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

WEDNESDAY, OCTOBER 8, 2025
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	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	Sharon Dwiers

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_K3yZ52WDQVyFlFvnofgi-A** and Join the Meeting.
Webinar ID: **813 2483 7526**
Passcode: **680114** -- 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. Approve Minutes of the June 18, 2025 Special 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 Quality Improvement Policies

5. Recommend that the Board of Directors Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

6. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2026 Member Health Rewards

INFORMATION ITEMS
7. Credentialing Update

8. National Committee for Quality Assurance Accreditation Update

9. Utilization Management Committee and Clinical Operations Updates

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on October 8, 2025 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_K3yZ52WDQVyFlFvnofgi-A

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. .
https://us02web.zoom.us/s/81324837526?pwd=2r6fFaH93azfmnsVbH0gYl40xyQd9Z.1

Phone one-tap:
+16694449171,,81324837526#,,,,*680114# US
+16699009128,,81324837526#,,,,*680114# US (San Jose)

Join via audio:
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+1 669 900 9128 US (San Jose)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+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
+1 646 558 8656 US (New York)
+1 646 931 3860 US
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+1 301 715 8592 US (Washington DC)
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Webinar ID: 813 2483 7526
Passcode: 680114
International numbers available: https://us02web.zoom.us/u/kuhcbULmu

Board of Directors'
Quality Assurance Committee Meeting
October 8, 2025

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.

June 25, 2025: PMAC Meeting Summary

Updates from the Director
Director Monica Macias-Garcia thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, and transportation. The Director welcomed new members who were joining us for the first time. Participants discussed transportation as there have been issues in the past and reporting that areas appear to be getting better. Participants shared that some of the trips were missed and/or late recently. The Director did share that the transportation vendor changed to a new software system and unfortunately some of the information did not transition and as such trips were missing. These issues have been fixed, and PACE is aware of the issues it created and worked quicky with the transportation vendor to mitigate the problems.

The Director also reminded participants of the importance of keeping their appointments and communicating with PACE if there are any changes to ensure care coordination and transportation trips are scheduled. The Director reminded participants that the specialists do not always communicate with PACE when changes are made.

PMAC Member Forum

- Participants expressed improvement with transportation services, even though there were some issues with the transportation vendor's software system change.
- Participants expressed gratitude for having a forum where they can express their concerns.
- Participants were reminded of the importance of keeping their specialty appointments.

Back to Agenda

Board of Directors'
Quality Assurance Committee Meeting
October 8, 2025

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

On August 26, 2025 the Whole-Child Model Member Family Advisory Committee (WCM FAC) conducted its quarterly meeting in-person and telephonically using Zoom Webinar technology.

The WCM FAC welcomed new Authorized Family Member Representatives Fabiana Avendano, April Johnston and Mayra Ortiz and Katya Aguilar as the Community Based Organization Representative. All were appointed by the Board of Directors at its August 7, 2025 meeting. This was the committee's first time accommodating two Spanish-only members and CalOptima Health successfully held the meeting with interpreter support via Zoom and in person.

Michelle Laba, M.D., MS, FAAP, Medical Services Deputy Director, California Children Services (CCS) Program in Orange County, provided an update for this fiscal year, noting that the program served a total of 11,253 clients, with 1,691 children receiving medical therapy services. These services accounted for over 35,000 therapy visits, reflecting the program's extensive reach and impact on children with special health care needs. Dr. Laba noted that key accomplishments included significant outreach, education, and collaboration efforts. The team conducted annual joint training with CalOptima on the Whole-Child Model, targeting local hospitals, physicians, and health networks. Dr. Laba also provided an overview of the CCS program to the Orange County Health Care Agency's Community and Nursing Services Division and noted that additional engagement included ongoing networking with CHOC specialty providers and continued collaboration with Kaiser, the Regional Center of Orange County, HealthBridge, and the Maternal Child Adolescent Health Division. Dr. Laba also noted that the Medical Outpatient Rehabilitation Center (OPRC) at the Westminster Medical Therapy Unit successfully passed its review and recertification in August.

Dr. Laba also addressed updates on CalAIM and noted that while the program's launch date remains pending, the Department of Health Care Services (DHCS) continues to provide oversight of CCS programs under the Health and Safety Code. Current performance measures include annual medical reviews, family participation tracking, timeliness of eligibility determinations, and service authorization turnaround times. Additionally, monthly chart audits are conducted across both general and therapy programs. She also noted that several currently optional oversight activities will become mandatory.

