doses received by December 31, 2023, up to four (one per dose). The current recommendations are budget neutral because the funds are already allocated, and staff will continue to monitor COVID-19 vaccinations trends and available funding.

OC and OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage. Staff recommends application of the same program modifications and the extension of the program end date through June 30, 2023, to eligible members within the OC and OCC programs. The total estimated cost is $550,000 through June 30, 2023. Staff requests that the Board authorize the use of existing reserves to fund these additional costs. Of note, OC and OCC members residing in long-term care settings and PACE members are excluded from the COVID-19 Member VIP.

Fiscal Impact

Medi-Cal Program Fiscal Impact:
The recommended action to authorize revisions to and extension of the CalOptima Health Member VIP through June 30, 2023, has no net fiscal impact to the CalOptima Health Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022.

As of September 30, 2022, approximately $27.9 million of the $35 million in IGT 10 funds allocated by the Board for the CalOptima Health Member VIP program has been spent. Staff anticipates the remaining $7.1 million in IGT 10 funds will be sufficient to cover program expenses through June 30, 2023. Expenditure of these IGT funds is for covered services to Medi-Cal members and does not commit CalOptima Health to future budget allocations.

OC and OCC Program Fiscal Impact:
The recommended action to authorize revisions to and extension of the CalOptima Health Member VIP for eligible OC and OCC members is an unbudgeted item. An allocation of up to $550,000 from existing reserves will fund these actions.

Rationale for Recommendation

CalOptima Health is committed to improving COVID-19 vaccination rates and promoting member engagement. The recommended actions will allow staff to continue outreaching to unvaccinated members, provide member incentives, and support overall vaccination efforts.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None.

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021	Calendar Year (CY) 2021	$20 million
March 4, 2022	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to COVID-19 Member VIP + fiscal impact	Calendar Year 2022 (CY 2022)	$695,974
December 20, 2021	Consider Authorizing an Extension of CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022	Calendar Year 2022 (CY 2022)	Original funding level of $35 million

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
4. Approve CalOptima Health's Calendar Year 2024 Member Health Rewards

Contacts
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action
1. Approve CalOptima Health's Calendar Year 2024 Member Health Rewards for Medi-Cal and OneCare.

Background
CalOptima Health provides health rewards and incentives in the form of physical gift cards to eligible members to improve member health and quality outcomes. In calendar year 2023, CalOptima Health provided members with health rewards for preventive services in both Medi-Cal and OneCare, including breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and annual wellness visits.

Discussion
Health rewards and incentives (R&I) motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Incentives were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health had performed below established benchmarks.

Staff recommends maintaining the following incentives from 2023 for calendar year 2024:

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Breast Cancer Screening- $25	Breast Cancer Screening- $25
Cervical Cancer Screening- $25	Colorectal Cancer Screening (colonoscopy)- $50
Diabetes A1c Test- $25	Diabetes A1c Test- $25
Diabetes Eye Exam- $25	Diabetes Eye Exam- $25
Postpartum Check Up- $50	Osteoporosis Management for Members with a Fracture- $25

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Staff also recommends adding incentives for the following:

Medi-Cal	OneCare
Colorectal Cancer Screening (colonoscopy)- $50	Health Risk Assessment- $25
Lead Screening- $25	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications-$25	
Follow-Up Care for Children Prescribed ADHD Medication- $25	

Members will receive R&I gift cards contingent upon complete member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15% based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board for additional funding requests at future meetings.

Fiscal Impact

The total estimated cost for the calendar year 2024 member health reward program is $4.76 million for Medi-Cal and $550,000 for OneCare. Funding for the recommended action for the period of January 1, 2024, through June 30, 2024, is a budgeted item under the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget. Management will include expenses for the period of July 1, 2024, through December 31, 2024, in the FY 2024-25 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

None.

/s/ Michael Hunn *10/27/2023*
Authorized Signature **Date**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.

Background

CalOptima Health provides health rewards to members in the form of physical gift cards and plans to explore providing digital e-card and flex card reward options to eligible members to improve member health and quality outcomes. In calendar year (CY) 2024, CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests (multiple), postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication. Member incentives are awarded based on provider attestations using an incentive form and passive rewards based on qualifying claims and encounter data.

Medi-Cal

The Medi-Cal member health rewards program utilizes both provider attestations and passive rewards to issue incentives. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications are historically passively rewarded incentives. The remaining member incentives require a provider attestation.

OneCare

For OneCare members, staff has discussed leveraging a preloaded "flex card" (debit card), to directly reward members for their participation in health rewards program activities. Currently, the OneCare member health rewards program is a passively rewarded program, where members are identified through claims and encounters data and are automatically issued a member health reward. Since there is no provider attestation and form submission required, adapting the reward process to payout through the flex card will increase health reward processing efficiency and minimize turnaround time for members to receive their rewards. CalOptima Health's OneCare flex benefit vendor has the capability to include member health rewards in the flex card for CY 2025. CalOptima Health plans to implement member health rewards in the flex card starting 2025 and will evaluate program effectiveness.

Discussion

Health rewards motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

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Staff recommends maintaining the following health rewards from CY 2024 for CY 2025:

Current	
Medi-Cal	**OneCare**
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Checkup- $50	

Staff also recommends revising the following health rewards for CY 2025. This includes piloting the change from attestation-based to passive identification and rewarding to enhance member experience for Blood Lead Test and to reduce the reward amount from $50 to $25 for Postpartum Checkup to align with other Medi-Cal rewards.

Changes	
Medi-Cal	**OneCare**
Blood Lead Test 12 Months of Age (change rewarding to passive)	N/A
Blood Lead Test 24 Months of Age (change rewarding to passive)	
Postpartum Checkup- $25 (decrease reward value)	

Members will receive health reward gift cards contingent upon completed member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15%* based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings.

**For passive health rewards: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79%, which is the current DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with the current CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People*

with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05%, which is the current DCHS minimum performance level.

Fiscal Impact

Medi-Cal:

The estimated cost for CY 2025 Medi-Cal Member Health Rewards program is $4.87 million. Funding included in the proposed CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program will be sufficient to fund the program.

OneCare:

The estimated cost for CY 2025 OneCare Member Health Rewards program is $660,000 and is a budgeted item in the proposed FY 2024-25 Operating Budget. Management will include expenses for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

1. Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

June 12, 2024

Linda M. Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Current 2024 Member Health Reward Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- Rewards in the form of retailer physical gift cards
  - Exploring digital e-cards and flex card reward options
- OneCare member health rewards are passively rewarded
  - Reward is based on identified claims and encounters
  - Health Risk Assessment (OC only), Annual Wellness Visit (MC and OC), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (MC only) are passively rewarded.
- Medi-Cal member health rewards are attestation-based
  - Reward is based on provider attestation and form submission

MC: Medi-Cal

OC: OneCare

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2024 Program and 2025 Proposed Changes

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Check Up- $25 *Change from $50 to $25	

*Proposed changes for 2025

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2025 Proposed Revisions

- Retain all member health rewards from calendar year 2024 with the following changes:
  - **Blood Lead Test 12 and 24 Months of Age**
    - Pilot to change from attestation-based to passive identification and rewarding to enhance member experience.
  - **Postpartum Checkup**
    - Reduce amount from $50 to $25 reward to align with other Medi-Cal rewards.

Summary of Fiscal Impact

- Estimated Cost at 15% Response Rate*
  - Medi-Cal: approximately $4,870,000
  - OneCare: approximately $660,000

	2024	2025	Budget Difference
Medi-Cal	$4,665,000	$4,865,244	$200,244
OneCare	$530,625	$656,130	$125,505

*For passive rewarded incentives: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79% which is DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05% which is the DHCS minimum performance level.

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2025 Proposed Incentives Cost Projections

Member Health Reward	Amount	Medi-Cal Eligible Members	OneCare Eligible Members	Estimated Cost at 5% Response Medi-Cal	Estimated Cost at 5% Response OneCare	Estimated Cost at 15% Response Medi-Cal	Estimated Cost at 15% Response OneCare
Annual Wellness Visit**	$50	198,562	17,233	$496,405	$43,083	$1,489,215[A]	$129,248
Blood Lead Test at 12 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Blood Lead Test 24 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Breast Cancer Screening	$25	78,524	5,466	$98,155	$6,833	$294,465	$20,498
Cervical Cancer Screening	$25	229,229	-	$286,536	-	$859,609	-
Colorectal Cancer Screening	$50	196,563	10,995	$491,408	$27,488	$1,474,223	$82,463
Diabetes A1C Test	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Eye Exam	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications**	$25	1,659	-	$2,074	-	$32,790[G]	-
Follow-up Care for Children Prescribed ADHD Medication	$25	1,265	-	$1,581	-	$4,744	-
Health Risk Assessment	$25	-	17,583	-	$272,537[D]	-	$329,681[E]
Osteoporosis Screening	$25	-	17,233[F]	-	$21,541	-	$64,624
Postpartum Checkup	$25	3,273	-	$4,091	-	$12,274	-
Totals				$1,845,325	$381,353	$4,865,244	$656,130

Eligible members are identified using the February 2024 Prospective Rate HEDIS denominator, but reward is not limited to condition or diagnosis. Annual Wellness Visit, Health Risk Assessment, and Osteoporosis Screening eligible population is based on health reward program eligibility criteria.
**Passive identification and rewarding. (continued next slide)

2025 Proposed Incentives Cost Projections (Continued)

A. Medi-Cal Annual Wellness Visit goal is 15% response rate.
B. Lead Screening estimated response rate is calculated based on administrative compliance rate for MY2023, 61.06%.
C. Lead Screening estimated response rate is calculated based on minimum performance level for MY2024, 62.79%.
D. Health Risk Assessment estimated for 3 STARs at 62% participation rate.
E. Health Risk Assessment estimated for 4 STARs at 75% participation rate.
F. Osteoporosis Screening eligible population is based on all OneCare members who are eligible and not restricted to specifications dictated in the HEDIS measure requirements for: Osteoporosis Management in Women Who Had a Fracture (OMW).
G. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications Follow-up Care for Children Prescribed ADHD Medication estimated response rate is calculated based on minimum performance level for MY2024, 79.05%.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards

Contacts

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Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

1. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare.

Background

In Calendar Year (CY) 2025, CalOptima Health offers health rewards to eligible members through physical gift cards for Medi-Cal and &more flex card rewards for OneCare, to enhance member health and quality outcomes. CalOptima Health provides Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication.

Medi-Cal

The Medi-Cal member health rewards program has both provider attestation and automated claims-based rewarding. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications have historically been automated reward incentives. The remaining member incentives require provider attestations.

OneCare

The OneCare member health rewards program has both self-attestation and automated claims-based rewards. Annual wellness visits and health risk assessment are automated rewards. The remaining member incentives require a self-attestation form. In CY 2025, the OneCare &more flex benefit card is being used as the vehicle for member health rewards, which can be used for any purchases permissible through the &more card. The transition to digital self-attestation forms and automated rewards in CY 2025 has increased health reward processing efficiency and minimized turnaround time for members to receive their rewards.

Discussion

Health rewards may motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests, reinforce health behaviors, and positively impact member experience. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

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Staff recommend maintaining the following health rewards from CY 2025 for CY 2026 as detailed in the table below:

Proposed CY2026 Member Incentives	
Medi-Cal	**OneCare**
Automated Reward	**Automated Reward**
Annual Wellness Visit- $50	Health Risk Assessment- $25
Blood Lead Test 12 Months of Age- $25	
Blood Lead Test 24 Months of Age- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Provider Attestation Reward	**Self-Attestation Reward**
Breast Cancer Screening- $25	Annual Wellness Visit- $50
Cervical Cancer Screening- $25	Breast Cancer Screening- $25
Colorectal Cancer Screening- $50*	Colorectal Cancer Screening- $50*
Diabetes A1c Test- $25	Diabetes A1c Test- $25
Diabetes Eye Exam- $25	Diabetes Eye Exam- $25
Postpartum Checkup- $25	Osteoporosis Screening- $25

*The reward amount will vary based on the type of colon cancer screening test completed: $15 for fecal occult blood test (FOBT) or fecal immunochemical test (sDNA FIT), $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy.

Staff recommends the following revisions to the health rewards program for CY 2026. To align with the US Preventive Services Task Force (USPSTF) recommendations, the Colorectal Cancer Screening health reward will be expanded to include four types of colon cancer screening tests: FOBT, sDNA FIT, CT colonography, and flexible sigmoidoscopy.

Additionally, in accordance with USPSTF guidelines, the Medi-Cal member health rewards will recognize screenings, tests, or exams completed outside the standard age criteria. This adjustment acknowledges that members may require these screenings, tests, or exams at different intervals and may not adhere strictly to the recommended age criteria.

Staff recommend Osteoporosis Screening be revised to reward members who get a bone mineral density test or additionally those who fill a prescription for a drug to treat osteoporosis. This addition is in alignment with clinical practice guidelines which aim to reduce fracture risk by encouraging early intervention rather than waiting for adverse events such as falls.

Staff recommends revising the OneCare Annual Wellness Visit Member Health Reward from an automated, claims-based reward to self-attestation. In 2025, OneCare Member Health Rewards were upgraded to digital form submission, eliminating the need for members to bring a physical form to the provider's office and either mail or fax it to CalOptima Health. This proactive, streamlined approach is designed to enhance member engagement, reduce barriers, minimize inquiries and grievances, and increase member ownership of their health. The Annual Wellness Visit Health Reward has shown a

strong correlation as a gateway to complete other screenings such as breast cancer screening, colorectal cancer screening, and retinal eye exams for members with diabetes. By implementing self-attestation, members will not only become more aware of other health offerings but also learn how to access their rewards through the &more flex card. This change is expected to further improve member satisfaction and health outcomes.

Program Changes		
Medi-Cal		**OneCare**
Breast Cancer Screening - Update age criteria to 40-74 years old		Osteoporosis Screening - Expand criteria to allow medication treatment as a qualifying event
Colorectal Cancer Screening - Update to allow other colon cancer screening methods		Colorectal Cancer Screening - Update to allow other colon cancer screening methods
		Annual Wellness Visit - Change process for rewarding to self-attestation

For CY 2026, the Behavioral Health Department recommends discontinuing the Follow-Up Care for Children Prescribed ADHD Medication (ADD) health reward due to the low participation rate (fewer than 5 participants in CY 2024) and the unique qualifications required. In its place, the Behavioral Health Department has developed an ADD text campaign to remind members who qualify for the ADD measure to follow up with their provider within 30 days of filling their first prescription.

Retire		
Medi-Cal		**OneCare**
Follow-up Care for Children Prescribed ADHD Medication		N/A

Members will receive a health reward upon completing the qualifying event. At the time of budgeting, staff assumed a member participation rate of 15-20%* based on historical participation rates and an anticipated increase in member participation. Should the participation rates exceed these assumptions and budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings. Other participation rate assumptions are as follows:

**** Automated Health Rewards:***

- *Annual Wellness Visit (OneCare): Participation rate is assumed at 45%, consistent with past participation.*
- *Blood Lead Test at 12 and 24 Months (Medi-Cal): Participation rate is assumed at 71.11% (75th percentile), which is the next benchmark following achievement of the DHCS minimum performance level for Measurement Year (MY) 2024.*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal): Participation rate is assumed at 84.63% (75th percentile), supporting alignment with Behavioral Health initiatives.*
- *Health Risk Assessment (OneCare): Participation rate is assumed at 76%, in line with the current CMS 4-star rating.*

**** Self-Attestation Rewards:***

- *Annual Wellness Visit (Medi-Cal): Participation rate is assumed at 25%, based on past participation.*
- *All other member health rewards participation rate is assumed at 15% for Medi-Cal and 20% for OneCare.*

Program Funding

Staff recommends utilizing unearned MY 2024 Pay for Value Performance Program (P4V Program) dollars to fund the member health reward program. MY 2024 Medi-Cal P4V rewards have been preliminarily calculated. The total Medi-Cal P4V pool was $101 million (based on 10% of professional capitation for Fiscal Year 2024-25) with $31 million earned and $70 million unearned. The MY 2024 OneCare P4V will be calculated in November 2025 pending results from member satisfaction surveys. Staff expects OneCare performance similar to Medi-Cal with 30% earned and 70% unearned.

Fiscal Impact

Medi-Cal:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 Medi-Cal Member Health Rewards program is $6.3 million. Staff anticipates that unearned funds from the MY 2024 Medi-Cal P4V Program will be sufficient to fund the program.

OneCare:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 OneCare Member Health Rewards program is $1.0 million. Staff anticipates that unearned funds from the MY 2024 OneCare P4V Program will be sufficient to fund the program.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachment

1. Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

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Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

October 8, 2025

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

Current 2025 Member Health Rewards Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- 11 Medi-Cal Health Rewards
  - Rewards are through physical cards
  - Provider attestation and passive reward mechanism
- 7 OneCare Health Rewards
  - Rewards are through the flex benefit card
  - Self attestation and passive reward mechanism

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2026 Medi-Cal Program and Proposed Changes

Mechanism	Medi-Cal Health Reward	Reward Amount	Proposed Changes
Passive	Annual Wellness Visit	$50	
	Blood Lead Test 12 Months of Age	$25	
	Blood Lead Test 24 Months of Age	$25	
	Diabetes Screening for People with Schizophrenia or Bipolar…*	$25	
Provider Attestation	Breast Cancer Screening	$25	Update age criteria to 40-74 years old
	Cervical Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Postpartum Checkup	$25	

*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications. **Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 OneCare Program and Proposed Changes

Mechanism	OneCare Health Reward	Reward Amount	Proposed Changes
Passive	Health Risk Assessment	$25	
Self Attestation	Annual Wellness Visit	$50	Change reward process to self-attestation
	Breast Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Osteoporosis Screening	$25	Expand criteria to allow medication treatment

**Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 Proposed Revisions

- Breast Cancer Screening, Medi-Cal:
  - Update age criteria to 40-74 years
- Osteoporosis Screening, OneCare:
  - Expand criteria to allow medication treatment
- Annual Wellness Visit, OneCare:
  - Change rewarding process to self-attestation

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2026 Proposed Revisions

- Colorectal Cancer Screening, Medi-Cal and OneCare:
  - Expand eligible screening options:
    - Health Reward 1:
      - $15 fecal occult blood test (FOBT), or
      - $15 fecal immunochemical test (sDNA FIT), or
      - $25 for CT colonography, or
      - $25 flexible sigmoidoscopy
    - Health Reward 2:
      - $50 for colonoscopy

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Retire

- Medi-Cal, Follow-up Care for Children Prescribed ADHD Medication

Summary of Fiscal Impact

- Estimated Cost at 15-20% Response Rate
  - Medi-Cal: approximately $6.25 million
  - OneCare: approximately $1.03 million

	2025	2026	Budget Difference
Medi-Cal	$4,865,244	$6,250,382	$1,385,138
OneCare	$656,130	$1,026,665	$370,535

Passive health rewards were calculated based on Quality Compass Benchmarks or Star goals.