These include implementing a grievance process, enhancing staff training, and completing transition planning logs for youth aging out of the CCS program.

Kim Goll, Chief Executive Officer, First 5 Orange County (First 5 OC), provided background on how First 5 was created in 1998 through a voter-approved initiative that added a 50-cent tax on tobacco products in California. This funded both state and county commissions to support children from prenatal to age five based on local needs and while often linked to school readiness, First 5 OC emphasizes health outcomes as a foundation for long-term success.

Ms. Goll highlighted a major challenge in that declining revenue due to reduced tobacco use. First 5 OC's funding has dropped from $62 million in 1999 to about $20 million today. Although this reflects positive public health trends, it also strains resources at a time when early childhood development is increasingly prioritized. She stressed that First 5 OC is committed to serving all children in Orange County, with a focus on equity. While services are universally available, the organization prioritizes children furthest from opportunity, using the Medi-Cal population as a proxy to guide targeted support.

Michaell Silva-Rose, Chief Health Equity Officer, presented on the Member and Population Health Needs Assessment and provided an overview of the various health assessments CalOptima Health is involved in, including the Population Needs Assessment (PNA), which is an annual requirement under the National Committee for Quality Assurance (NCQA). Dr. Rose also discussed the Community Health Assessment, which is led by the Orange County Health Care Agency (OCHCA) and noted that in 2028, CalOptima Health will collaborate with the county to conduct a joint health needs assessment.

Dr. Rose reviewed the Member and Population Health Needs Assessment, which is currently underway and noted that this comprehensive assessment is designed to inform CalOptima Health's equity interventions, community investments, and strategic program development. She noted that CalOptima is partnering with the National Opinion Research Center (NORC) for this assessment which will use a three-pronged approach: (1) surveys of both members and providers, (2) key informant interviews, and (3) community focus groups. These methods aim to gather a broad range of perspectives and data to better understand both the assets and barriers within the community that impact health outcomes. Dr. Rose emphasized that this work is foundational to shaping future strategies and ensuring that CalOptima Health's programs are responsive to the needs of its members.

Dr. Rose shared that CalOptima Health is conducting a Member and Population Health Needs Assessment using a strength-based approach. The goal is to identify both community needs and existing assets, such as support from organizations like First 5. Findings will support CalOptima's accreditation and inform future collaboration with the OCHCA on the 2028 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The final report is expected by Q2 2026.

Veronica Carpenter, Chief Administrative Officer, provided an overview of the state and federal budget updates and their implications for CalOptima Health members. She highlighted that her department oversees Government Affairs, Communications, Community Relations, Strategic Development, and the Clerk of the Board. A handout titled Fiscal Year 2025–2026 Enacted State Budget was distributed, summarizing the key changes. She noted that Governor Newsom had released the revised state budget

on May 14, 2025, and it was passed by the state legislature on June 13, 2025. Ms. Carpenter reviewed the key changes including a freeze on new enrollment for undocumented individuals aged 19 and older, effective January 1, 2026 and that the asset limit test will be reinstated on the same date, setting a threshold of $130,000 for individuals and $65,000 for each additional household member. She noted that other changes included pharmaceutical policy updates and that beginning on July 1, 2027, a $30 monthly premium for undocumented individuals aged 19–59 would take effect. Ms. Carpenter emphasized that no immediate changes are in effect and encouraged members to continue accessing care, including well-child and wellness visits. CalOptima's communications team will ensure timely updates as changes are implemented.

Ms. Carpenter also provided a Federal update which included a handout that outlined changes under HR 1, the Federal Reconciliation Bill that is grouped into three categories: eligibility, financing, and access with notable changes including a work or community engagement requirement beginning between December 31, 2026, and December 31, 2028, and a six-month revalidation requirement for the expansion population starting December 31, 2026. She also noted that CalOptima Health will work closely with community partners and the Social Services Agency to ensure members are well-informed and prepared to respond to these changes, including watching for revalidation notices.

Zeinab Dabbah, M.D., JD, MPH, FACP, Deputy Chief Medical Officer, provided key updates from the American Academy of Pediatrics (AAP) vaccination recommendations released in July 2025. As a reminder, immunizations remain the safest and most cost-effective way to prevent disease, disability, and death. She noted that COVID-19 continues to circulate, and the AAP recommends an annual, strain-matched COVID-19 vaccine for all children aged six months and older as this ensures protection against the most current circulating variant. Dr. Dabbah also discussed the new the high-dose Influenza vaccine which is recommended for high-risk individuals aged six years and older, especially as flu season will begin in early fall. She also noted that the Human Papillomavirus (HPV) vaccination is now recommended starting at age nine to improve early protection against cervical cancer and that Meningococcal B vaccination is now routinely recommended for all adolescents aged 16 to 18.
Dr. Dabbah also provided an update on the Respiratory Syncytial Virus (RSV) and that prevention has expanded significantly. She noted that for infants, a single intramuscular dose is recommended for all babies eight months or younger during RSV season (October–March). This provides protection for up to five months and that a second dose is advised for high-risk infants aged 8–19 months, including those with chronic lung disease, congenital heart disease, or who are immunocompromised. For pregnant individuals, the maternal RSV vaccine is now recommended between 32-36 weeks gestation during RSV season. This approach which is endorsed by the American College of Obstetrics and Gynecology, helps pass immunity to the unborn child. If the maternal vaccine is given, the infant dose is not needed except for high-risk infants. Dr. Dabbah also discussed the new updated catch-up schedules which are available for children with interrupted vaccine series, immunocompromised children, and those with uncertain vaccination histories, such as refugees and immigrants.

Veronica Carpenter, Chief Administrative Officer, provided an update on how CalOptima Health is preparing to launch its Covered California line of business in 2027, with a go-live date set for January 1, 2027. She noted that the Strategic Development team is collaborating across departments including clinical, operations, and customer service to support this major initiative. She also noted that on the

regulatory front, the Board approved the submission of the licensure application at the state level in June and that since then, the team has been actively engaged in reviewing and responding to feedback on the application, which will continue as an ongoing process.

Ms. Carpenter also noted that Network development was underway, with contracting efforts focused on engaging health and behavioral health providers to ensure most of the Covered California network was in place by summer to meet the October submission deadline. Operational readiness is also progressing, guided by internal assessments and a consultant-developed roadmap. New workstreams, including in claims for premium collection, are being implemented, and the team is nearly halfway through the launch year with strong momentum.

Michael Hunn, Chief Executive Officer, presented his CEO Report and welcomed the new members to the committee. He noted that there is growing concern about the changes to the Medi-Cal program, particularly the end of continuous eligibility that began in January. This shift is expected to impact many families especially the approximately 72,000 young children (ages 0–5) currently enrolled and that outreach and communication will be critical with coordination with First 5, community clinics, health networks, pediatricians, and that direct member messaging is essential in the coming months. He noted that fewer parents and caregivers were bringing children in for their well-child visits, immunizations, and developmental screenings and felt that this decline was deeply concerning and highlighted the urgent need for clear, widespread messaging. He discussed how the WCM FAC could play a key role in supporting this effort. CalOptima Health will ensure information is available on its website, shared with delegated health networks, and distributed to community and hospital partners.

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

MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

June 18, 2025

A Special Meeting of the CalOptima Health Board of Directors' (Board) Quality Assurance Committee (Committee) was held on June 18, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and at the teleconference location: Orange County Water District, 18700 Ward Street, Fountain Valley, CA 92708, which was accessible to members of the public and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Jose Mayorga called the meeting to order at 3:00 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, except for Director Catherine Green, who participated remotely under traditional Brown Act rules)

Members Absent: None.

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Ryan Dunlevy, Outside General Counsel, Kennaday Leavitt; Kelly Giardina, Executive Director, Clinical Operations; Ladan Khamseh, Executive Director, Operations; Linda Lee, Executive Director, Quality Improvement; Monica Garcia-Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

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 overview of the PACE Member Advisory Committee (MAC) activities. Ms. Macias-Garcia noted that CalOptima Health leadership continues to monitor the transportation situation. She reported that based on feedback from PACE participants, the situation was improving.

2. Whole Child Model Family Advisory Committee Updates

Back to Agenda

Lori Sato, a member of the CalOptima Whole Child Model Family Advisory Committee, shared updates on the committee's recent two-month recruitment campaign. The recruitment campaign resulted in five new applications, three for new appointments, two for reappointments, and one each for a consumer advocate and a community-based organization representative. These appointments are expected to be approved at the August 7, 2025, Board meeting, allowing the committee to be fully staffed. Additionally, Ms. Sato expressed her appreciation for the contributions made during recent meetings with staff and their efforts in addressing the concerns of parents of children with special needs.