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Appendix

Medi-Cal 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$3,125,000.00
Blood Lead Test at 12 Months of Age (BLT12)	$25.00	$175,161.71
Blood Lead Test at 24 Months of Age (BLT24)	$25.00	$175,161.71
Breast Cancer Screening (BCS)	$25.00	$254,250.00
Cervical Cancer Screening (CCS)	$25.00	$756,255.00
Colorectal Cancer Screening (COL)	$50.00	$1,292,520.00
Diabetes A1C Test (GSD)	$25.00	$172,875.00
Diabetes Eye Exam (EED)	$25.00	$172,875.00
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	$25.00	$105,152.78
Postpartum Checkup (PPC)	$25.00	$21,131.25
	Total	$6,250,382.44

AWV projected at 25% participation rate. BLT 12, BLT 24 and SSD projected at the 75th percentile. All other health rewards projected at 15% participation rate.

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OneCare 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$450,000.00
Breast Cancer Screening (BCS)	$25.00	$27,680.00
Colorectal Cancer Screening (COL)	$50.00	$109,580.00
Diabetes A1C Test (GSD)	$25.00	$21,380.00
Diabetes Eye Exam (EED)	$25.00	$21,380.00
Health Risk Assessment (HRA)	$25.00	$380,000.00
Osteoporosis Screening (OSW, OMW)	$25.00	$16,645.00
		$1,026,665.00

AWV projected at 45% participation rate. HRA projected at 4 Stars Goal. All other health rewards projected at 20% participation rate.

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Grant Management Activities and Updates

Quality Assurance Committee

June 18, 2026

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

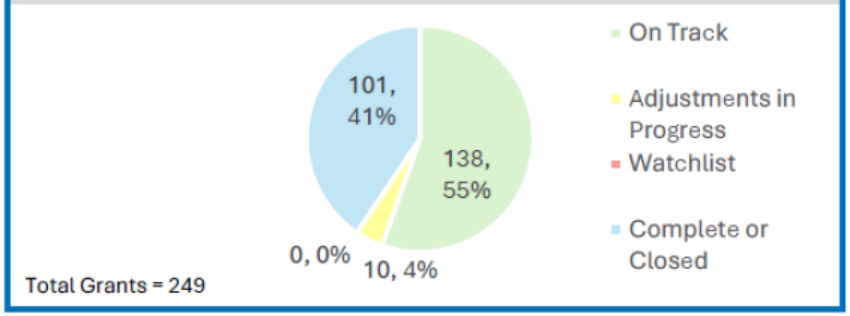
Our Vision

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.

Grants Monitoring Report

CalOptima Health Grants Monitoring Report
Prepared May 21, 2026

Current Pulse Check Across All CalAIM Grants



Grant Assessment Key

- **Grant program is on track for timeline, objectives and budget.** All reports and progress meet expectations.
- **Grant program is delayed or off track and adjustments are in progress.** Staff is actively working with grantee to address program or spending performance. The program is not at risk, but needs additional attention to ensure it stays aligned.
- **Grant program is on a watch list and not progressing enough toward outcomes or spending.** Grantees are completing Performance Improvement Plans. Staff are actively involved to ensure program can be returned to "on track." Executive team or legal counsel advise on any potential agreement amendments, recoupment of funds, or other actions needed.
- **Grant program completed or terminated upon mutual agreement.**

Pg.	Portfolios Under Active Management*	Portfolio Value	# of Grants	Status Breakdown Across Each Portfolio
2	Behavioral Health Grants	$ 9,571,250	3	3
3	Street Medicine	$ 23,460,083	7	5 | 2
4	HHIP- Round 1	$ 36,631,423	35	6 | 29
5	HHIP- Round 2	$ 52,300,000	15	5 | 2 | 8
6	HHIP- Round 3	$ 25,780,000	14	3 | 4 | 7
7	HHIP – Round 4	$ 2,700,000	6	6
8	HHIP – Round 5*	$ 10,000,000	6	6
9	Pulse for Good	$ 660,000	22	15 | 7
10	Community Enrollers Round 1	$ 4,073,325	12	5 | 2 | 5
11	Community Enrollers Round 2	$ 2,200,000	22	7

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Grants Monitoring Report (continued)

13	Community Supports Capacity 2023	$ 3,499,160	7	3 / 19
14	ECM Academy Cohort 3	$ 1,200,000	12	12
15	Justice Involved Learning Network	$ 1,000,000	5	4 / 1
16	Cancer Screening Program	$ 16,417,044	15	15
17	Quality Improvement Grants (MY2023)	$ 4,633,957	37	16 / 21
18	Quality Improvement Grants (MY2024)	$ 1,752,482	8	8
19	Workforce Development Round 1	$ 24,596,300	7	7
20	Workforce Development Round 2	$ 5,140,772	6	6
21	UCI HPSP Evaluation	$ 269,703	1	1
22	OCHCA - Be Well Hubs (Orange/Irvine)	$ 11,400,000	1	1
23	CSUF - MSW Stipend Program	$ 5,000,000	1	1
24	Mind OC	$ 15,000,000	1	1
25	Coalition - PHVBC	$ 50,000,000	1	1
26	OCHCA – CHIP/CHA	$ 990,678	1	1
27	Food Bank Grants	$ 4,200,000	4	2 / 2
	TOTAL	$ 312,476,177	249	

* Three of these grants are technically amendments/increases to prior awards.
**Portfolios are removed from this list after being 100% closed for at least one month.

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Grant Management Updates

Grant Monitoring

- HHIP R2
  - Community Development Partners needs a very short, 2-month extension while they await utilities getting turned on and
  - City Net is pending permits on their project and will need a no-cost extension amendment. We provide monthly check-ins for extra support until they are on track with permits and construction begins.
- HHIP R3
  - Two projects, Golden State Recuperative Care and Casa Youth Shelter, are both behind schedule but continue to actively pursue approved construction permits. We provide monthly check-ins for extra support until they are on track with permits and construction begins.
  - Orange County Housing Finance Trust, is on a PIP due to slow completion of objectives; we anticipate them to be on track in the next two months.

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Grant Management Updates

- Community Enrollers R1
  - Two of the grantees, Orange County United Way and Vista Community Clinics, are on PIPs until they increase their enrollment numbers. We provide additional support and feedback to ensure they reach their goals by the close of the grant.
- JI Learning Network
  - Mariposa did poorly on their ECM audit and ECM provision is a key component of that grant; strategizing with the CalAIM Operations team on next steps for this provider.
- OCHCA Be Well Hubs
  - They are behind schedule in expending their funds and there is ongoing discussion at the leadership level to resolve this situation.

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Grant Management Assessment and Leading Practices Report

June 18, 2026

Samantha Pellón
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Why This Assessment Was Conducted

1. Evaluate how CalOptima Health's Grant Management framework compares to applicable requirements and comparable organizations.

2. Assess how the current framework supports effective grantmaking across the lifecycle.

3. Identify targeted opportunities for continued strengthening.

Summary of Findings

1. CalOptima Health has established a strong, well-structured Grant Management framework.
2. The framework is broadly consistent with practices observed across comparable organizations.
3. The opportunities identified are targeted refinements intended to support continued consistency, transparency, and sustainability.

Key Finding: Overall, Chapman found that CalOptima Health has established a strong, well-structured grant management framework that is broadly aligned with practices observed across comparable organizations.

Regulatory Landscape and Key Compliance Considerations

- Grantmaking flexibility exists, but within important limits.
- Program-specific funding requirements remain a key consideration.
- Federal Medicaid managed care rules shape the design of state incentive arrangements.
- Conflict-of-interest and ethics requirements remain relevant even where grantmaking rules are flexible.
- Department of Health Care Services (DHCS) Community Reinvestment requirements introduce an important forward-looking planning consideration.

Key Takeaway: *CalOptima Health's grant program should maintain existing clear, consistent, and well-documented internal processes that align with evolving DHCS requirements, organizational priorities, and community needs while incorporating relevant leading practices from peer organizations.*

Benchmarking Scope

Chapman reviewed grantmaking practices across a comparison group of 12 organizations, including:

3
Commercial Health Plans that also operate MCPs

3
Grantmaking Healthcare Focused Foundations

The review was supplemented with interviews from four Medi-Cal MCPs and one commercial plan to better understand operating practices not always fully visible in public materials.

Benchmarking Insights and Leading Practices Review

- Most organizations define funding priorities in advance.
- Grantmaking structures vary, but open competitive processes are common among peer plans.
- Providing more than one grant to the same organization is common, often with guardrails.
- More mature grantmaking models place greater emphasis on standardization and ongoing oversight.
- Conflict-of-interest controls are strongest when embedded into decision-making processes.

Key Takeaway: *CalOptima Health's Grant Management program is broadly aligned with prevailing industry practices, with opportunities to further strengthen consistency, transparency, and operational clarity through targeted refinements to existing processes and governance structures.*

Current State Review

- CalOptima Health has solid documentation for its grant management program.
  - Clear lifecycle coverage from pre-award through closeout.
  - Grant Management Operations Manual establishes defined roles.
  - Grant agreement template is comprehensive and aligned with the broader framework.
  - Evaluation guide reviewed provides a strong example of a more developed process document.
- CalOptima Health manages a large and complex grant portfolio through a relatively lean team.

Key Takeaway: *CalOptima Health has established a strong and well-structured grant management foundation, with opportunities to further improve consistency, strategic alignment, and administrative efficiency through targeted process and documentation refinements.*

Recommendation Themes

1 Formalize Strategic Funding Priorities

A clearer, approved set of funding priorities could better align grantmaking with strategy, support more consistent decisions, and give staff a stronger basis for declining out-of-scope requests.

2 Refine Governance and Portfolio Management

A substantial, varied portfolio is managed by a lean team. The Community Investment Governance Committee and related review processes are already in place. There may also be opportunities to further refine governance, reporting cadence, and portfolio management practices.

3 Strengthen Standardization and Lifecycle Management

Existing investments in template development and standardization create an opportunity to further improve consistency, visibility, and administrative efficiency across the portfolio.

4 Clarify Definitions and Decision Processes

Opportunity for targeted clarification of select definitions and decision points that could benefit from greater specificity in applicant, reviewer, or Board-facing materials.

5 Enhance Conflict of Interest Procedures

The conflict-of-interest framework is well established but relies heavily on self-disclosure. Peer models more explicitly embed checks, recusals, and documentation into workflows. The opportunity is to make existing expectations more proactive and consistently operationalized.

The recommendations are intended to build on CalOptima Health's existing strong grant management foundation and support continued alignment, consistency, and administrative sustainability across the grant lifecycle.

Formalize Strategic Funding Priorities

Specific actions to consider:

- Finalize and operationalize a funding priorities framework that can be applied across grant programs.
- Align funding priorities with CalOptima Health's broader strategic goals, outcome measures, and evolving external drivers, including community reinvestment requirements and other changes affecting community-based organizations and the safety net.
- Consider aligning these priorities with local planning efforts such as Orange County Health Care Agency's Community Health Assessment and Community Health Improvement Plan.
- Use the priorities framework to inform NOFO design, threshold screening, and portfolio management decisions, and revisit it periodically as priorities evolve.

Refine Governance and Portfolio Management

Specific actions to consider:

- Continue assessing whether current governance roles, approval pathways, and reporting practices remain well matched to the size and complexity of the portfolio.
- Consider whether the timing and cadence of NOFO releases and internal reporting can be further aligned to reduce administrative burden and support more efficient portfolio management.
- Clarify how audit findings, corrective action plans, or closeout issues affect future grant eligibility, monitoring intensity, and escalation pathways. For example, if a grantee is placed on a corrective action plan or has unresolved documentation issues at closeout, the written framework could specify whether that affects eligibility for future funding, triggers enhanced monitoring, or requires additional approvals before a new award is made.

Strengthen Standardization and Lifecycle Management

Specific actions to consider:

- Continue leveraging the lifecycle software solution and existing templates to support portfolio-wide consistency, document management, and process visibility.
- Confirm where templates are already effectively program-agnostic and identify any remaining opportunities to standardize key fields, definitions, or process steps across applicant, reviewer, and Board-facing documents.
- Use stronger internal templates already in place, such as the more developed evaluation guide, as models for broader standardization.

Clarify Definitions and Decision Processes

Specific actions to consider:

- Clarify threshold concepts such as “good standing,” “prior compliance”, and “basic eligibility” so they are applied more consistently across programs. Publicly available materials from other MCPs suggest that “good standing” is a commonly used concept, but the level of specificity varies. CalOptima Health could consider whether a more explicit internal definition, applied uniformly across grantmaking materials, would support clarity while preserving appropriate operational discretion.
- Consider whether a limited number of scoring terms and reviewer expectations would benefit from additional guidance to reduce interpretation where needed.
- Explicitly describe how recommendations move from application review to final funding decisions, including how exceptions, partial awards, or special circumstances are documented for decision-makers.

Enhance Conflict-of-Interest (COI) Procedures

Specific actions to consider:

- Finalize and expand the COI Attestation Template for portfolio-wide use.
- Consider whether periodic training, annual questionnaires, or other proactive disclosure tools could help operationalize existing COI expectations for Board members, staff, and reviewers.
- Clarify how disclosure, review, recusal, and documentation steps are handled within grant review and approval workflows. For example, if a reviewer discloses that they serve on the board of an applicant organization, the written framework should identify who receives that disclosure, who determines whether recusal is required, whether the reviewer is excluded from scoring and discussion, and how that determination is documented.

Any Questions

Thank you!

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Grant Management Assessment and Leading Practices Report

CalOptima Health

June 18, 2026

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Executive Summary

CalOptima Health engaged Chapman Consulting (Chapman) to assess its grant management framework, evaluate alignment with applicable regulatory and contractual requirements, benchmark current practices against comparable organizations, and identify opportunities to strengthen governance, consistency, transparency, and operational sustainability across the grant lifecycle.

The assessment included:

- A review of relevant federal, state, and Department of Health Care Services (DHCS) requirements and guidance.
- Benchmarking of grantmaking practices across:
  - Six Medi-Cal managed care plans (MCPs);
  - Three commercial health plans;
  - Three California-based health-focused foundations; and
  - Supplemented review with interviews from four Medi-Cal MCPs and one commercial plan.
- A review of selected CalOptima Health grant management policies, procedures, templates, and operational documentation.

The organization's use of articulated funding priorities, open competitive grantmaking processes, lifecycle-based documentation, structured evaluation approaches, and governance oversight reflects many of the core elements commonly associated with mature grant management programs.

Overall, Chapman found that CalOptima Health has established a strong, well-structured grant management framework that is broadly aligned with practices observed across comparable organizations.

The assessment also highlighted the operational complexity of CalOptima Health's grants portfolio. The organization manages approximately 14 to 15 Notices of Funding Opportunity (NOFOs) annually and roughly 160 active grants totaling more than $200 million across multiple funding streams and program areas, including California Advancing and Innovating Medi-Cal (CalAIM)-related incentive programs and community-focused initiatives. This work is supported by a relatively lean Grant Management team, increasing the importance of standardized processes, clear governance structures, and efficient portfolio management tools.

The regulatory review confirmed that CalOptima Health has significant discretion in designing its grantmaking processes, and is generally aligned with DHCS program requirements, Medicaid managed care rules, contractual obligations, fiscal accountability standards, and conflict-of-interest and ethics requirements applicable to public agencies. Looking ahead, DHCS Community Reinvestment requirements will increase the need for clear funding priorities, strategic alignment, and documentation of community investment decisions.

Benchmarking findings showed that variation in grantmaking structure and governance is common across peer organizations and often reflects differences in organizational scale, staffing, funding sources, and portfolio complexity. However, several consistent themes emerged across organizations reviewed, including the importance of:

- Clearly defined funding priorities tied to organizational strategy and community needs.
- Standardized application, scoring, and monitoring processes, which were particularly noteworthy among more mature grantmaking models.
- Transparent governance and oversight structures.
- Well defined lifecycle management tools and reporting expectations.
- Operationalized conflict-of-interest safeguards embedded within grantmaking workflows.

Based on the current-state review, Chapman identified several opportunities for targeted refinement that could further strengthen CalOptima Health's already well-developed framework. These opportunities are intended to support continued alignment, consistency, and administrative sustainability as the portfolio evolves.

Priority recommendations include:

1. Continue to formalize and operationalize enterprise-level funding priorities to support strategic alignment and portfolio discipline.
2. Refine governance and portfolio management practices as the program continues to grow and evolve.
3. Leverage standardization and lifecycle management tools to improve consistency, visibility, and administrative efficiency.
4. Clarify select definitions, eligibility standards, scoring concepts, and decision-making pathways to support consistent application across programs.
5. Further operationalize conflict-of-interest expectations within grantmaking workflows, documentation, and review processes.

Overall, the assessment found that CalOptima Health is well positioned to build on its existing grant management foundation. The opportunities identified in this report are best understood as targeted refinements to an already aligned and structured framework that can help support long-term consistency, transparency, strategic alignment, and operational durability as external requirements and community investment expectations continue to evolve.

Introduction and Assessment Approach

CalOptima Health engaged Chapman to assess its grant management framework, evaluate alignment with applicable requirements and grantmaking practices used by health plans and similar organizations in California, and identify opportunities to strengthen governance, compliance, transparency, and operational consistency.

This assessment report outlines the regulatory landscape and key compliance considerations, summarizes benchmarking insights and leading practices from other grantmaking organizations, and reviews CalOptima Health's current grant management documentation in light of those findings.

Regulatory Landscape and Key Compliance Considerations

CalOptima Health's grant program is not governed by a single, comprehensive federal or California structure. Instead, the program operates within a broader compliance framework that includes program-specific DHCS requirements, general fiscal accountability expectations, and conflict-of-interest and ethics rules applicable to public agencies and their personnel.

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Key Regulatory and Contractual Themes

- **Grantmaking flexibility exists, but within important limits:** CalOptima Health has discretion in how it designs its grantmaking processes, but that discretion must be exercised within the terms of applicable DHCS programs, contractual obligations, and general governance standards.
- **Program-specific funding requirements remain a key consideration:** For grant programs tied to DHCS incentive initiatives or other state-directed funding streams, CalOptima Health must comply with the requirements of the underlying program, including any limits on allowable uses of funds, performance expectations, timelines, and reporting obligations.
- **Federal Medicaid managed care rules shape the design of state incentive arrangements:** Federal Medicaid managed care rules under 42 CFR § 438.6(b)(2) govern how states may direct MCP participation in certain incentive-based programs. In California, programs such as the Incentive Payment Program and the Housing and Homelessness Incentive Program under the CalAIM Initiative illustrate how DHCS can establish time-limited, performance-based funding arrangements tied to state quality goals.
- **Conflict-of-interest and ethics requirements remain relevant even where grantmaking rules are flexible:** CalOptima Health's own conflict-of-interest policy cites several statutes, including the Political Reform Act, Government Code § 87100, Government Code § 1090, Government Code § 1126, and related federal requirements. These authorities reinforce the importance of disclosure, recusal, and avoiding participation in decisions where financial or personal conflict may exist.
- **DHCS Community Reinvestment requirements introduce an important forward-looking planning consideration:** Per All Plan Letter (APL) 25-004, DHCS requires MCPs and qualifying subcontractors to reinvest a percentage of annual net income into local communities. These reinvestment activities must be coordinated with Local Health Jurisdictions and be aligned with one or more mandatory DHCS use categories as outlined in the APL. Initial community reinvestment plans are due to DHCS in Q3 2026 and will cover calendar years 2027 through 2029 based on calendar year 2024 annual positive net income.

Implications for CalOptima Health

Given the discretion available within the regulatory and contractual framework, CalOptima Health's internal policies, procedures, and documentation play an important role in clarifying the scope and requirements of its grant program. Clear review criteria, documented approval pathways, consistent monitoring expectations, and well-defined conflict-of-interest controls help support transparency, administrative consistency, and sound governance.

CalOptima Health must also ensure that its program reflects evolving requirements from DHCS. For example, the community reinvestment planning and updated guidance increase the importance of having a clear internal framework for setting priorities and documenting how grantmaking decisions align with organizational goals, contractual requirements, community needs, and existing local planning efforts such as the Orange County Community Health Assessment and Community Health Improvement Plan. Benchmarking to other similar organizations allows CalOptima Health to identify the range of approaches currently in use and the practices most relevant to its grants program.

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Benchmarking Insights and Leading Practices Review

Chapman reviewed grantmaking practices across a comparison group of six Medi-Cal MCPs, three larger commercial health plans (who also operate Medi-Cal MCPs), and three grantmaking foundations with experience funding health-related community initiatives in California. The review was supplemented with interviews from four Medi-Cal MCPs and one commercial plan to better understand operating practices not always fully visible in public materials.

Across the organizations reviewed grantmaking structures varied in scale, staffing, and governance. Some organizations administer grants through a core internal team, while others establish separate foundations, pooled governance structures, or more formalized board-aligned processes. Local Medi-Cal MCPs generally operated with leaner grant management capacity, while commercial health plans and foundations tended to have more specialized staffing and infrastructure.

Key Benchmark Themes

- **Most organizations define funding priorities in advance:** Plans and foundations generally organize grantmaking around articulated focus areas, formal strategies, or alignment criteria that connect funding decisions to broader organizational goals and community needs. Even where structures are less formalized, funding decisions are typically guided by some form of strategic prioritization rather than being entirely ad hoc.
- **Grantmaking structures vary, but open competitive processes are common among peer plans:** Most of the Medi-Cal MCPs reviewed do not rely primarily on invitation-only grantmaking and instead use open or partially open solicitation models. Commercial health plans and foundations more often use a mix of open and invite-only approaches.
- **Providing more than one grant to the same organization is common, often with guardrails:** Across the organizations reviewed, repeat funding to the same organization is generally permitted, particularly where the work supports distinct projects, geographies, or funding categories. Some organizations use guardrails, such as limiting one application per funding category or avoiding overlapping funding for the same scope of work.
- **More mature grantmaking models place greater emphasis on standardization and ongoing oversight:** Organizations with more grantmaking infrastructure tend to use standardized templates, prescriptive application and scoring processes, defined reporting expectations, and more routine monitoring and performance review. Commercial health plans and foundations generally demonstrate greater formalization in these areas, while Medi-Cal MCPs vary more widely in structure and resourcing.
- **Conflict-of-interest controls are strongest when embedded into decision-making processes:** Across the organizations reviewed, strong approaches operationalize conflict-of-interest (COI) safeguards through required disclosures, recusal protocols, and conflict checks within grantmaking and procurement workflows. Ensuring potential conflicts are actively identified and managed at the point of decision to award a grant.

Implications for CalOptima Health

Overall, Chapman found that CalOptima Health's Grant Management program is broadly aligned with the range of practices observed across comparable health plans and other grantmaking organizations reviewed as part of this assessment. Its use of articulated funding priorities, an open competitive grantmaking model, lifecycle-based documentation, and structured scoring and reporting reflects many

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of the same core features seen across peer organizations, indicating that CalOptima Health is generally consistent with prevailing industry practice, even though the degree of formalization varies.

The benchmarking analysis also suggests that variation across organizations is common and often reflects differences in portfolio size, governance structure, staffing, and funding sources. In that context, the opportunities identified for CalOptima Health are best understood as targeted refinements to an already aligned framework, particularly around organizational-level funding priorities, selected definitions and process clarity, continued standardization through lifecycle tools, and more explicit operationalization of conflict-of-interest controls.

Current State Review

This section reflects Chapman's review of selected CalOptima Health grant management policies, procedures, and templates. The purpose of the review was to assess how the written framework supports governance, consistency, transparency, and accountability across the grant lifecycle. This assessment relied primarily on document review rather than interviews or direct process observation, thus the observations below are intended to identify areas of strength, alignment, and targeted opportunities for refinement within the written framework.

CalOptima Health Grant Program Context

CalOptima Health appears to administer a large and operationally complex grant portfolio, including programs tied to CalAIM incentive funding as well as other community-focused efforts such as cancer screening and provider workforce development. The organization manages approximately 14 to 15 NOFOs per year and roughly 160 active grants at any given time, with the total grant funding exceeding $200 million across the portfolio. Grant Management currently consists of four staff, with input from sponsoring departments on program-specific design, review, and oversight.

This context is important in evaluating the current written framework. In a portfolio of this size and complexity, clear funding priorities, well-aligned tools, and efficient processes are not only governance considerations but also practical supports for consistent grants administration over time.

CalOptima Health has solid documentation for its grant management program. The reviewed materials reflect a grant management framework with clear lifecycle coverage from pre-award through closeout. The Grant Management Operations Manual establishes defined roles for the Grant Management Department and sponsoring departments, the grant agreement template is comprehensive and aligned with the broader framework, and the evaluation guide reviewed provides a strong example of a more developed process document. Taken together, these materials suggest that CalOptima Health has established many of the core building blocks of a mature grant management function.

CalOptima Health manages a large and complex grant portfolio through a relatively lean team. Given the number of NOFOs, active grants, and total funding involved, clear priorities, standardized tools, and efficient workflows are especially important to support consistency across the portfolio.

Implications for CalOptima Health

The current-state review suggests that CalOptima Health has developed a strong and structured grant management framework that is broadly aligned with peer practice and reflects many of the core elements seen across comparable organizations. The reviewed materials indicate that the program has already established a strong foundation for governance, lifecycle management, scoring, monitoring, and documentation.

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Given the size and diversity of the portfolio and the relatively lean staffing structure supporting it, refinements that improve strategic guardrails, document alignment, reviewer guidance, and workflow clarity could yield additional benefits. These types of refinements would support more consistent decision-making and reduce administrative burden as the portfolio continues to evolve.

Recommendations for CalOptima Health

The recommendations are intended to build on CalOptima Health's existing strong grant management foundation and support continued alignment, consistency, and administrative sustainability across the grant lifecycle.

Formalize Strategic Funding Priorities

In a grant program of this size, a clearly articulated and vetted statement of funding priorities can serve as both a governance tool and a practical operational guardrail. Based on discussions with CalOptima Health, the previously limited use of a more formal priorities framework has made it harder at times to identify when requests align with organizational priorities. One comparable plan recently addressed a similar issue by revising its grants and sponsorships policy to align investments with its broader strategic plan, clarify annual priorities, and support a more structured governance and implementation approach.

CalOptima Health has already begun advancing a more explicit funding priorities framework. Continuing that work could help further align grantmaking with organizational strategy, support more consistent decisions across programs, and provide staff with a clearer basis for distinguishing between in-scope and out-of-scope requests.

Specific actions to consider:

- Finalize and operationalize a funding priorities framework that can be applied across grant programs.
- Align funding priorities with CalOptima Health's broader strategic goals, outcome measures, and evolving external drivers, including community reinvestment requirements and other changes affecting community-based organizations and the safety net.
- Consider aligning these priorities with local planning efforts such as Orange County Health Care Agency's Community Health Assessment and Community Health Improvement Plan.
- Use the priorities framework to inform NOFO design, threshold screening, and portfolio management decisions, and revisit it periodically as priorities evolve.

Refine Governance and Portfolio Management

CalOptima Health already has a governance structure in place through its Community Investment Governance Committee and related review processes. As the portfolio continues to evolve, there may be opportunities to further refine governance, reporting cadence, and portfolio management practices to support administrative efficiency and long-term sustainability.

Specific actions to consider:

- Continue assessing whether current governance roles, approval pathways, and reporting practices remain well matched to the size and complexity of the portfolio.
- Consider whether the timing and cadence of NOFO releases and internal reporting can be further aligned to reduce administrative burden and support more efficient portfolio management.

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- Clarify how audit findings, corrective action plans, or closeout issues affect future grant eligibility, monitoring intensity, and escalation pathways. For example, if a grantee is placed on a corrective action plan or has unresolved documentation issues at closeout, the written framework could specify whether that affects eligibility for future funding, triggers enhanced monitoring, or requires additional approvals before a new award is made.

Strengthen Standardization and Lifecycle Management

CalOptima Health has already made meaningful investments in template development and standardization and is in the process of implementing a lifecycle software solution to further support portfolio management. This creates an opportunity to continue using those tools to improve visibility, consistency, and administrative efficiency across the grant lifecycle.

In a few cases, the structure described in internal materials is not fully visible in external-facing templates. For example, the operations manual describes a more defined evaluation and oversight framework than is reflected in the sample NOFO and CalOptima Health Board Action Agenda Referral materials. CalOptima Health should ensure that the processes in place are consistently and transparently reflected across the full set of materials.

Specific actions to consider:

- Continue leveraging the lifecycle software solution and existing templates to support portfolio-wide consistency, document management, and process visibility.
- Confirm where templates are already effectively program-agnostic and identify any remaining opportunities to standardize key fields, definitions, or process steps across applicant, reviewer, and Board-facing documents.
- Use stronger internal templates already in place, such as the more developed evaluation guide, as models for broader standardization.

Clarify Definitions and Decision Processes

The reviewed materials suggest that most of CalOptima Health's written framework is clear and well developed. The main opportunity in this area appears to be targeted clarification of select definitions and decision points that could benefit from greater specificity in applicant, reviewer, or Board-facing materials. The materials use important terms such as "good standing," "prior grant compliance", and "basic eligibility" without always defining how those determinations are made. Similarly, some scoring criteria and evaluation language remain open to interpretation, which may create room for inconsistent application unless supplemented by clear definitions and guidance.

Specific actions to consider:

- Clarify threshold concepts such as "good standing," "prior compliance", and "basic eligibility" so they are applied more consistently across programs. Publicly available materials from other MCPs suggest that "good standing" is a commonly used concept, but the level of specificity varies. CalOptima Health could consider whether a more explicit internal definition, applied uniformly across grantmaking materials, would support clarity while preserving appropriate operational discretion.
- Consider whether a limited number of scoring terms and reviewer expectations would benefit from additional guidance to reduce interpretation where needed.

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- Explicitly describe how recommendations move from application review to final funding decisions, including how exceptions, partial awards, or special circumstances are documented for decision-makers.

Enhance Conflict-of-Interest Procedures

CalOptima Health's broader conflict-of-interest framework appears well established, and its existing policy applies broadly to employees, Board members, and certain contractors and consultants. The reviewed materials suggest an opportunity to make those expectations more proactive, explicit, and consistently embedded within grantmaking documents and workflows.

Specific actions to consider:

- Finalize and expand the COI Attestation Template for portfolio-wide use.
- Consider whether periodic training, annual questionnaires, or other proactive disclosure tools could help operationalize existing COI expectations for Board members, staff, and reviewers.
- Clarify how disclosure, review, recusal, and documentation steps are handled within grant review and approval workflows. For example, if a reviewer discloses that they serve on the board of an applicant organization, the written framework should identify who receives that disclosure, who determines whether recusal is required, whether the reviewer is excluded from scoring and discussion, and how that determination is documented.

Conclusion and Next Steps

Overall, this assessment suggests that CalOptima Health's Grant Management framework reflects a strong foundation and is broadly consistent with the range of practices observed across comparable Medi-Cal MCPs and other grantmaking organizations. The reviewed materials indicate that the program has established many of the core elements of a structured grant management function, including lifecycle-based documentation, defined roles, and a meaningful governance and oversight framework.

The opportunities identified in this assessment report are best understood as targeted refinements to an already well-developed framework. In particular, CalOptima Health may benefit from continuing to strengthen organizational-level funding priorities, clarifying a limited number of definitions and decision points, further leveraging standardization and lifecycle tools, and making select governance and conflict-of-interest expectations more explicit across grantmaking materials and workflows.

Looking ahead, CalOptima Health is well positioned to build on this foundation as external requirements and funding considerations continue to evolve. Continuing to formalize organizational-level funding priorities and aligning them, where appropriate, with local community needs and emerging requirements such as DHCS community reinvestment planning could help support consistency, strategic alignment, and long-term program durability.

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CalOptima Health

First Quarter 2026 Summary of the Quality Improvement Health Equity Transformation Program

Quality Assurance Committee Meeting

June 18, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

QIHEC Actions in First Quarter 2026

- QIHEC oversees and monitors the Quality Improvement Health Equity Transformation Program (QIHETP) Annual Work Plan
- In Quarter 1, 2026, QIHEC evaluated:
  - Subcommittee reports
  - CalOptima Health programs and business functions
  - Quality performance measures, including OneCare Star measures and Managed Care Accountability Set (MCAS) measures
  - National Committee for Quality Assurance (NCQA) Accreditation

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QIHEC Actions in First Quarter 2026

- QIHEC evaluated the following:
  - Quality oversight functions, including credentialing, potential quality issues (PQIs), credentialing of providers and facility site reviews (FSRs)
  - Performance Improvement Projects (PIPs)
  - Access and availability, including appointment availability and network adequacy
  - Member experience, including customer service performance, grievances and data from member experience surveys
  - Coordination of care

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QIHEC Actions: Program Oversight

- QIHEC reviewed and approved the following:
  - Meeting minutes from December 9, 2025, January 13, 2026, and February 19, 2026
  - 2026 QIHETP Description and Work Plan
  - 2026 Population Health Management Strategy
  - 2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description
  - Measurement Year 2026 Medi-Cal and OneCare Pay-for-Value Programs
  - 2025 QIHETP Evaluation

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QIHEC Actions: Program Oversight

- QIHEC reviewed and approved:
  - 2026 CalOptima Health Integrated Utilization Management/Case Management Program Description
  - 2025 Utilization Management Program Evaluation
- QIHEC accepted and filed the following items:
  - Reports on campaign outreach effectiveness and electronic health record (EHR) adoption
  - 2026 QIHETP Work Plan Quarter 1 Update
  - All subcommittee meeting minutes

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QIHEC Actions: Policy Review

- QIHEC reviewed and approved the following policies:
  - Policy GG.1618:Member Request for Medical Records

QIHEC Findings/Outcomes

- Alinea Mobile Mammography screened 251 members, with 64.5% receiving their first bilateral screening.
- CalOptima Health achieved NCQA Health Equity Accreditation in December 2025, with accreditation valid through December 2028.
- NCQA Health Plan Accreditation file review in Q1 of 2026 identified noncompliant files related to credentialing, and staff have implemented a remediation plan to address the issues.

NCQA = National Committee for Quality Assurance

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QIHEC Findings/Outcomes

- Data sharing with county partners improved behavioral health measures.
  - For Antipsychotic Medication Adherence (SSA/SAA), Medi-Cal reached 66.39% (+ 27.88%), and OneCare reached 78.72% (+ 5.96%)
  - For Follow-Up After ED Visit for Mental Illness (FUM), rates improved to 33.99% (7-day) and 53.02% (30-day), approaching the 30-day goal.
  - First Line Psychosocial Care for Children and Adolescents increased by 20.3 percentage points from Q3 to Q4, surpassing the work plan goal with a Q4 rate of 57.69%.

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QIHEC Findings/Outcomes

- To support medication adherence, staff conducted outreach to 13,136 pharmacies, providers, and members (3,435 unique members), and issued 17,733 interactive voice response (IVR) refill reminders.
- Sexual Orientation Gender Identity (SOGI) member data collection reached 3%, below the 10% goal.
- Diversity, Equity, and Inclusion (DEI) Training achieved 98.22% staff completion rate across three modules.

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QIHEC Findings/Outcomes

- Health Risk Assessment (HRA) completion reached 76% in 2025, meeting the 4-star cut point. 85% of members enrolled ≥4 months had a face-to-face provider visit.
- Annual Wellness Visit (AWV) completion increased from 35.1% (October) to 38.0% (December) through text/email campaigns and Optum outreach.
- The ED Support Program increased member outreach by 15.6% in Q4 2025.

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QIHEC Findings/Outcomes

- In 2025, the Health Education Program processed 5,856 referrals, conducted 27 virtual coaching sessions, and held 171 classes to 810 participants.
- In 2025, the Street Medicine Program exceeded goals by connecting:
  - 94% of unhoused participants to Enhanced Care Management (ECM)/Housing Navigation (goal 90%).
  - 95% of unhoused participants to a primary care provider (PCP) (goal 80%).