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR
3. Approve the Minutes of the March 12, 2025, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORTS/DISCUSSION ITEMS
4. Recommend New Appointments and Reappointments to the CalOptima Health Whole-Child Model Family Advisory Committee.
This item was continued to the August 7, 2025, Board meeting.

INFORMATION ITEMS
5. Update on Quality Improvement Programs

a. Transplant Program Update
Richard Lopez, M.D., Medical Director, provided an in-depth update on the CalOptima Health transplant program. He noted that CalOptima Health facilitates transplants to approximately 150 members annually, including bone marrow, heart, liver, kidney, lung, and simultaneous pancreas-kidney procedures. These are performed at certified Centers of Excellence, many of which are outside Orange County. Dr. Lopez stated that key partners include Children's Hospital Los Angeles, Children's Hospital Orange County, City of Hope, University of California, Irvine (UCI), University of California, San Diego, and Loma Linda. CalOptima Health also provides comprehensive support services, such as transportation to and from the center of excellence, lodging with the caregiver near the center, meals for both the patient and caregiver, and when needed home health care services and pharmacy services.

Dr. Lopez provided an overview of enhancements to the program that included establishing strong contracts with high-performing centers, promoting adherence to national guidelines, and improving coordination and communication. Additionally, CalOptima Health identified an opportunity for cost-saving measures, such as the recruitment of a transplant specialist, shifting to UC transplant rates and reducing referrals to non-contracted centers. These cost saving measures led to a 40% reduction in transplant-related expenses in 2024 saving over $24 million and an average cost per day of approximately 25%. Looking ahead, the program aims to track patient outcomes more closely and

expand its transplant network, particularly in Los Angeles. Dr. Lopez concluded by reaffirming CalOptima Health's commitment to delivering high-quality, cost-effective transplant care.

Dr. Mayorga asked whether the extra services provided to transplant members, like meals and housing, were only done during the surgery. Dr Lopez clarified that services could be provided prior to the operation as many patients who are on the waiting list are usually already in the hospital, so their caregiver is allowed to stay with the member in local housing even after surgery for further monitoring.

b. Accreditation Status Update

Linda Lee, Executive Director of Quality Improvement, provided an update on CalOptima Health's progress toward maintaining its long-standing health plan accreditation with the National Committee for Quality Assurance (NCQA) and pursuing its first-ever health equity (HE) accreditation. Ms. Lee stated that the health plan accreditation review spans a 24-month look back period from April 2025 to April 2027. She also stated that the health equity accreditation file review commences next year with a service date of April 6, 2027. The HE accreditation has a 6-month review period ending in a virtual audit on October 7, 2025. Ms. Lee stated that CalOptima Health is currently on track to meet both deadlines and will be bringing updates to this Committee in the future. Ms. Lee further explained that an external consulting team of NCQA surveyors has been reviewing documents and training stakeholders to ensure compliance. She clarified that the external team would not be auditing CalOptima Health to avoid conflict of interest. Ms. Lee explained that most documents for the HE accreditation are already compliant, and ongoing efforts include submitting year-one documents and addressing gaps identified in a prior assessment. The team is also preparing for upcoming changes to NCQA standards expected in 2026. Lastly, Ms. Lee stated that for next steps consultants will continue to work with staff. One pending task is to analyze newly completed HEDIS results to identify and act on health disparities. The next major milestone is the HE surveys on October 7, 2025.

c. Credentialing Update

Ms. Lee addressed ongoing challenges with credentialing at CalOptima Health, noting a backlog that had built up over time. Remediation efforts began in August 2024, including the engagement of an external credentialing verification organization (CVO) in February 2025 to streamline the process by leveraging existing credentials from other plans. Ms. Lee explained that additional staff members were assigned to handle the high volume of provider inquiries, and robotic process automation was introduced in March 2025 to reduce manual data entry. Despite these efforts, the backlog persisted, prompting a more aggressive remediation plan in April 2025. The remediation plan included hiring temporary staff and implementing voluntary overtime shifts, resulting in the processing of 130–200 files weekly. With that new strategy, the data showed a downward trend in total inventory and an increase in closed files, indicating progress. Furthermore, the Credentialing team also added two full-time staff to manage unexpected administrative demands from the CVO. Ms. Lee stated that CalOptima Health is also transitioning to a new credentialing system that will integrate with provider contracting and data management systems to streamline workflows and improve the entire provider onboarding process over time. Currently, daily monitoring of credentialing volumes is now in place to ensure timely onboarding and reduce manual work.