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QIHEC Actions: Sub-Committee Oversight

- QIHEC accepted and filed the following items:
  - UMC Meeting Minutes (12/18/25)
  - WCM CAC Meeting Minutes (11/18/2025)
  - PowerPoint Presentation Appendices for UMC Oversight, CPRC and Delegation Oversight

QIHEC Sub-Committee Report

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Subcommittee Actions in the First Quarter of 2026: Credentialing and Peer Review

- The committee met on 10/23/2025, 11/20/2025 and 12/18/2025, with closed session on 10/23/2025.
- Approved two policies, the credentialing clean/closure list and the potential quality issue (PQI) closure list.
- Reported three preventable provider conditions (PPC) to DHCS.
- Monitored four physicians on probation through the fair hearing process.
- Identified 3 providers on sanction lists, resulting in probation, citation, and reprimand.

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Subcommittee Actions in the First Quarter of 2026: Member Experience

- The committee met on January 27, 2026.
- 2024 Medi-Cal Network Adequacy Validation (NAV) Virtual Audit completed and closed.
- OneCare met all specialty time/distance requirements and bed capacity standards at the plan level; Identified gaps for Medi-Cal in several specialties and South Orange County.

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Subcommittee Actions in the First Quarter of 2026: Utilization Management

- The committee met on January 22, 2026.
- Approved the following documents:
  - 2026 Utilization Management Charter
  - 2026 UM Criteria & Hierarchy of Clinical Decision Making
  - 2026 Liberty Dental Medicare Criteria
  - 2025 UM Program Evaluation
  - 2026 UM/CM Integrated Program Description

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Subcommittee Actions in the First Quarter of 2026: Utilization Management

- Approved revisions to 4 utilization management and 19 pharmacy policies.
- Benefits Management Subcommittee (BMSC) reviewed 39 codes.
- Pharmacy and Therapeutics (P&T) Committee reviewed the Physician Administered Drug Prior Authorization list and 11 new drugs, where 9 new drugs were added to the OneCare formulary with prior authorization.

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Subcommittee Actions in the First Quarter of 2026: Whole Child Model (WCM) Clinical Advisory Committee (CAC)

- The committee met on February 17, 2026.
- Reviewed Q4 2025 network adequacy data, and coverage requirements were met for both the plan and network level.

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Quality Improvement Health Equity Committee (QIHEC) Purpose

- QIHEC provides overall direction for continuous quality improvement and health equity processes
- QIHEC oversees activities that are consistent with CalOptima Health's strategic goals and priorities
- QIHEC monitors compliance with regulatory and licensing requirements related to Quality Improvement and Health Equity (QIHE) projects and activities

QIHEC's Responsibilities

- Analyzes and evaluates the results of Quality Improvement and Health Equity (QIHE) activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees
- Institutes actions to address performance deficiencies, including policy recommendations; and
- Ensures appropriate follow-up of identified performance deficiencies

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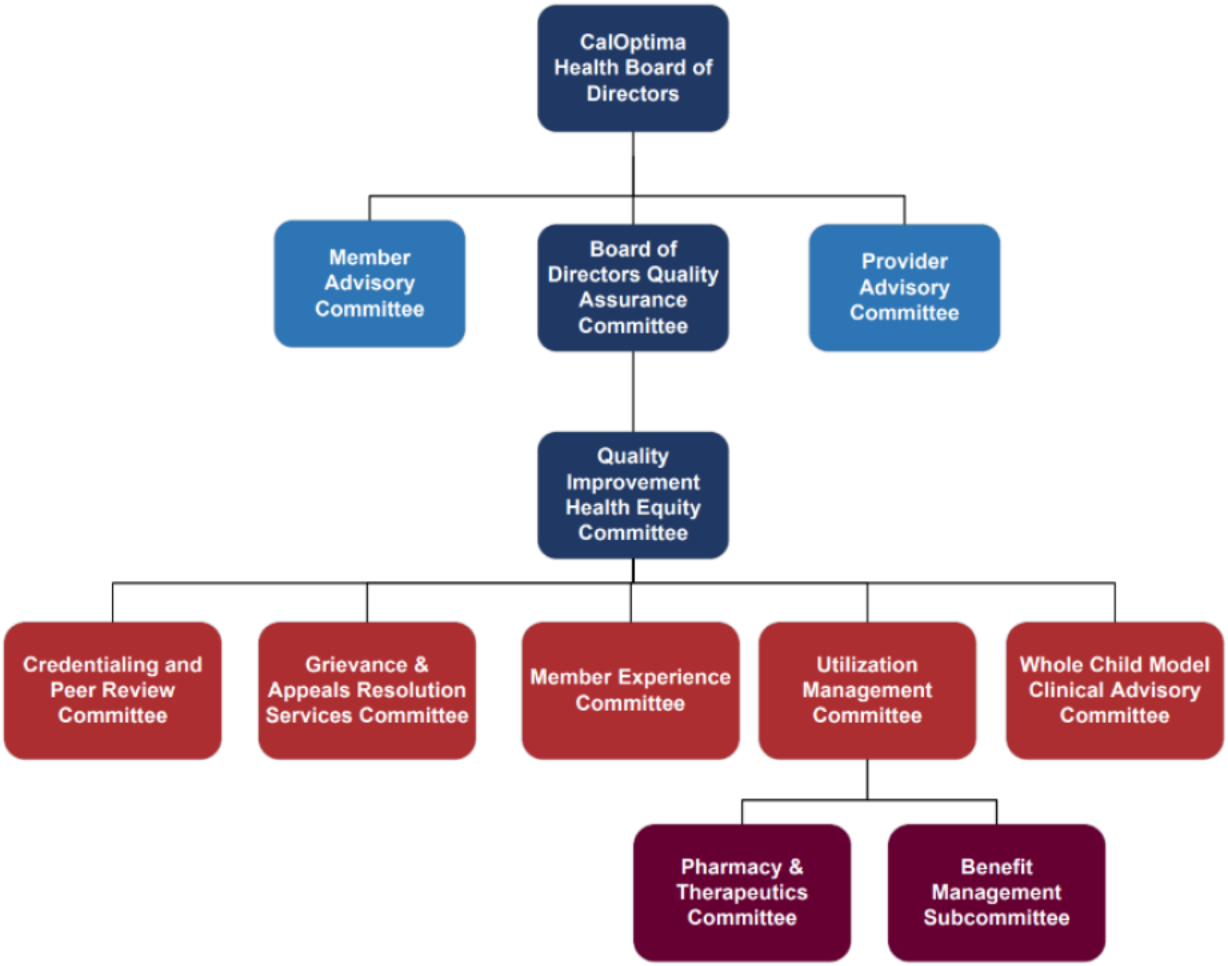
Quality Improvement and Health Equity Governance



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National Committee for Quality Assurance (NCQA) Health Plan Accreditation Update

Quality Assurance Committee

June 18, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

NCQA Health Plan Accreditation Medi-Cal

- CalOptima Health completed its most recent Health Plan Accreditation survey in April 2024 and will maintain accreditation through April 2027.
- Year One of the look-back period has been completed, and we remain on track.
- A credentialing compliance risk was identified during file review, as several delegate applications lacked required NCQA elements and complete documentation, creating potential exposure to Must-Pass non-compliance; the issue was mitigated through corrective action plans, validated file updates, and strengthened oversight to ensure continued adherence to credentialing standards.
- Next survey: April 6, 2027

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NCQA Health Plan Accreditation Covered California (Exchange Product)

- CalOptima Health **is required** to obtain NCQA Health Plan Accreditation (HPA) at least 90 days prior to the start of 2027 Open Enrollment
- Health Outcomes Accreditation (formerly Health Equity Accreditation) is **not required** for the Exchange product.
- CalOptima Health will pursue **Interim Health Plan Accreditation (HPA),** rather than an Initial (or First) survey, for 2027
  - Interim accreditation focuses on foundational structures, policies, and procedures rather than full evidence demonstration.
  - It uses the same standard set as Medi-Cal but covers approximately half the elements of an Initial survey.
  - Interim accreditation is valid for up to 18 months and requires a follow-up full review.
- Survey date: June 15, 2027

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APPENDIX

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NCQA Health Plan Accreditation Covered California (Exchange Product)

Action	Status	Date of Completion
Accreditation Workplan (Exchange QHP) developed for April 2027 submission	Completed	04/13/2026
NCQA Application: Formal application submission and application fee payment	Completed	04/21/2026
Workstreams Launch: Kick-off cross-functional workstreams to prepare for survey	Completed	04/27/2026
Initial Gap Analysis and Delegation Review: Compare current Medi-Cal processes to NCQA Exchange standards; validate delegated entities and required evidence	Completed	05/29/2026
Develop Workplan and Action Plans: Develop goals and action plans to close gaps	In-Progress	6/30/2026
Policy Revision: Update policies and procedures to meet Exchange Standards	In-Progress	8/31/2026

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Quality Assurance Committee

June 18, 2026

Kelli Glynn, Director Quality Initiatives, Quality Analytics

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To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

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Quality Improvement Strategy Update

Quality Improvement Strategy

Integrative Member Focus	Deploy a comprehensive, multimodal outreach strategy; tailor messaging based on primary drivers to noncompliance.
Data-Driven Strategy	Obtain and relay the most accurate and complete data possible through the deployment of Cozeva PayerOne and EMR integration.
Expand At-Home Services	Meet members where they are by offering at-home annual wellness visits and testing.
Facility Collaboration	Collaborate with radiology facilities to increase screening, obtain historical data, and complete member outreach.
Health Network Partnership	Deploy joint initiatives and offer Quality Improvement (QI) Grants to provide support for the implementation of QI activities.
Collaborative Provider Engagement	Improve performance and build deeper relationships through direct physician engagement with both PCPs and specialists.

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At-Home Programs

At-Home Quality Programs for Members

Program	Details	Target Population
Annual Wellness Visit (AWV)	• Comprehensive AWV • Point-of-care lab testing and other preventive services • Referral to providers/facilities for cancer screenings	CalOptima Health Community Network (CHCN) members due for an AWV with multiple quality care gaps
Diabetes	• HbA1c test via finger prick • Kidney health evaluation via urine collection	CHCN members due for the GSD and/or KED HEDIS measures*
Colorectal Cancer Screening	• Cologuard testing	CHCN members due for the COL HEDIS measure*

*GSD: Glycemic Status Assessment for Patients with Diabetes; KED: Kidney Health Evaluation for Patients with Diabetes; COL: Colorectal Cancer Screening

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At-Home Visit Program Results

Target Population:
OneCare CalOptima Health Community Network (CHCN) members due for an AWV with multiple quality care gaps

Timeframe:
1/1/2026 - 5/18/2026

2,219	806	94%
Total Eligible Members	**Home Visits Completed**	**Of Members Tested - HbA1c Result < 9** (123/131 Mbrs)

Reflects services completed between 1/1/2026 and 5/18/2026

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At-Home Diabetes Testing Program Results

Line of Business	Total Sent: HbA1c Kits	Response Rate	Total Sent: Kidney Health Evaluation Kits	Response Rate	Total Sent: Combo Kits*	Response Rate
Medicare	27	14.81%	425	8.94%	114	4.39%
Medi-Cal	134	2.24%	870	3.22%	1,368	2.27%
Total	161	4.35%	1,295	5.10%	1,482	2.43%

Results reflect services completed between 12/6/2025 and 5/19/2026; *combo kits include both HbA1c and kidney health evaluation tests

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At-Home Colorectal Cancer Screening Program Results

Line of Business	Cologuard Tests Distributed	Cologuard Tests Completed	Response Rate
Medicare	722	134	18.6%
Medi-Cal	14,348	1,625	11.3%
Total	15,070	1,759	11.7%

Results reflect services completed between 11/18/2025 and 5/26/2026

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Lessons Learned / Key Takeaways

- Re-confirm addresses prior to sending at-home lab kits to decrease volume of returned mail
- Wrap-around communication is key
  - Priming text prior to the initiative
    - We're working with <provider name> to offer you care from the comfort of your home. Look for a call soon from <provider phone number> to schedule an at-home wellness visit.
  - Follow-up reminder text
  - Follow-up phone call
- Include 'how to' videos with digital messaging

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Member Outreach Programs

Telephonic Outreach Program Results

- Our outbound telephonic outreach strategy utilizes a vendor to contact CalOptima Health members across all lines of business
- 19 HEDIS measures are addressed as part of these campaigns
- The results below reflect calls made in 2026:
  - Total members outreached: 99,280
  - Contact rate: 16.07% (15,955 / 99,280)

Reflects calls made from 1/1/2026 and 5/31/2026

Telephonic Outreach Program Results by Domain

Domain	Members Reached	Appointments Scheduled	Appointment Rate
Adult Preventive Care / Older Adult	24,940	15,038	60%
Cancer Prevention	12,170	7,794	64%
Child & Adolescent Health	445	215	48%
Chronic Disease Management	17,113	11,211	66%
Reproductive Health	30	8	27%
Total	**54,698**	**34,266**	**63%**

Reflects calls made from 1/1/2026 and 5/31/2026

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Unengaged Member Outreach

- CalOptima Health implemented a pilot to identify barriers for members that have not received primary care over a two-year period.
- The quality team outreached to members to assist with appointment scheduling.
- Members indicated as barriers: long appointment wait times, work conflicts, conflicting priorities with child's appointments, and lack of need since member felt healthy.
- CalOptima Health is using this info to refine outreach and reminders.

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Mobile Mammography

Mobile Mammography Summary

- Hosted 20 mobile clinic events from April 2025-May 2026
- 432 members screened thus far
- Recurring events with UCI and Camino Health
- Looking ahead:
  - 6 upcoming scheduled events
  - Expanding to PACE members
  - Focusing on the OneCare population to improve Stars performance
  - Conducting 1:1 telephonic outreach to providers with high non-compliant rates
  - Expand services to the Health Network level

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Quality Improvement Grant Program

Quality Improvement Grant Program

- Background: CalOptima Health reinvests unearned Pay for Value (P4V) funds by offering grant opportunities to Health Networks to support targeted quality improvement efforts.
- CalOptima Health will distribute Measure Year (MY) 2024 unearned P4V dollars through two grant rounds, allowing Health Networks to apply to target up to two Medi-Cal Managed Care Accountability Set (MCAS) measures and two OneCare Star measures.
- Round 1 concluded in April 2026; 5 Health Networks were awarded 8 grants at a total of $1,752,482.22.

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Quality Improvement Grant Program

Organization	Line of Business	Measures	Program
AltaMed Health Services	Medi-Cal	• Follow-Up After ED Visit for Mental Illness: 30 days • Follow-Up After ED Visit for Substance Abuse: 30 days	Outreach Coordinators will obtain discharge reports, initiate member outreach within 48 hours, assess barriers to care, provide education, and facilitate scheduling into appropriate follow-up services.
CHOC Health Alliance	Medi-Cal	• Prenatal and Postpartum Care: Postpartum Care • Postpartum Depression Screening and Follow Up	Engage eligible members through tailored events, sustained outreach, and expanded prenatal and postpartum services. Formalize relationships with high-volume OBGYN providers through targeted outreach, collaborative events, and educational forums.
Family Choice Health Services	Medi-Cal	• Controlling Blood Pressure • Glycemic Status Assessment for Patients with Diabetes	Multimodal outreach by Patient Engagement Coordinators and a Nurse Practitioner. Cozeva-driven identification of noncompliant members, with supplemental supports such as telehealth, in-home visits, and coordinated follow-up scheduling.
Family Choice Health Services	OneCare	• Care for Older Adults – Medication Review • Care for Older Adults – Functional Status Assessment	Multimodal outreach by Patient Engagement Coordinators and a Nurse Practitioner. In-home visits offered, and a Clinical Pharmacist will provide Medication Therapy Management for members with complex medication needs.

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Quality Improvement Grant Program

Organization	Line of Business	Measures	Program
HPN-Regal Medical Group	Medi-Cal	• Breast Cancer Screening • Colorectal Cancer Screening	Clinic-based and community-based approaches, including dedicated clinic days, in-home engagement, and use of a mobile mammography unit, to reduce barriers and increase completed screenings. To expand colorectal cancer screening access, members will be offered FIT kits and Cologuard through multiple channels such as mail distribution and clinic handouts.
HPN-Regal Medical Group	OneCare	• Controlling Blood Pressure	Offer dedicated blood pressure clinic days to obtain accurate in-clinic readings, complete standardized rechecks, and ensure all follow-up actions are fully documented in the electronic health record (EHR).
Optum	Medi-Cal	• Postpartum Depression Screening and Follow Up • Prenatal Depression Screening and Follow Up	Patient- and provider-focused outreach model to strengthen continuity of care and support maternal well-being. Funding will support essential staffing, outreach infrastructure, provider engagement, patient communications, and OB/GYN incentives.
Optum	OneCare	• Comprehensive Diabetes Care – Blood Sugar Controlled • Controlling Blood Pressure	Patient-outreach and provider-engagement model that will address care gaps, expand access to screenings, and strengthen continuity of care. Funding will support staffing, at-home HbA1c testing, community screening events, and home-health phlebotomy services.

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Cozeva PayerOne Software Solution

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Cozeva Strategy

- One system to view quality and risk care gaps at the point-of-care.
- Automatic bidirectional data exchange with Health Network partners for overlapping members.
- Providers can close gaps in real-time.
- Real-time measure computation.
- Automatic extraction of quality data elements for gap closure through electronic health record (EHR) integration.
- Calculate, present, and distribute provider incentive payments to encourage gap closure at the point of care.