Additionally, Ms. Lee shared a regulatory update from the Department of Health Care Services (DHCS). As of May 5, 2025, DHCS qualified autism service providers can now apply to be Medi-Cal

enrolled and offer services in Medi-Cal fee-for-service or through a Medi-Cal managed care plan. Ms. Lee stated that applications submitted by June 30, 2025, will be retroactively effective from July 1, 2025, while later submissions will be processed in order, potentially taking up to a year. Existing contracted providers must also enroll in Medi-Cal. Ms. Lee explained that CalOptima Health notified providers via email, fax, and a webinar, and is requiring proof of submission of their Medi-Cal application before continuing with credentialing.

Ms. Lee responded to Committee members' comments and questions.

d. Utilization Management Update

Kelly Giardina, Executive Director, Clinical Operations, provided a quarter one 2025 update on the Utilization Management Committee along with Robin Hatam, M.D., Medical Director. Ms. Giardina highlighted the launch of the Emergency Department Diversion (EDD) Program at UCI in February 2025. Since its launch the program has already supported 90 members face-to-face and improved coordination between emergency departments and community services. Additionally, materials have been created for the UCI emergency department staff to share with members. Ms. Giardina explained that CalOptima Health has been a support for some delegated health network partners so when issues arise CalOptima Health can connect both the member and the hospital team to their health network leaders in real time. Through the EDD program, CalOptima Health along with UCI has been helping members to better navigate CalAIM community services and supports.

Additionally, Ms. Giardina noted that the Transitional Care Services (TCS) workgroup enhanced support for members during care transitions, such as sharing resources where members can access ambulatory care if there are delays. Resources also include after-hours access and outreach to OneCare members to work with them in understanding the TCS program. Ms. Giardina noted that CalOptima Health has launched a campaign to connect with OneCare members via text to connect them with a personal care coordinator or case manager that delivers transitions of care services.

Ms. Giardina reported that the over/under-utilization group focused on refining the prior authorization process with external consultants, aiming to streamline workflows and improve visibility through dashboards. The gender-affirming care group completed cultural competency training for all staff and providers and is addressing network gaps. The Early and Periodic Screening Diagnostic and Treatment (EPSDT) workgroup worked on expanding the private duty nursing network and developed dashboards for dental, vision, and hearing services. Enhanced Care Management oversight included medical director rounding and case reviews with high-volume providers. Utilization data showed rising obstetrics admissions and emergency department visits among Medi-Cal adults 18 and older. Ms. Giardina noted that data represented was from November 2023 through October 2024. The data showed stable pediatric inpatient metrics and declining emergency department visits for Whole Child Model members, with the total volume ranging from 53 to 81 admissions per month. Additionally, for OneCare members, admissions and readmissions were low, with emergency department visits driven by conditions like urinary tract infections and cognitive symptoms.

Ms. Giardina responded to Committee members' comments and questions.

Robin Hatam, M.D., Medical Director, provided an overview of the organization's health oversight activities, focusing on delegated health networks. Dr. Hatam explained that quarterly clinical

meetings are held with each network, attended by internal leadership and their counterparts from the networks, including medical directors. These meetings review submitted work plans and key utilization metrics such as emergency department utilization, readmission rates, and case management engagement. If metrics fall short of targets, the team discusses interventions. In addition to these quarterly meetings, a monthly dashboard tracks performance across delegated functions like utilization and case management, credentialing, claims, and customer service. Dr. Hatam noted that metrics are reviewed monthly and signs of non-compliance triggers one-on-one meetings with business owners and delegated health networks. If non-compliance is unresolved, a new policy is in place that allows escalations to corrective action plans. He also highlighted recent efforts, including an ad hoc review of pediatric denials and the development of a case management workbook to guide expectations around enrollment and staffing. A biweekly forum with health networks supports ongoing dialogue on topics like quality measures. He also described support for inpatient and skilled nursing facilities, including transitional care coordination and quarterly meetings to address services and operational issues. Lastly, Dr. Hatam discussed a pilot program at UCI's emergency room, where a social worker connects frequent emergency department users with appropriate outpatient services. This initiative, supported by a medical director with emergency department experience, aims to reduce unnecessary emergency department visits and is available to all CalOptima Health members.