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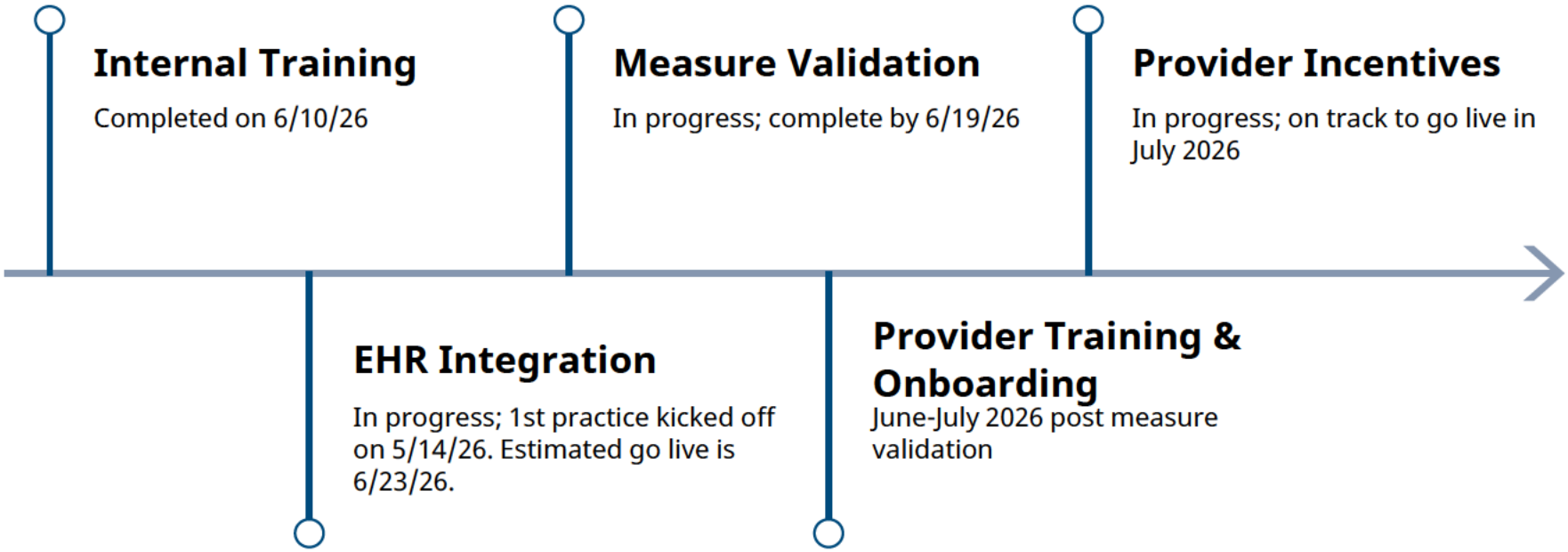
Cozeva Timeline



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MY 2026 CalOptima Health Community Network OneCare Primary Care Provider P4V Program

Star Measure	Amount Per Gap Closed
Breast Cancer Screening	$50
Colorectal Cancer Screening	$50
Care for Older Adults – Medication Review	$25
Care for Older Adults – Functional Status Assessment	$25
Osteoporosis Management in Women who had a Fracture	$25
Diabetes Care – Eye Exam	$25
Diabetes Care – Blood Sugar Controlled	$50
Kidney Health Evaluation for Patients with Diabetes	$25
Controlling Blood Pressure	$50
Statin Therapy for Patients with Cardiovascular Disease	$25
Transitions of Care: Medication Reconciliation	$25
Transitions of Care: Patient Engagement After Inpatient Discharge	$25
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	$50
Statin Use in Persons with Diabetes	$25

Per approval by the Board of Directors on November 13, 2025, staff will initiate a pilot PCP P4V Program with OneCare and subsequently add Medi-Cal.

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Member Grievances and Appeals Report First Quarter 2026

Quality Assurance Committee Meeting

June 18, 2026

Heather Sedillo, Grievance and Appeals Resolution Services (GARS), Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.

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Grievances

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Grievances Q1 2026 Summary

- Total grievance volume (Customer Service + GARS) decreased from 5,200 in Q4 to 4,925 in Q1.
- CCN remained the highest-volume Health Network, with top grievance drivers being Provider / Staff Attitude, Authorizations, and Plan Customer Service.
- In Q1, from the members with multiple grievances presented in Q4, there was a decrease of 61% of grievances submitted in Q1 from that group of members.
- Grievance category drivers in Q1 were Provider Services, Plan Customer Services, and Delay in Referral by Provider which was consistent with what we presented in Q4.
- Discrimination grievances increased, from 40 in Q4 to 50 in Q1.

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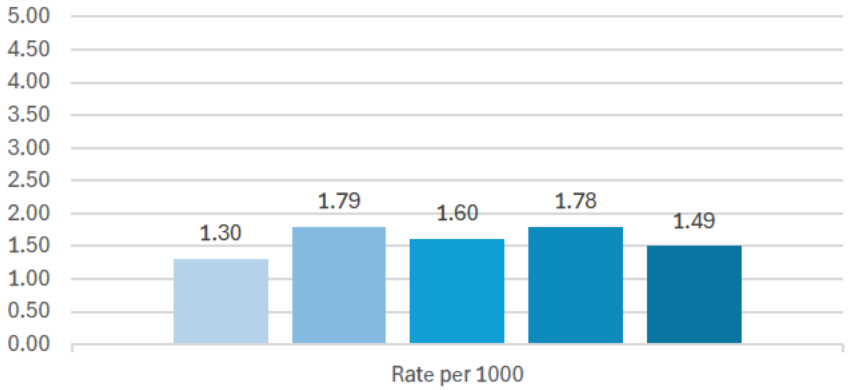
Grievance Volume by Line of Business (LOB)

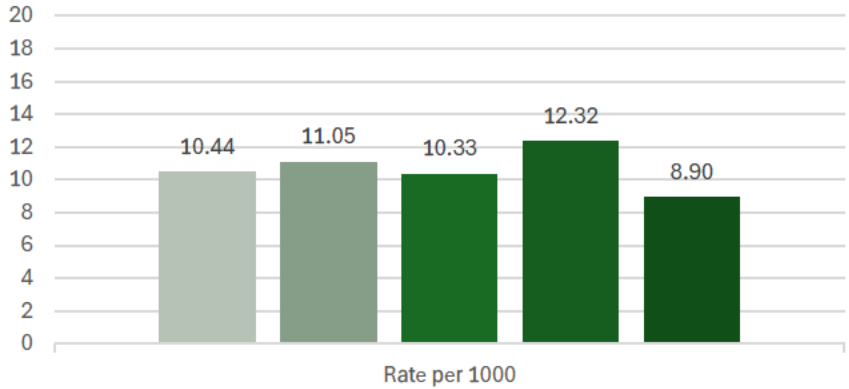
Medi-Cal
Rate per 1,000 Member Months



Total Grievances

Timeframe	Total Grievances
Q1 2026	4,023
Q4 2025	4,554
Q3 2025	4,781
Q2 2025	4,778
Q1 2025	3,958

OneCare
Rate per 1,000 Member Months



Total Grievances

Timeframe	Total Grievances
Q1 2026	902
Q4 2025	713
Q3 2025	643
Q2 2025	574
Q1 2025	552

Note: Totals on this slide include Customer Service and GARS data.

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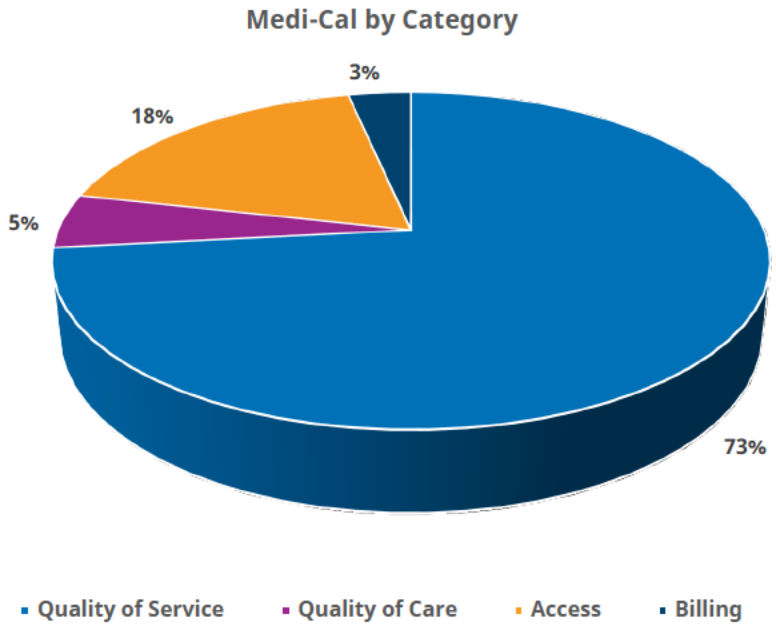
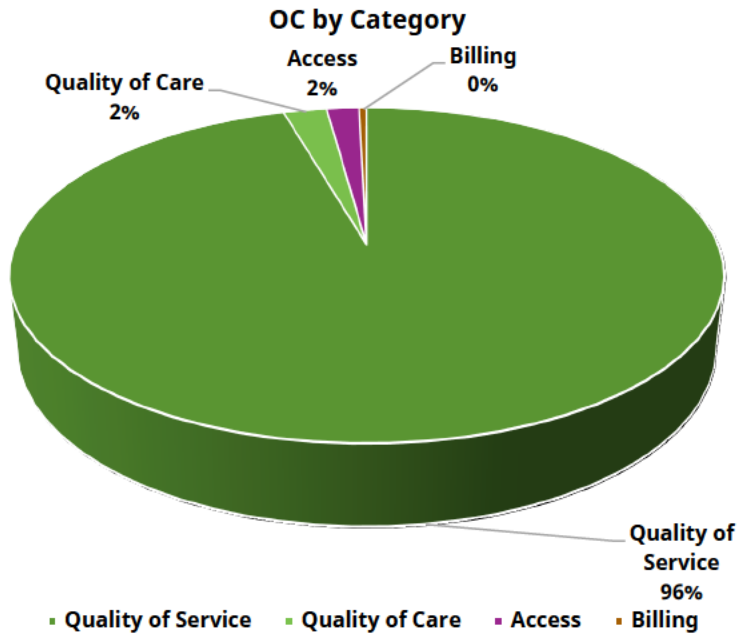
Medi-Cal and OneCare Q1 2026 Grievance Type by Category





Keynote:
The Nurse Specialist triage process continues to improve the identification of true Quality-of-Care cases, resulting in more accurate categorization and a quarter-over-quarter decline in QOC classifications.

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Grievance Trends for Q1 2026

Medi-Cal- Quality of Service

Trend	Percentage of Total Volume
Provider Services	19% (498)
Plan Customer Services	14% (358)
Delay in Referral by Provider	10% (271)

Medi-Cal- Access

Trend	Percentage of Total Volume
Appointment Availability	25% (160)
Telephone Accessibility	16% (101)
Delay in Referral Provider	10% (63)

OneCare- Quality of Service

Trend	Percentage of Total Volume
Transportation NMT	16% (76)
Provider Services	11% (53)
Gift Card Related	9% (44)

OneCare- Access

Trend	Percentage of Total Volume
Telephone Accessibility	33% (3)
Appointment Availability	33% (3)

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Actions Taken in Response to Trends

- Trends identified
  - Medi-Cal grievances about provider services.
  - OneCare grievances about transportation providers.

- Actions Taken
  - Collaborated with the Provider Action Workgroup to review providers with 10+ grievances; service issues included Telephone Accessibility, Appointment Availability, and Provider Staff. Provider Relations receives these reports for awareness and follow-up.
  - Ongoing collaboration with the transportation vendor through recurring meetings to address on-time performance, root causes, and strengthen monitoring. Members identified with multiple transportation-related grievances were added to escalation monitoring for enhanced oversight and timely service improvement.

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Appeals

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Appeals Q1 2026 Summary

- Medi-Cal and OneCare appeals volume decreased by 70 from Q4 to Q1, with 100% compliance and an average turnaround time (TAT) of 27 days for case closures.
- Top overturn reasons: Criteria met based on new information received during the appeal; Community-Based Provider/INN access standards were not met; and Plan-Directed Care guideline met.
- Medi-Cal and OneCare overturn rates increased from 25% to 36% and 24% to 43%, respectively.
- UM Provider appeals volume increased from 446 in Q4 to 452 in Q1. Genetic Lab appeals decreased from Q4, from 156 to 84. The overturn rate remained consistent with Q4 at 6%.
- External reviews (QIO, IRE, SFH) had low overturn rates, except for SNF continued-stay denial appeals (QIO). The leading reason for SNF overturns was that the member was deemed unsafe for discharge.

Reference Slides: 33-45

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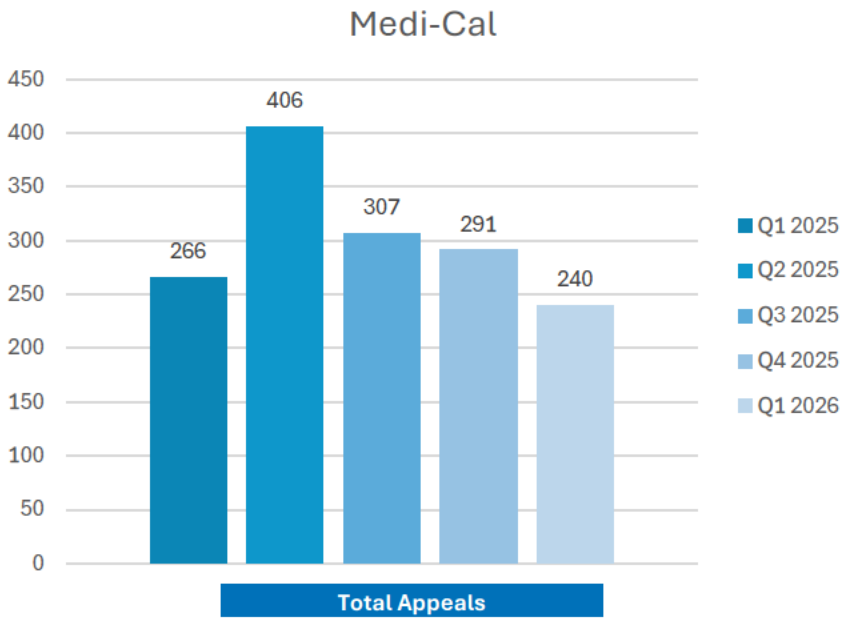
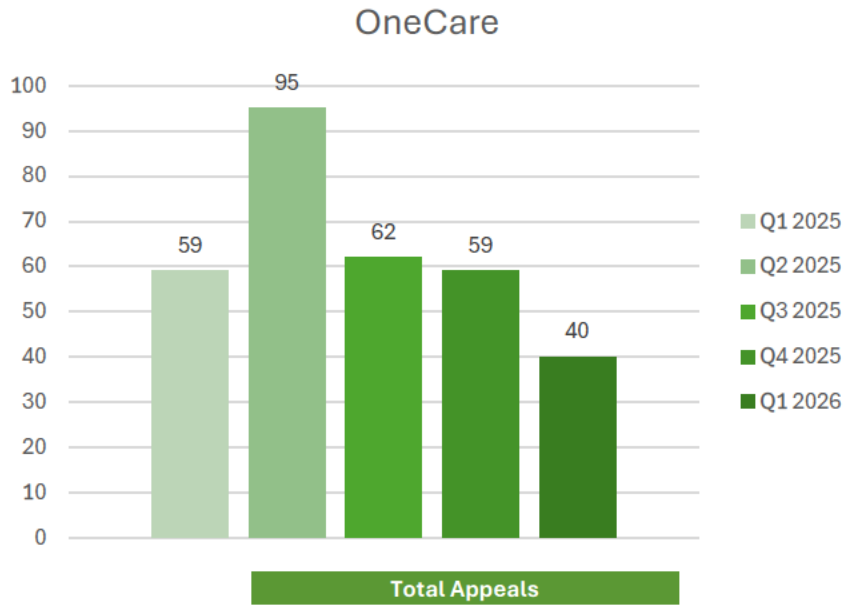
Appeals Volume by Line Of Business (LOB)



Q1 2026	240
Q4 2025	291
Q3 2025	307
Q2 2025	406
Q1 2025	266



Q1 2026	40
Q4 2025	59
Q3 2025	62
Q2 2025	95
Q1 2025	59

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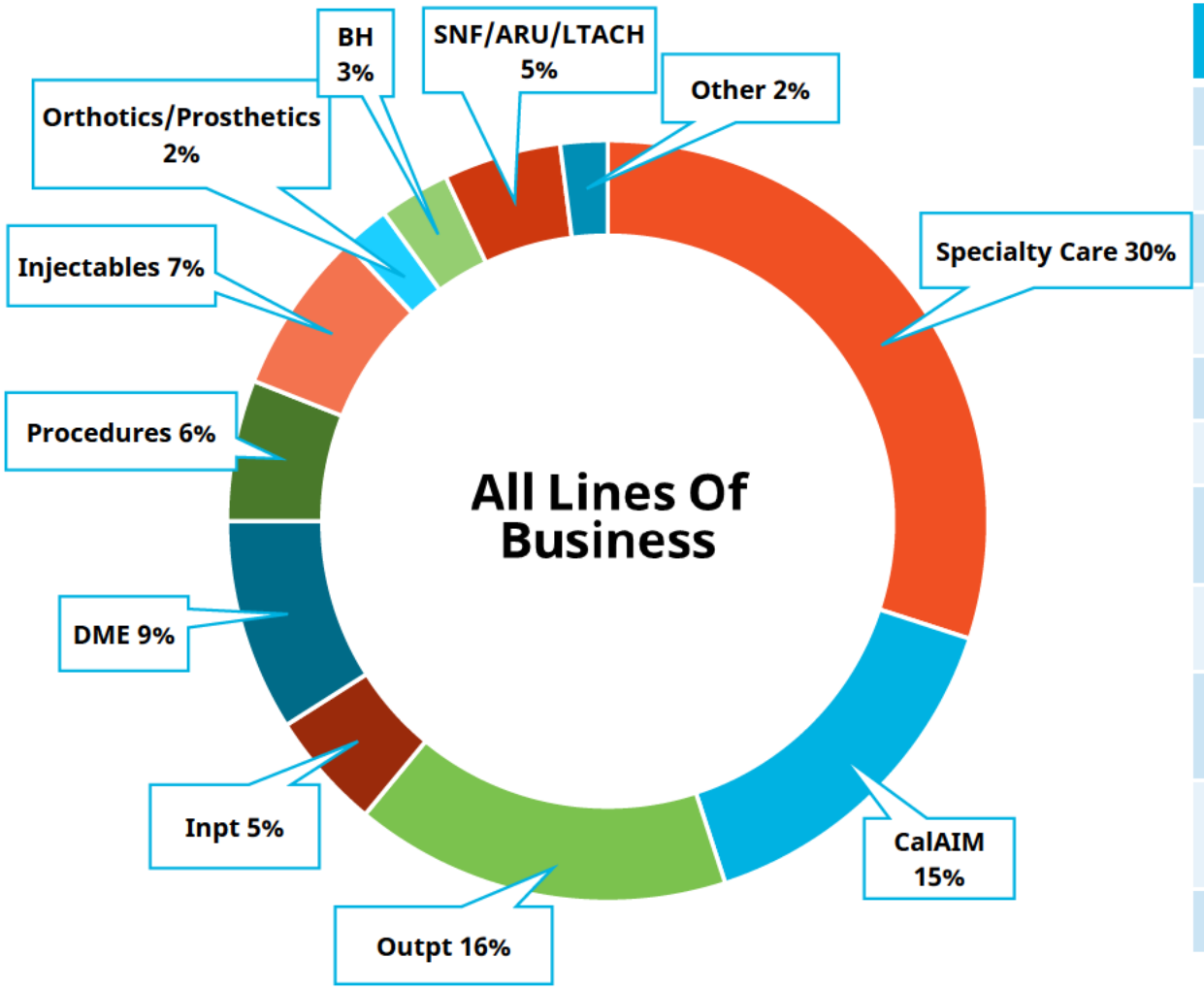
Member Appeals

All Lines of Business
Appealed Services



Services	Qty	%
Specialty care	81	30%
Outpatient	46	16%
CalAIM	42	15%
DME	25	9%
Injectables	20	7%
Procedures	18	6%
SNF/ARU/ LTACH	15	5%
Inpatient	13	5%
Behavioral Health (BH)	9	3%
Orthotics/ Prosthetics	6	2%
Other	5	2%

Keynote: In Q1, CalAIM appeals continued to decline and became the third most frequently appealed service among members. Specialty care appeals slightly increased from 72 to 81, while Outpatient appeals increased by 64% compared to Q4.