Ms. Giardina responded to Committee members' comments and questions regarding Dr. Hatam's update.

6. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Ms. Lee presented an update on the work completed by the Quality Improvement Health Equity Committee (QIHEC) during the first quarter of 2025. The committee reviewed and acted on a broad range of quality oversight functions, including potential quality issues, oversight of credentialing of both physician providers and facilities, as well as credentialing facility site reviews. Ms. Lee noted that the committee also reviewed performance improvement projects, access and availability, member experience, and care coordination. Furthermore, key documents that were approved included evaluations and work plans for population health management, cultural and linguistic services, utilization and care management, and quality improvement programs. The committee also approved several policies related to corrective actions, service availability changes, and member medical record requests. Ms. Lee reported that subcommittees, such as Grievance and Appeals, Member Experience, and Population Health Management, reported their activities and were approved. However, Ms. Lee noted that CalAIM community supports did not meet the benchmark of 95% in November and December of 2024 due to staffing shortages. A corrective action plan (CAP) was immediately implemented by the QIHEC committee that included cross training of staff so that coverage could occur, and the addition of temporary staff. Resulting in 98% compliance and improved turnaround times by January 2025. The CAP was later reviewed and closed by the Quality Improvement Committee.

Ms. Lee highlighted that CalOptima Health achieved a three-star rating from the Centers for Medicare & Medicaid Services for the Health Risk Assessment measure. The Credentialing and Peer Review Committee reviewed and approved seven policies related to credentialing; the committee approved the credentialing clean/closure list and recommended the requiring of primary care provider minimum appointment hours. Ms. Lee noted that the Member Experience subcommittee approved its

charter, changing the quorum from seven to nine voting members, and issued corrective action plans to health networks based on quarter four 2024 performance on network adequacy. The Member Experience committee further made recommendations to prioritize the hiring of rheumatology, neurology, and urology specialists due to appointment delay issues. Furthermore, the Population Health Management subcommittee also updated its charter to add the CalOptima Health Chief Medical Officer as a voting member of the subcommittee and recommended follow-up with Access California Services to educate CalOptima Health benefits for the South Asian, Middle Eastern, and North African (SAMENA) collective, a community-based organization advancing care for SAMENA individuals. The Benefit Management subcommittee reviewed prior authorization codes and identified 19 codes for which prior authorization will be required and removed 24 codes from the prior authorization requirement. Finally, Ms. Lee reported that the Pharmacy and Therapeutics Committee approved drug criteria and formulary updates.

Ms. Lee responded to Committee members' comments and questions.

b. Member Grievances and Appeals Report

Ladan Khamseh, Executive Director, Operations, provided an overview of the first quarter 2025 grievances and appeals report. Overall, CalOptima Health received a total of 4,046 grievances and 324 appeals for the combined Medi-Cal and OneCare lines of business. The turnaround time for both complaint types remained compliant, averaging a closure rate of 23 days.

For the grievances, Ms. Khamseh reported that Medi-Cal experienced a decrease in grievances from 4,018 in the fourth quarter 2024 to 3,675 in the first quarter 2025, representing a decrease of 9% from prior quarter. Grievance types making up the overall first quarter volume for Medi-Cal included dissatisfaction in provider/staff attitude, transportation issues, and grievances related to provider services, specifically delays in referral submissions by treating providers. Ms. Khamseh noted that OneCare experienced a decrease in grievances from 419 in the fourth quarter 2024 to 371 in the first quarter 2025, representing a decrease of 11% from prior quarter. Grievance types making up the volume for OneCare included dissatisfaction in provider/staff attitude, telephone accessibility with providers offices, referral submission delays, and transportation grievances regarding driver punctuality and scheduling of services.