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Q1 2026 Appeals Trends

Medi-Cal Appeals

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
Specialty Care	27	44	71	38%
CalAIM	7	35	42	17%
Outpatient	16	19	35	46%

OneCare Appeals

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Outpatient Services	6	5	11	45%
Specialty Care	5	5	10	50%
Inpatient Services	8	2	10	20%

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Actions Taken in Response to Trends

- Trends identified
  - Requests for specialists or higher-level care are being redirected to in-network providers who cannot treat the condition or see the member in a timely manner based on their needs and access to care standards.
  - Post service inpatient hospitalization appeals from Non-Contracted Providers.

- Actions Taken
  - After an appeal is overturned, health networks receive the review criteria for educational purposes.
  - Network overturn trends are tracked and shared with the Delegation Oversight Medical Director during quarterly meetings with Health Network partners.
  - Education provided to Health Networks on the Post-Stabilization Authorization requirements.

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Utilization Management & Clinical Operations Updates: Q1 2026

Quality Assurance Committee

June 18, 2026

Kelly Giardina, Executive Director, Clinical Operations

Dr. Robin Hatam, Medical Director

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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.

Agenda

- Utilization Management Timeliness
- UM Program Performance: Utilization Outcomes & Sub Workgroup Updates
- Health Network Clinical Oversight
- Emergency Department Support
- Transitional Care Services
- New Clinical Initiatives

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Utilization Management Turnaround Time Compliance

Kelly Giardina, Executive Director, Clinical Operations

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior authorization turnaround time compliance for prospective routine and urgent and retrospective cases remained complaint at or above 95% for the reporting period.

Prior Authorization Turnaround Time Compliance (TAT) Q2 2025 – Q1 2026 (CCN/COD)

Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2025	95%	Q2	April	99.9% ▲	99.9% ▲	99.1% ▲
			May	99.9% ▲	99.8% ▲	99.7% ▲
			June	100.0% ▲	100.0% ▲	100.0% ▲
	95%	Q3	July	100.0% ▲	99.9% ▲	99.9% ▲
			Aug	99.9% ▲	99.9% ▲	100.0% ▲
			Sept	99.9% ▲	99.9% ▲	100.0% ▲
	95%	Q4	Oct	99.9% ▲	99.8% ▲	100.0% ▲
			Nov	100.0% ▲	99.9% ▲	99.8% ▲
			Dec	99.9% ▲	99.9% ▲	100.0% ▲
2026	95%	Q1	Jan	99.9% ▲	99.9% ▲	100.0% ▲
			Feb	100.0% ▲	99.9% ▲	99.9% ▲
			March	99.9% ▲	99.9% ▲	100.0% ▲

▼ ▲ Denotes comparison to goal

Source: Authorization Inventory Tableau Data Q2 2025 – Q1 2026. Data pulled 5/11/2026

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Inpatient Turn Around Time – Medi-Cal and OneCare

Inpatient urgent concurrent review and retro post service turnaround time remained compliant at 95% or higher throughout the reporting period.

Inpatient Turnaround Time Compliance (TAT) Q2 2025 – Q1 2026 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2025	95%	Q2	April	97.8% ▲	96.8% ▲
			May	97.3% ▲	98.8% ▲
			June	98.2% ▲	100.0% ▲
	95%	Q3	July	97.9% ▲	98.7% ▲
			Aug	99.0% ▲	100.0% ▲
			Sept	98.5% ▲	100.0% ▲
	95%	Q4	Oct	98.6% ▲	100.0% ▲
			Nov	97.8% ▲	98.3% ▲
			Dec	98.2% ▲	98.8% ▲
2026	95%	Q1	Jan	99.0% ▲	100.0% ▲
			Feb	99.3% ▲	98.6% ▲
			March	99.2% ▲	100.0% ▲

▲▼ Denotes comparison to goal

Source: Authorization Inventory Tableau Data Q2 2025-Q1 2026. Data pulled 5/11/2026

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LTSS Turn Around Time
Q2 2025 – Q1 2026

CBAS Turnaround Time (TAT) Determination Completed within 7 Calendar Days			
Year	**Goal**	**Quarter**	**TAT Compliance Rate**
2025	95%	Q2	100.0% ▲
	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲
2026	95%	Q1	89.6% ▼

CBAS Inquiry to Determination Completed within 30 Days			
Year	**Goal**	**Quarter**	**TAT Compliance Rate**
2025	95%	Q2	100.0% ▲
	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲
2026	95%	Q1	98.4% ▲

CalAIM Turnaround Time Compliance (TAT)				
Year	**Goal**	**Quarter**	**Routine**	**Expedited**
2025	95%	Q2	99.3% ▲	97.0% ▲
	95%	Q3	99.1% ▲	100.0% ▲
	95%	Q4	99.5% ▲	93.6% ▼
2026	95%	Q1	99.1% ▲	95.8% ▲

▲▼	Denotes comparison to goal

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LTSS Turn Around Time Continued
Q2 2025 – Q1 2026

New for 2026, presenting LTC by service

LTC Turnaround Time (TAT) Determination Completed within 7 Calendar Days				
Year	**Goal**	**Quarter**	**LTC Service**	**TAT Compliance Rate**
2025	95%	Q2	LTC	99.4% ▲
	95%	Q3	LTC	99.4% ▲
	95%	Q4	LTC	99.6% ▲
2026	95%	Q1	Skilled Nursing Facility & Intermediate Care Facility Services	99.8% ▲
			Subacute	99.5% ▲
			ICF/DD	100.0% ▲

▲▼ **Denotes comparison to goal**

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UM Program Performance: Utilization Outcomes & Sub-Workgroup updates

Dr. Robin Hatam, Medical Director

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To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

Data Trends and Findings from UMC | Utilization

Data as of Q4 2025 ,CCN/COD only; LTAC and Acute Rehab excluded, MC excludes Duals/WCM

Metric	Medi-Cal Adult 18+		Medi-Cal Peds Non-WCM		SPD		LTC		OneCare		WCM	
	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual
ALOS	114.9	122.0 ▼	29.1	28.7 ▲	241.5	252.1 ▼	583.2	804.6 ▼	261.5	260.1 ▲	N/A	272.8
Admit PTMPY	4.3	4.5 ▼	12.2	11.2 ▲	5.7	6.3 ▼	7.8	8.3 ▼	5.5	5.4 ▲	N/A	9.3
Days PTMPY	515.9	551.1 ▼	374.7	321.1 ▲	1,438.7	1,598.0 ▼	4,501.1	6,659.0 ▼	1,520.3	1,391.8 ▲	N/A	2,529.0
Readmit %	16.4%	18.2% ▼	2.2%	0.0% ▲	21.6%	24.4% ▼	23.3%	20.0% ▲	14.6%	21.0% ▼	N/A	1.7%
ED util. PTMPY	499.7	503.9 ▼	382.8	389.8 ▼	642.9	644.0 ▼	271.3	388.4 ▼	549.7	631.6 ▼	653.9	736.5 ▼
Membership (Q4)	122,410		28,783		12,581		289		3,983		1,027	

▲▼ **Denotes comparison to goal**

Note: Goals reflect revised targets for 2026

Source: Membership and Utilization Trends dashboard data as of 5/8/2026, pulled 5/26/2026

CalOptima Health

Q1 2026: Sub Workgroup Updates

Over/Under Utilization	• Emergency Department Dashboard Review and Analysis: Goal: current ED utilization trends and prioritize targeted interventions.
	• Focused enhancements to strengthen the review and documentation standards for the following:
	  • Varicose Vein Case File Reviews
	  • Opioid Utilization & Safety Reviews
	  • Lumbar MRI Case File Reviews
	  • Home Health Utilization Reviews

High-Risk Management	• Review of January 2026 Population Health Management (PHM) Policy Guide • First submission to DHCS: PHM Key Performance Indicators • Transitional Care Services resource flyers to Health Network & facility partners to support awareness and engagement. • OC Urgent Care Post-Discharge Clinic expanded to all discharges and all of their clinics.
EPSDT	• Launched Health Network EPSDT annual audit • Behavioral Health Dashboard completed • A biannual texting campaign was established for overdue dental, hearing, and vision screenings

CalOptima Health

Q1 2026: Sub Workgroup Updates

Skilled Nursing Facility (SNF)	• SNF Pilot with Southern California Hospital Network (SCHN) launched March 15th • Skilled Nursing Facility Performance Metrics Reporting in development with a focus on readmissions • SNF Appeals Documentation Process Improvement- template development for use by UM and Medical Directors

Population Health Management (PHM)	• PHM Key Performance Indicators were submitted to DHCS on January 30, 2026. CalOptima Health performed better than average in several key areas:
	  • Complex Case Management Enrollment: 68.6%
	  • Care Management After Discharge: 27.7%
	  • Members Using the ED More Than PCP: 4.6%

Potential Quality Issue Outcomes: UM

The number of Potential Quality Issues (PQI) related to authorizations dropped in Q1 2026 as compared to Q2 2025. The increase in Q2 2025 was due to authorizations for Behavioral Health, which has since declined. Three of the PQIs in Q1 2026 were leveled as quality-of-care; ten were leveled as quality-of-service.

Sub-Category	Q2 2025	Q3 2025	Q4 2025	Q1 2026
Authorization denial or delayed	21	10	4	3
Authorization issues - delayed or incomplete (BH)	0	0	0	0
Authorization issues - Medical records or documentation (BH)	0	0	2	0
Delay of service	0	2	0	0
Failure to notify the member of the referral	0	0	1	0
Failure to refer	6	4	4	4
Failure to submit referral timely	5	3	0	6
Referral submitted to wrong specialist or specialty	6	2	0	0
TOTAL	38	21	11	13

CalOptima Health

Health Network Clinical Oversight

Dr. Robin Hatam, Medical Director

Health Network Clinical Oversight

- **Enhanced oversight through the Delegation Oversight performance dashboard** and a structured audit and monitoring program, resulting in improved compliance and operational performance across delegated health networks.

- **Streamlined CAP escalation processes** by formalizing internal and delegate procedures, tightening follow-up and enforcement, and accelerating CAP closure timelines.

- **Covered CA Pre-Delegation Readiness Assessments launched** in June for all CCA delegates, supported by newly developed audit tools aligned with commercial LOB regulatory requirements.

CalOptima Health

Emergency Department Support

Dr. Robin Hatam, Medical Director

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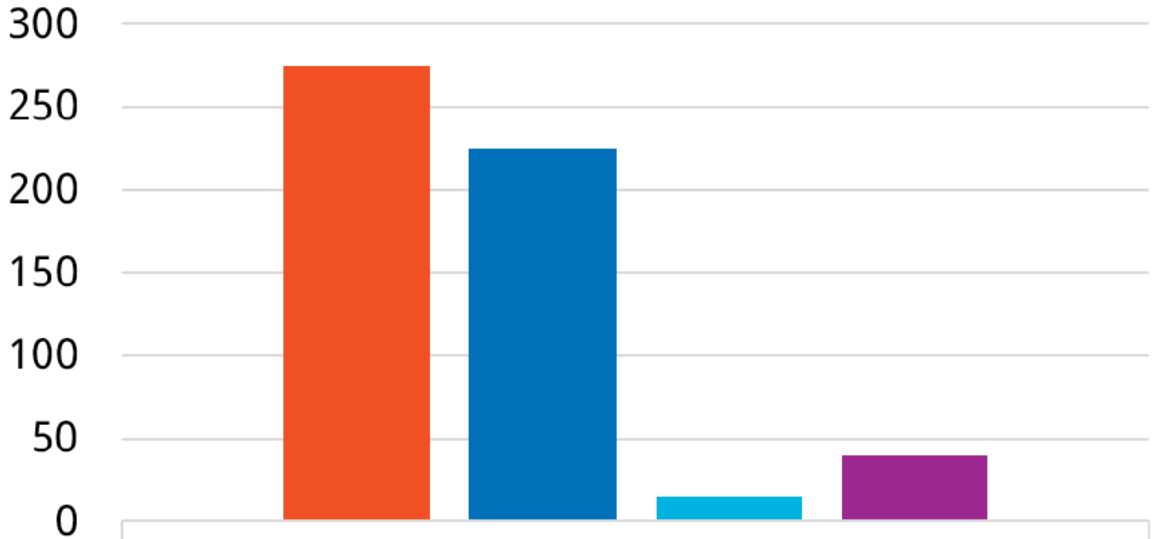
Emergency Department Support: Embedded Social Worker

2026 ED PROGRAM ENGAGEMENT



	Q1 2026
Total Members Engaged	275
Recup Care Support	225
Referrals	15
Handoffs	40

Source: Manually tracked

Emergency Department Support

Referrals include:

- Community Supports
- Disease Management
- Transitional Care Services
- Case Management and Enhanced Case Management (ECM)

Program Enhancements

- Expanded support to include hospital and recuperative care provider for recoup bed day information.
- OneCare FMC follow-up
  - Outreach to members while in ED for post-discharge follow-up appt with PCP or OC Urgent Care.

CalOptima Health

Transitional Care Services (TCS)

Kelly Giardina, Executive Director Clinical Operations

DHCS: TCS Key Performance Indicators

- Case Management for High-Risk Members after discharge
  - % of high-risk member transitions with at least one care manager interaction within 7 days post-discharge.
- **Goal:** Increase successful interactions for TCS high-risk members within 7 day of discharge by 10%

Successful interactions for TCS high-risk members within 7 day of discharge			
Year	**Goal**	**Quarter**	**TCS Engagement**
2026	Baseline Performance	Q4 2025	27.66%

DHCS report date: 1/31/2026. Measurement period 10/1/2024-09/30/2025

New Clinical Initiatives

Kelly Giardina, Executive Director Clinical Operations

Supporting Hospital-SNF Transitions

Southern California Hospitalist Network (SCHN) program pilot

- Launched March 16, 2026.
- CCN Medi-Cal and OneCare members
- 19 Participating SNF's

- Benefits:
  - Strengthens medical oversight
  - Improving care coordination
  - Enhancing quality of documentation
  - Supporting compliance and improved clinical outcomes.

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Orange County Urgent Care Support: Post-Discharge Follow-Up

- Schedule post-discharge appointments when members are unable to see their PCP within 7 days.
- Functions as a gap visit to ensure timely follow-up care.
- Dedicated liaison and number to call.
  - Operates 7 days a week from 8am to 8pm.
- Target population for this appointment option is CCN OneCare and CCN Medi-Cal patients.
- Appointments can be scheduled at the OC Urgent Care ***location nearest to the member***. The available locations are:

Anaheim	Foothill Ranch
Garden Grove	Huntington Beach
Lake Forest	Mission Viejo
Santa Ana	

CalOptima Health

New Disease Management Intervention: TeleMed2U

- Contracted with **TeleMed2U** for expanded specialty access via telehealth, starting with OneCare CHCN:
  - Endocrinology
  - Rheumatology
  - Urology
  - Neurology
- Endocrinology pilot initiated with **158 OneCare** CHCN members with **diabetes and A1c ≥9%**
  - As of 5/21/2026, **38 appointments completed (21 initial)**; 9 cancelled; 8 no-show
  - Average Baseline A1c 10.6%; 70% Female; 75% Spanish Speaking

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Data from April 1, 2026 – May 21, 2026

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Whole Child Model (WCM) Age Out Transition-PCP Incentive Pilot

Quality Assurance Committee

June 18, 2026

Kelly Giardina, Executive Director, Clinical Operations

Michael Gomez, Executive Director, Network Operations

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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.

Whole Child Model (WCM) Age Out Transition: Three-Year PCP Incentive Pilot

- CalOptima Health is recommending a three-year, performance-based incentive pilot (pending board approval) designed to improve continuity and reduce care disruptions for CCS/WCM members transitioning into the adult system, while boosting provider engagement and addressing system barriers.

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Critical System Barriers

California Children's Services (CCS) members age out of the Whole Child Model (WCM)at age 21. CalOptima Health has adopted early planning, beginning at age 14, but the shift to adult care continues to present challenges for our members:

- Adult system fragmentation creates barriers to seamless care. Members lose long-standing pediatric PCPs, specialists, and DME vendors during the transition.
- Adult PCPs often lack readiness and competency to establish care for the transition of complex needs. Members' biopsychosocial complexity further complicates transitions.
- Pediatric providers must develop transition plans with limited adult-care options and resources.

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CCS/WCM Age-Out Impact

Health Network	# of total WCM Eligible Members as of March 2026	# of total newly eligible WCM members as of March 2026	# 19-21 Year Old WCM members
CalOptima Health (All Health Networks)	8,914	190	1,105
CalOptima Community Network	1,023	65	195
HPN - Regal	38	2	7
Optum Care Network	742	9	129
Prospect Medical Group, Inc.	99	1	21
AltaMed Health Services	347	12	53
Family Choice Health Network	144	1	16
Rady's/ CHOC Health Alliance	6,040	91	605
AMVI Care Health Network	80	0	10
Noble Mid-Orange County	130	5	27
Providence	108	0	11
United Care Medical Group	163	4	31

PCP Incentive Pilot Philosophy

- Targeted incentive-supported activities are started ~six months prior to transition age 21.
- The model incorporates warm handoffs, ICT coordination, and family engagement to support continuity of care.
- Emphasizes a proactive, structured, and coordinated transition approach.
- Pilot to be launched with accompanying Member and Provider Standardized transition playbook

CalOptima Health

Financial Foundation & Incentive Model

- Primary Care Providers currently receive payment through annual capitation rebasing and existing funding structures.
- This pilot introduces targeted performance-based payment enhancements for coordination activities rather than changes to underlying rates.
- The pilot directly incentivizes providers for high-touch coordination and communication while reinforcing accountability and quality performance.

CalOptima Health

Focused Incentives on High-Impact Activities

- **PCP Acceptance (G9001):** Supports adult PCP engagement in accepting members with complex transition needs.
- **Care Coordination / ICT (99367):** Reinforces multidisciplinary care coordination and transition planning.
- **Specialist Transition Completion (G9002):** Promotes successful transition and continuity of specialty care services.
- Incentives are designed to strengthen key transition activities and reduce care disruption risks.

CalOptima Health

Provider Partnership & Care Impact of Pilot

- Incentive payment potential up to 243% of Medicare-equivalent value in high-performance scenarios.
- Estimated enhanced payment ranges from $781–$1,491 per member.
- Approximately $3M dedicated to provider partnership over three years.
- Expected outcomes: Reduction in ED utilization/unnecessary hospitalization rates, improved access and member satisfaction.
- Strengthens PCP capacity while advancing quality access and cost stewardship goals.

CalOptima Health

Strategic Value Summary

- Expands upon existing provider support infrastructure.
- Adds meaningful performance-based incentive alignment.
- Advances care coordination, quality performance, and member outcomes.
- Creates strong clinical value while supporting value optimization goals.

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Board of Directors'

Quality Assurance Committee Meeting

June 18, 2026

Quality Improvement Health Equity Committee (QIHEC) First Quarter 2026 Report

QIHEC Summary	
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer
Reporting Period	Quarter 1, 2026
QIHEC Meeting Dates	January 13, 2026, February 10, 2026, March 10, 2026

January 13, 2026, QIHEC Meeting

Compliance: No compliance issues were reported.

Review/Approval of December 9, 2025, Meeting Minutes: The committee reviewed and approved the meeting minutes.

Conflict of Interest (COI) & Confidentiality: The committee collected the required Annual Conflict of Interest and Confidentiality forms. Staff confirmed full compliance and identified no conflicts.

Chief Medical Officer (CMO) Update: The CMO emphasized a 2026 organizational priority to improve diabetes outcomes, particularly through increased use of glucagon-like peptide 1 (GLP-1) medications. The update highlighted evidence of improved A1c control, reductions in diabetes related complications, and cardiovascular and metabolic benefits. Staff also discussed access challenges and the expectation that a lower-cost oral GLP 1 formulation may improve availability. A demonstration project for prior authorization is planned for June to streamline access.

Old Business: Point-of-Care Self-Collection for Cervical Cancer Screening (CCS) & Alinea Mobile Mammography for Breast Cancer Screening (BCS): Staff provided updates on point-of-care self-collection for cervical cancer screening and on efforts to strengthen reporting for mobile mammography. A total of 251 members received mobile mammography through Alinea, and 64.5% had no prior screening mammogram on record, demonstrating the program's reach to first-time participants.

National Committee for Quality Assurance (NCQA) Accreditation Updates: CalOptima Health achieved Health Equity Accreditation with a score of 100%, valid through December 2028. Staff outlined the transition to the new Health Outcomes Accreditation program and described ongoing staff training. While Year One deliverables are on track, remediation activities are underway to address risks associated with untimely

January 13, 2026, QIHEC Meeting

denials, incomplete appeals, and missing credentialing elements. The committee asked how many CalOptima Health providers use Electronic Medical Records (EMR) and if that would improve accreditation performance. Staff reported that 20% of providers continue to use paper charts; to improve data accuracy, CalOptima Health will offer a $1,000 incentive to support EMR adoption.

2026 Quality Improvement Health Equity Transformation Program (QIHETP) Description and Work Plan: The committee reviewed and approved the 2026 QIHETP Description and Work Plan, which includes HEDIS Medicaid/Medicare goals, Population Health Management (PHM) Strategy, Culturally and Linguistically Appropriate Services (CLAS) Program, and Pay-for-Value programs. Updates include aligning with the 2025 Comprehensive Quality Strategy, incorporating Covered California requirements, launching the Behavioral Health Integration Pay-for-Value Program, and updating the organizational structure to strengthen quality oversight. Goals include meeting or exceeding the Medi-Cal Managed Care Accountability Set (MCAS) minimum performance levels, maintaining accreditations, improving Health Plan Ratings (HPR), and achieving operational readiness for Covered California by January 1, 2027.

Population Health Management (PHM) Strategy and Work Plan: Integrated with the QIHETP and Work Plan, the PHM strategy focuses on prevention, emerging risk, patient safety, and support for members with chronic conditions. Initiatives include the "Keeping Children Healthy" campaign, well-child visits, maternal health, expanding disease management services, and emergency department programs.

Culturally and Linguistically Appropriate Services (CLAS) Program: Integrated with the QIHETP and Work Plan, the CLAS Program focuses on strengthening demographic data collection for members and providers, including disability, accommodations, and military status.

Behavioral Health Quality Measures: Staff reported improvements at the measure level and described barriers to data capture, coding, and provider engagement.

- Antipsychotic Metabolic Monitoring improved to 33.43% but remained below the 37.93% minimum performance level. Staff continue to focus on data sharing.
- Depression Screening and Follow Up improved modestly, with continued data ingestion and coding challenges.
- Antipsychotic Medication Adherence increased substantially across Medi-Cal and OneCare populations, Medi-Cal reached 66.39% (up 27.88%), and OneCare reached 78.72% (up 5.96%), supported by expanded data exchange with the county.
- Diabetes Screening for members with serious mental illness improved but remains below target ranges.
- Follow-Up After Emergency Department (ED) Visit and Follow Up After Hospitalization for mental illness both improved year over year, though gaps remain relative to minimum performance levels.
- First-Line Psychosocial Care for Children and Adolescents increased by 20.3 percentage points from Q3 to Q4, surpassing the work plan goal with a Q4 rate of 57.69%.
- Pharmacy for Opioid Use Disorder improved slightly but continues to face member engagement and system barriers.

January 13, 2026, QIHEC Meeting

DHCS BH Performance Improvement Project (PIP): The PIP aims to increase case-management enrollment after ED visits for specialty mental health (SMH)/substance abuse disorder (SUD), moving from a 1.08% baseline to 2.32% and meeting the goal for the remeasurement period; the second remeasurement was submitted and awaits DHCS feedback, with barriers including data timeliness, protected health information (PHI)-sharing constraints, and difficulty engaging members.

Maternal & Child Health: The Maternal Health Program continues to expand outreach, provide standardized assessments, and coordinate care with community resources. Planned improvements include enhanced risk stratification, postpartum text campaigns, expansion of doula services, and provider education to increase participation in the Comprehensive Perinatal Services Program. 2026 enhancements include aligning with DHCS Omnibus All Plan Letter (APL) and Transitions of Care (TCS), updating the risk stratification model, reestablishing a cross-department maternal health workgroup, and developing a dashboard to monitor risk and interventions.

Medication Management and Adherence: Medication adherence improved across diabetes, hypertension, and statin therapy. Staff completed more than 13,000 outreach calls, including refill reminders, and engaged 3,435 unique members. The organization is working with provider networks to increase 100-day supplies and expand pharmacist-supported refill processes. Medi-Cal performance on avoiding inappropriate antibiotics remains below benchmarks for both acute bronchitis/bronchiolitis and pharyngitis, and staff are implementing education and targeted outreach to high-prescribing providers. OneCare medication adherence trends are improving, with diabetes and hypertension adherence increasing by 1.6% and statin adherence increasing by 2.4%. Current projections show diabetes medication adherence trending toward a four-star rating, while hypertension and statin adherence remain at two stars, with statins potentially receiving a "significant improvement" adjustment.

Network Cultural Responsiveness: Member Demographic Data: The 2025 Sexual Orientation and Gender Identity (SOGI) survey goal of collecting 10% of member SOGI data was not met, with 286,334 surveys offered and 8,690 completed (a 3% response rate). Barriers included reluctance to share personal information and survey fatigue. Low response rates for SOGI and demographic surveys.

Language Services: Cultural & Linguistics and Accessibility: Russian was added as a threshold language in August 2025, and efforts continued to expand interpreter and translation services. Supported by a full-time translator and averaging 360 translations per quarter since Q3, alongside high Spanish and Vietnamese volumes. Translation services have increased, and interpreter services have slightly decreased in the last quarter.

Experience with Language Services: A member survey mailed to 32,480 recipients yielded 1,883 responses (6% response rate) with high satisfaction, while a staff survey yielded 73 responses out of 1,645 (4% response rate), indicating a need to strengthen engagement. Member and staff satisfaction surveys indicated high satisfaction but low response rates, prompting planned improvements in survey engagement. Planned

January 13, 2026, QIHEC Meeting

strategies include leadership-led promotion, staff education on the importance of surveys, concise member surveys focused on improvements, and text reminders to increase response rates.

Diversity, Equity, and Inclusion (DEI) Training: Staff achieved a 98.22% completion rate for three new training modules. Provider completion is underway and will continue through December 31, 2026. DHCS draft language updates in January 2026, with final revisions expected in Q2 2026.

Comprehensive Community Cancer Screening Program (CCCSP): No updates were reported for CCCSP at this meeting but was kept on the agenda item for visibility and announcement of updates in the next quarter.

Open Discussion:

- Attendance requirements and 2026 QIHEC meeting schedule were reviewed.

Items Approved by QIHEC

- Approval of December 2025 QIHEC meeting minutes.
- 2026 QIHETP Description and Work Plan
- 2026 Population Health Management Strategy
- 2026 CLAS Program Description
- Measurement Year 2026 Medi-Cal and OneCare Pay-for-Value Programs

Items Accepted & Filed

- Appendix: NCQA Accreditation
- Reports on campaign outreach effectiveness and EHR adoption

February 10, 2026, Meeting

Compliance: No compliance issues reported.

Review/Approval of January 13, 2025, Meeting Minutes: The committee reviewed and approved the meeting minutes.

Chief Medical Officer Update: The Chief Medical Officer emphasized the importance of vaccination amid a regional measles outbreak and reinforced providers' roles in vaccine advocacy.

2026 Quality Improvement Health Equity Transformation Program (QIHETP) Description Update: The committee approved an addition to the QIHETP appendix, a list of positions and job descriptions supporting the QIHETP.

2025 Quality Improvement Health Equity Transformation Program (QIHETP) Evaluation (including PHM & CLAS Evaluations): The committee approved the evaluation of the 2025 QIHETP, including the PHM and CLAS evaluations. Accomplishments included approval to participate in Covered California, expansion of Street Medicine services, major outreach investments, onboarding of a new health network, and attainment of NCQA Health Outcomes Accreditation. The organization met two of seven priority goals: closing the maternity care disparity for Black members and exceeding the 50th percentile for all children's

February 10, 2026, Meeting

preventive care measures. Medi-Cal met 15 of 18 MCAS measures and achieved 100% of quality withhold dollars. OneCare achieved a 3-Star overall rating with strong clinical performance. Recommendations for 2026 focus on expanding at-home care (visits and labs), improving demographic and quality data infrastructure (including disability and veteran/military status), enhancing data exchange, and achieving operational readiness for Covered California by January 1, 2027.

2025 PHM Strategy Evaluation (Highlights): Six of nine PHM goals were met or partially met. Hypertension control improved by six percentage points, though disparities persist across several racial and ethnic groups. Street Medicine connected 90% of participants to Enhanced Care Management or Housing Navigation and 80% to an active primary care provider. Housing placements remain limited due to broader community constraints. Program accomplishments included distributing 709 blood pressure monitors, improving child health measures, stronger case/disease management satisfaction, increased engagement of high-risk members (62%→76%), data sharing with the Orange County Health Care Agency (OCHCA), and a Community Health Worker toolkit for blood lead screening. Challenges with measures regarding Follow-Up After ED Visit For Mental Illness (FUM) and Substance Abuse (FUA) were driven by the following barriers: data delays, inconsistent network engagement, and technology constraints, with partial mitigation achieved through daily reporting in the provider portal.

2025 CLAS Program Evaluation: Two of five goals were met or partially met. Russian was successfully implemented as a threshold language with dedicated translator staffing. Member and staff survey response rates were low, limiting data completeness. Staff recommended earlier evaluation development, clearer program goals, and improved collaboration across departments.

2025 UM Program Evaluation & 2026 Integrated UM/CM Program Description: The committee approved the 2026 Integrated Utilization Management/Case Management (UM/CM) Program Description. The program outlines accomplishments from the UM sub workgroups (High Risk Management, Over/Under Utilization, Gender Affirming Care, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Enhanced Care Management (ECM) Clinical Oversight, skilled nursing facility (SNF) and committees (Pharmacy & Therapeutics (P&T), Benefits Management Subcommittee (BMSC), Behavioral Health Quality Improvement (BHQI)). Staff identified accomplishments such as improved inventory management and oversight, report refinements, PSA oversight and monitoring, established the Pediatric Workgroup, provider portal automation and capabilities, implementation of prior authorization consultant workgroup, established facility hospital rounds with Loma Linda to support transplant services, removed preventative and screening prior authorization requirements for OneCare, enhanced TCS and assigned dedicated Medical Director, launched SNF Work Group and launched Usher texting campaign. Consumer Assessment of Healthcare Providers and Systems (CAHPS) trends showed increased satisfaction with the access measure,Getting Needed Care, UM/Pharmacy/BH/Long-Term Support Services (LTSS) targets were met for turnaround time (TAT) and OneCare adherence measures, and all staff passed IRR at ≥90%.

Special Needs Plan (SNP) Model of Care (MOC)
The 2026 Model of Care updates require completing Initial Individualized Care Plans (ICPs) within 90 days of enrollment, standardizing terminology by renaming ECM–like services to California Integrated Case Management, adding dementia as a new population of focus, and maintaining palliative care services; the

February 10, 2026, Meeting
2027 Model of Care will be submitted to the Centers for Medicare & Medicaid Services (CMS) by May 2026. Health Risk Assessment (HRA) completion reached 76% in 2025, meeting the four-star cut point, and 85% of members enrolled for four months or more had a face-to-face provider visit. Annual Wellness Visit (AWV) completion increased from 35.1% to 38.0% in the fourth quarter, supported by text and email outreach and Optum engagement efforts. **Pediatric & Adolescent Wellness (EPSDT/Children's Preventive & Screening):** Performance improved in immunizations, well-child visits, and lead screening. Measures such as Childhood Immunization Status (CIS) and Immunizations for Adolescents reached the 75th percentile, supported by chart reviews, member outreach, and increased use of at-home testing for select populations. **Adult Wellness (Preventive & Screening Services):** Breast Cancer Screening (BCS) performance in Medi-Cal remains below prior-year levels and benchmark cut points, while Cervical Cancer Screening (CCS) improved; projections place OneCare BCS at 2 stars and Colorectal Cancer Screening (COL) at 3 stars, with Cozeva expected to close the remaining gaps. Improvement efforts include expanded chart chases, at-home FIT and Cologuard testing for CalOptima Health Community Network (CHCN) members, collaborations with gastroenterology providers, targeted care-gap lists for more than 70 primary care groups, and standing orders to increase completion of screening mammography. **Maternity Care for Black Members:** Postpartum Care reached 75.75% and Prenatal Care reached 81.43% as of December 2025, but both remain below 50th-percentile benchmarks, with preliminary rates for Black members lagging behind overall performance. Interventions include ECM authorizations, doula services, and Black Infant Health enrollment supported through data sharing with the OCHCA and the maternal health workgroup continues aligning with the DHCS Birthing Care Pathway ahead of the Omnibus All-Plan Letter. **Performance Improvement Projects (PIPs) – Medi-Cal**: The PIP aims to raise well-child visit rates for Black/African American members (0–15 months) to 55.78%; preliminary December 2025 data show 45%, with final rates pending. Improvement efforts include telephonic outreach, contact validation, culturally responsive materials and multi-modal campaigns. **Chronic Conditions: Heart Health (Hypertension)**: Controlling Blood Pressure (CBP) measured 45.49% in Medi-Cal. CBP measured 49% in OneCare, below the 2-star cut point; disparities persist (e.g., Black, Korean, and Vietnamese populations); interventions include telephonic outreach, education, self-reported BP collection, and 709 BP monitors via standing orders to reduce access barriers. **Chronic Care Improvement Projects (CCIPs) – Diabetes:** Diabetes performance in Medi-Cal improved across blood sugar control, eye exams, and kidney health evaluation, with several measures reaching the 33rd to 75th percentiles and OneCare stars projections trending toward three- to four-star cut points. Fourth-quarter initiatives included condition-specific assessments, rapid-follow-up outreach, enhanced provider communications, improved stratification tools, pre-call texting, and standing orders for glucose meters to support home monitoring. Member feedback remained strong, with 92.3% satisfaction reported through the 2025 Disease Management Satisfaction Survey.

February 10, 2026, Meeting

Plan All-Cause Readmissions (PCR): Plan All-Cause Readmissions did not meet performance targets for either Medi-Cal or OneCare, despite quarter-over-quarter improvement. To address this, staff are implementing provider education on transitional care management, strengthening transitional care workflows, increasing daily post-discharge outreach, assisting members with primary care appointments, expanding staff training, and conducting targeted post-discharge outreach for OneCare emergency department visits.

Emergency Department Member Support: The Emergency Department Support Program, launched in early 2025, increased member outreach by 15.6% in the fourth quarter and expanded in-person and telephonic engagement, resulting in more referrals to ECM, TCS, Case Management, and community resources. Key barriers include member declination and inconsistent facility engagement. Ongoing interventions focus on maintaining onsite presence, strengthening warm handoffs and referral monitoring, weekly workgroup review, expanding ED coverage, and optimizing workflows.

Network Cultural Responsiveness: Practitioner Demographic Data (REL): Race and ethnicity data collection exceeded the 10% goal at 16.04%, while language data collection fell short at 4.5%; 2026 targets increase to 18% and 7%, respectively. Barriers include voluntary participation and prior confusion about whether English qualifies as a reportable language—an issue clarified with updated NCQA guidance. Data collection efforts continue through email and phone outreach to provider offices, as well as through provider forms.

Open Discussion

- Discussion addressed provider guidance on handling vaccine refusals; leadership will promote American Academy of Pediatrics (AAP) guidance and tools on the provider website with aligned recommendations.

Approved by QIHEC

- 2025 QIHETP Evaluation and supporting documents; 2026 QIHETP Support Positions and Job Descriptions
- 2026 CalOptima Health Integrated Utilization Management/Case Management Program Description
- 2025 Utilization Management Program Evaluation

March 10, 2026, QIHEC Meeting

Review/Approval of February 10, 2026, Meeting Minutes: The committee reviewed and approved the meeting minutes.

Committee Operations and Compliance: No compliance issues were reported.

Chief Medical Officer Update: The CMO highlighted the need to achieve five-star performance in Glycemic Status Assessment and presented new analysis showing that 62% of OneCare members with uncontrolled diabetes are not receiving GLP-1 therapy. Staff developed provider tools to support proper prescribing and titration.

March 10, 2026, QIHEC Meeting

Increase Primary Care Utilization — Initial Health Appointment (IHA): IHA requirements were expanded to all Dual Eligible Special Needs Plan members, resulting in a current completion rate of 34.87%, below the 50% benchmark, although pediatric performance remains strong at 72%
For members under 18 months: Two system enhancements—Cozeva integration in April 2026 to document outreach attempts and day-one auto-assignment of primary care providers beginning July 1, 2026—are expected to improve rates, and the benchmark will be reassessed following implementation.

Health Education Program: The Health Education Program processed 5,856 referrals in 2025, a 6% year-over-year increase, and delivered 171 classes to 810 participants across virtual and in-person formats, along with individual virtual coaching sessions. Staff also launched two hypertension text campaigns and developed a new multilingual curriculum, "Sleep Well for Good Health." The HealthHub digital engagement platform launched in March 2026, providing accessible, clinically reviewed content with built-in translation and accessibility features that support health equity goals.

CalAIM Community Supports and ECM: Provider audits for housing and ECM services began in early 2026, with corrective action plans issued to providers that did not meet quality thresholds and potential contract termination for continued non-compliance. Phase I Housing Trio audits showed an average score of 66.4% across the first 10 of 50 providers reviewed; Phase II will require at least 80% to pass, with corrective actions required for providers below the threshold. Phase II ECM audits also began, with 15 of 18 providers meeting standards and three undergoing corrective action with 90-day remediation and re-audit requirements; failure to reach 80% may result in termination.

Street Medicine Program: The Street Medicine Program exceeded 2025 goals by connecting 95% of participants to primary care and 94% to ECM or Housing Navigation, though only 13% secured shelter or housing due to regional constraints. Since launching in April 2023, the program has served more than 1,000 members and permanently housed 44 individuals, including many who were previously considered service-resistant. More than 400 members remain actively enrolled; services were expanded to Santa Ana in March; and a multi-city expansion approved by the Board will begin accepting applications in April.

Credentialing Peer Review Committee (CPRC) Oversight: The committee reviewed credentialing, peer review, and facility site review activities for Q4 2025, including quality-of-care actions and audit findings. All potential fair hearings concluded, with four physicians placed on probation and one administratively terminated; ongoing monitoring resulted in additional sanctions, including probation, citation, and reprimand. Quality-of-Care PQIs increased, and three preventable conditions were identified across three hospitals. The Provider Action Workgroup issued a corrective action plan to a primary care provider due to high grievance volume. The committee also approved updated Board Certification Requirements and Minimum Physician Standards, recognizing the National Board of Physicians and Surgeons. Facility Site Review and Medical Record Review failures decreased, although corrective action plans increased as oversight strengthened.

Grievance & Appeals Resolution Services (GARS) Committee: The GARS meeting was rescheduled to March 12 due to the DHCS audit; an update will be provided at the following QIHEC.

Member Experience (MEMX) Committee: MemX met January 27, 2026:

March 10, 2026, QIHEC Meeting

The 2024 Medi-Cal Network Adequacy Validation (NAV) audit closed successfully, and as part of health network readiness, Providence was found fully compliant in its 2025 network adequacy assessment. While OneCare met network adequacy standards at the plan level, gaps persist in South Orange County and several specialties, prompting ongoing recruitment, telehealth expansion, and streamlined credentialing. Timely Access performance improved from 65% to 90% following education and outreach, with corrective actions planned as monitoring continues. Customer Service met all Medi-Cal and OneCare goals, and with increased CMS weighting for member experience, CalOptima Health is expanding data-driven strategies, real-time text-based feedback, and service recovery to address CAHPS priorities and recurring access concerns.

Utilization Management Committee (UMC): UMC met on January 22, 2026

The committee reviewed utilization trends and operational performance, noting that several utilization goals—including adult Medi-Cal admissions and readmissions, Temporary Assistance for Needy Families (TANF) under-18 length of stay, seniors and persons with disability (SPD) readmissions, OneCare admissions, and emergency department use for Medi-Cal adults and long-term care members—were not met, though progress is improving through targeted workgroups, enhanced dashboards, and provider education. The committee approved key 2026 UM program documents and reviewed multiple policies across lines of business. Turnaround times remained compliant at or above 95%, and post-discharge outreach improved by 7.1% toward the 10% goal. The ED Diversion Program reported a 15.6% increase in outreach, and related committees advanced work in benefits management, pharmacy review, risk stratification, and Medi-Cal Connect. Complex Case Management audits identified performance below goal, prompting coaching, while LTSS corrected an expedited turnaround time issue. Community-Based Adult Services and Multipurpose Senior Services Program metrics were met or exceeded.

Whole Child Model Clinical Advisory Committee (WCM CAC) and Pediatric Care: WCM CAC met on February 17, 2026

The committee reviewed updates on IHA requirements and noted that UCI Fountain Valley's hospital, NICU, PICU, and High-Risk Infant Follow-Up Program are no longer California Children's Services–approved following ownership and NPI changes, requiring CCS members to be triaged and transferred to approved facilities; emergency guidance was also clarified. Staff shared measles preparedness materials due to regional under-immunization concerns, and reported that network coverage remains adequate, with improvements in behavioral health measures and increased outpatient and ABA utilization. Additional work includes screening for Adverse Childhood Experiences (ACES), developing a transition planning playbook, and offering provider incentives to support youth aging out of pediatric care. Staff also reported that, effective January 1, 2026, GLP-1 drugs are not covered by Medi-Cal Rx for weight-loss indications except under EPSDT, while coverage continues for diabetes and other approved conditions with prior authorization. The DHCS audit is progressing well.

Delegation Oversight: Annual audits of delegated entities, including Optum, AltaMed/Altura, and Family Choice/Altura, identified recurring UM issues such as timeliness and quality of Notices of Action (NOA), clarity of denial rationale, adherence to clinical criteria, post-stabilization turnaround times, post-acute discharge procedures, and accuracy of member and provider communications. Corrective action plans were issued across all entities, with Optum findings spanning both Medi-Cal and OneCare lines and similar remediation themes identified for AltaMed/Altura and Family Choice/Altura.

March 10, 2026, QIHEC Meeting

Quality Performance Improvement: MCAS / Stars / DHCS Quality Withhold / Health Plan Accreditation: Preliminary HEDIS Measurement Year 2025 results show that 11 of 18 Medi-Cal MCAS measures already meet minimum performance levels and are trending above last year's final rates. Five measures remain below minimum levels, though four hybrid measures are expected to improve after chart review and topical fluoride varnish rates are anticipated to rise with additional dental claims. Follow-Up After Emergency Department Visit and Follow-Up After Hospitalization for Mental Illness remain below benchmarks but show year-over-year improvement; more than 20% of non-compliant members completed follow-up just outside the 30-day window, indicating the need to accelerate engagement timelines.

Value-Based Payment Program — Hospital P4V (2024 Results): The committee reviewed the Hospital Quality Program's incentive structure and performance results. The program evaluates hospitals using CMS Hospital Compare and Leapfrog data across quality, patient experience, and safety domains, with payments based on tiered performance. In 2024, hospitals earned $16.7 million of the $30 million incentive pool, leaving $13.2 million unearned due to lower performance, with notable variability across hospitals when compared to 2023 results. A $150,000 reporting grant remains available for hospitals initiating CMS or Leapfrog reporting, though participation continues to be limited.

Items Approved by QIHEC

- February 2026 QIHEC Meeting Minutes
- Policy GG.1618 (Member Request for Medical Records) – annual review, no changes

Items Accepted and Filed

- UMC Meeting Minutes 12/18/25
- WCM CAC Meeting Minutes 11/18/2025
- Policy GG.1618 slide materials
- Appendices for UMC Oversight, CPRC, Delegation Oversight, and Hospital Quality Program 2023–2027

Board of Directors' Quality Assurance Committee Meeting
June 18th, 2026

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
First Quarter 2026 Meeting Summaries

February 3rd, 2026: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary of the Health Plan Monitoring Data and PACE Quality Initiatives

- Infection Control Subcommittee: PACE's Response to COVID-19:
  - PACE will continue to report on any updates in recommendations regarding COVID and any outbreaks or reporting trends for quality purposes.
  - There were 5 reported participant cases of COVID-19 in Q4 2025, only 1 case reported in 2026 as of this meeting date.
  - PACE Staff have been reminded to report exposure/illness to their supervisor and CalOptima Health HR, and not to come in if feeling sick.
  - COVID-19 latest vaccine is being administered by clinic as of October 2025.
- Presentation of the Q4 2025 HPMS Elements:
  - Membership data. Q4 2025 ended with 543 total enrolled (internal goal of 549 not met).
  - Immunizations
    - Pneumococcal Immunization rate in Q4 2025 was 93.4% (no exclusions).
    - Influenza Immunization rate in Q4 2025 was 83% (no exclusions).
  - Falls without Injury. Q4 2025 ended with 80 falls without injury. Most happened in bathroom or bedroom of home due to loss of balance.
  - Denial of Prospective Enrollees. 0 denials in Q4 2025.
  - Grievances. 8 grievances received in Q4 2025.
  - Emergency Room Visits. 112 ER visits, a decrease of 14 from Q3 2025. 53 were discharged to their homes and 59 were admitted to hospital. Trends in admission diagnoses for Q4 2025: Chest Pain, Falls and Altered Mental Status/Dizziness and Giddiness. Other common admission diagnoses were pain, weakness/malaise.
  - Medication Errors Without Injury. 1 medication error reported in Q4 2025.

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        - Medication Not Administered – Dispensed to wrong participant. Pharmacy delivery error. Pharmacy accidentally delivered Patient A's medications to Patient B. This error was discovered same day and was rectified with no harm to either patient.
    - Quality Incidents with Root Cause Analysis Reported in HPMS.
        - 6 Falls with Injury, 3 Pressure Ulcer, 2 Burns and 1 Elopement. Root cause analysis (RCA) completed for each case and shared with CMS/DHCS account managers.
- Presentation of the 2025 PACE Quality Initiatives
    - Advanced Health Care Directive
        - Goal: ≥ 55% of participants will have completed AHCD by end of 2025.
        - Q4 2025 ended at 39%. Goal not met in 2025.
    - Dental Satisfaction Quality Initiative.
        - Goal: ≤ 1 dental-related grievance per quarter in 2025.
        - 0 dental grievances reported in Q4 2025. Goal was met.
    - Transportation Satisfaction Quality Initiative
        - Goal is ≤ 3 **valid** transportation related grievances per quarter in 2025.
        - QI received 2 total transportation grievances in Q4 2025. Goal was met.

February 3rd, 2026: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of Q4 2025 Quality Work Plan Elements
    - *Elements 3 – 4 Immunizations*
        - Pneumococcal Immunization rate in Q4 2025 was 93% (exclusions defined in quality work plan). Goal of 94% was just barely missed. In 2026, the goal will be reduced from 94% to 90%, primarily due to vaccine fatigue.
        - Influenza Immunization rate Q4 2025 rate is 84%. Goal of 94% was not met. In 2026, the goal will be reduced from 94% to 90%, primarily due to vaccine fatigue.
    - *Element 5: Colorectal Cancer Screening.* Goal is >65.21% will have colorectal cancer screening as defined in quality workplan. Q4 2025 rate was 80%. Goal met. In 2026, the goal will increase to >69.66%.
    - *Elements 6: Breast Cancer Screening.* Goal is >82.80% will have breast cancer screening as defined in quality workplan. Q4 2025 rate was 84%. Goal met. In 2026, the goal will increase to >83.60%.

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- *Element 7: Blood Pressure Control.* Goal is >85.60% of qualifying participants will have a blood pressure reading <140/90mm. Q4 2025 rate was 86.06 %. Goal met. In 2026, the goal will increase to >87.21%.
- *Elements 8: Diabetic Eye Exams.* Goal is >88.08% of qualifying diabetic enrollees will receive annual eye exams. Q4 2025 rate was 94.2%. Goal met. In 2026, the goal will increase to >89.04%, aligning with the HEDIS 95th percentile.
- *Elements 9: Diabetic Care – Blood Sugar Control.* Goal is <12.24% of qualifying diabetics will have blood sugar level (HbA1c) measurement of >9%. Q4 2025 rate was 9.36 %. Goal met. In 2026, the goal will be <12.50%.
- *Element 10: Osteoporosis Treatment.* Goal is 75% of qualifying participants receive osteoporosis monitoring via bone density scan. Q4 2025 rate was 87%. Goal met. The goals for this element have been consistently met over the past several years and the process for diagnosing and monitoring osteoporosis are firmly established within the PACE clinic. Therefore, in 2026, this element has been removed. Participants who need bone density scans will continue to receive them by the discretion of their provider.
- *Element 11: Reduce Percentage of Falls reported by PACE Enrollees.* Q4 2025 ended with 77 falls, which is slightly above the Goal of <72 falls per quarter in 2025. Goal not met. In 2026, the Goal will be changed to reduce the number of falls to 150 per 1,000 participants each quarter.
- *Element 12: Decrease the Risks of Use of Opioids at High Dosage.* Goal is that 100% of members receiving opioids for 15 or more days at an average milligram morphine dose of (MME) 90mg will be reevaluated monthly by their treating provider. Goal not met. In Quarter 4 of 2025, there was one month in which one of the two participants who received a dose greater than 90 MME did not have a follow-up appointment with their PCP. In 2026, this element will be removed.
- *Element 13: Medication Reconciliation Post Discharge (MRP)*. Goal is ≥93% of participants will have medications reconciled within 7 calendar days after discharge from Hospital or SNF. Q4 2025 rate was 94%. Goal met.
- *Element 14: Access to Specialty Care.* Goal is 100% of appointments to be scheduled within 7 calendar days *per 2025 CMS Final Rule*. Q4 2025 rate was 73%. Goal not met. Strategies are being implemented to meet this regulation include increasing number of available contracted providers, using new scheduling software, creating utilization management of outside orders, and re-training/oversight of scheduling staff. In 2026 the PACE

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Scheduling Work Group was created to investigate underlying issues causing noncompliance

- *Element 15: ACS Utilization.* Goal is ≥10% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by the end of 2025. At the end of Q4 2025, the rate was 9%. Goal not met. In 2026, the goal will increase to 12% based on plans for the addition of two more PACE ACSs.
- *Element 16: Acute Hospital Days.* Goal of <3,300 per 1000 per year was met with 2,680 hospital days for participants in Q4 2025. In 2026, goal of has been changed to <2,800 per 1000 per year.
- *Element 17: ER Visits.* Goal of <820 ER visits per 1000 per year. Q4 rate was 850. Goal not met.
- *Element 18: All Cause Readmissions.* Goal is <14% of hospital readmission will occur within 30 days of discharge of previous stay. The rate for Q4 was 18.5%. Goal not met. In 2026, goal was changed to <20% of hospitalized participants will be re-admitted to hospital within 30 days after discharge, to reflect the acuity of our patients.
- *Element 19*: *Long Term Care Placement (Custodial Care).* Goal is <4% of participants will be under custodial care in a nursing facility. The rate was 0.43% in Q4 2025. Goal met. In 2026, this element will be removed, although still monitored and reported monthly to CalOptima Health Accounting team.
- *Element 20: Enrollment Conversion.* In 2025, the goal was 70% conversion from inquiries to active enrolled participants. Rate in Q4 2025 was 84%. Goal met. In 2026 this element has been removed and replaced. New Element for Enrollment in 2026- 80% of participants will be enrolled into the PACE program <45 days from their initial inquiry.
- *Element 21: 3 Month Disenrollments.* The goal is that <6% of controllable disenrollments are by new enrollees in 2025. Rate in Q4 2025 was 21.43%. Goal not met.
- *Element 22: Total Attrition Rate.* The goal is <8% overall attrition rate in 2025. Q4 2025 rate is 5.16%. Goal was met.
- *Element 23: Transportation <60 minutes.* Goal is that 100% or trips will be 60 minutes or less in 2025. There were 26 one-hour violations in October 2025, 3 in November 2025, and 4 in December 2025. PACE continues to monitor all violations and investigate whether they are considered controllable (based on poor planning) or uncontrollable (based on traffic incidents). There were a total of 11 *controllable* 1-hour Violations in Q4 2025.

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- *Element 24: Transportation on Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. The goal is ≥93% of all transportation rides will be on time. Q4 2025 rate was 79%. Goal not met, although demonstrated significant improvement from Q3 2025.
- *Element 25: Transportation Satisfaction.* Goal in 2025 was ≥93.2%. 2025 score was 94%. Goal Met. In 2026 the goal is ≥93.2% (2025 National PACE average).
- *Element 26: Meal Satisfaction.* Goal in 2025 was ≥72%. 2025 score was 80%. Goal Met. In 2026 the goal is ≥73.6% (2025 National PACE average).
- *Element 27: Home Care Satisfaction.* Goal in 2025 was ≥85.5% Satisfaction with Home Care Service. 2025 score was 88%. Goal Met. In 2026 the goal is ≥85.7% (2025 National PACE average).
- *Element 28: Overall Satisfaction.* Goal in 2025 ≥87.3%. 2025 score was 94%. Goal Met. In 2026 the goal is ≥87.9% (2025 National PACE average).

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