For the appeals, Ms. Khamseh reported that Medi-Cal experienced a decrease in appeals from 346 in the fourth quarter 2024 to 265 in the first quarter 2025, representing a decrease of 23.4%, with an overturn rate of 26%. The overall appeal volume was for redirection or modifications to community specialists, CalAIM personal care/homemaker services, and housing tenancy. Ms. Khamseh noted that OneCare experienced an increase in appeals from 41 in the fourth quarter 2024 to 59 in the first quarter 2025 representing an increase of 44%, with an overturn rate increase from 44% to 47%. She noted that the contributing factors in the appeals volume increase were inpatient hospital care with non-contracted providers, redirected authorizations from CalOptima Health tertiary providers to community providers who can treat the condition, and durable medical equipment requests.

Ms. Khamseh provided detailed information to committee members, on the grievances and appeals for both Medi-Cal and OneCare including steps taken to address current trends in grievances and appeals. She noted that CalOptima Health monitors all grievances and appeals and meets with vendors, staff and provider offices' staff to continually improve member satisfaction.

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Ms. Khamseh responded to Committee members' comments and questions.

c. Program of All-Inclusive Care for the Elderly Report

Monica Macias-Garcia, Director, PACE, presented the 2024 participant satisfaction survey results, which were delayed due to fire-related disruptions affecting the research vendor. The survey evaluated nine service areas, including transportation, medical care, social work, meals, and overall satisfaction. Ms. Macias-Garcia noted that CalOptima Health PACE scored above both the national and CalPACE averages in several categories, including center aide services, medical care, social work, activities, and overall satisfaction. However, four areas were identified for improvement. Transportation, while scoring 90%, fell short of the 93.6% goal, prompting changes such as a new transportation manager and the addition of a supplemental vendor. Meal satisfaction dropped from 88% to 79%, leading to plans for participant focus groups and demographic analysis. Home care services also underperformed, with efforts underway to standardize service authorization and educate participants on service expectations. Lastly, while overall satisfaction remained strong at 90%, staff training in customer service and faster communication were identified as areas for enhancement. Ms. Macias-Garcia noted that CalOptima Health ranked fourth among PACE programs in California, though specific rankings of other programs were not disclosed by the surveyor.

Ms. Macias-Garcia further provided an update on the non-clinical work plan, focusing on three key areas: enrollment, alternative care site partnerships, and transportation provider performance. She stated that the team is analyzing participant enrollment trends and working to improve the current 56% conversion rate toward the 70% goal. Strategies are being developed to understand and address the reasons behind the shortfall. In terms of partnerships with alternative care sites like CBAS centers, the goal is to increase day center authorizations to 15%, though the current rate is only 4%. Ms. Macias-Garcia reported that on a positive note, transportation provider performance had shown improvement, with zero violations reported in both quarter four of 2024 and quarter one of 2025. She noted that the data for quarter two of 2025 was still being finalized.

There were no questions from the Committee.

COMMITTEE MEMBER COMMENTS

The Committee thanked staff for the depth of information and the ease of understanding the reports, highlighting the importance of transparency and communication.

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 4:46 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 8, 2025

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 8, 2025
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Quality Improvement Policies

Contacts

Richard Lopez, M.D., Medical Director, Medical Management, (657) 900-1483
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Recommend that the Board of Directors approve modifications to the following CalOptima Health policies pursuant to CalOptima Health's annual review process:

- GG.1650: Credentialing and Recredentialing of Practitioners; and
- GG.1651: Assessment and Re-Assessment of Organizational Providers.

Background/Discussion

Modifications to Existing Quality Improvement Policies and Procedures

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

Below are the existing Quality Improvement policies that require modifications:

- ***GG.1650: Credentialing and Recredentialing of Practitioners [Covered California, Medi-Cal, OneCare, PACE]*** describes the process by which CalOptima Health evaluates and determines whether to approve or decline practitioners for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's annual review process, and revisions include the following:

Policy Section	Change
Section II.J.7.vi	Clarifies the inclusion of Qualified Autism Services (QAS) providers, also known as Applied Behavior Analysis providers, as other medical practitioners requiring Medi-Cal enrollment and credentialing.
Section II.N	Adopts the credentialing and recredentialing conducted by a Federally Qualified Health Center (FQHC) for practitioners, where CalOptima Health will no longer credential or recredential FQHC practitioners who practice exclusively with a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.
Section III.A.3.k	Removes the requirement for practitioners to be Medicare enrolled to align with adjustments to regulatory requirements. Verbiage was also corrected to provide consistency.

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- ***GG.1651: Assessment and Reassessment of Organizational Providers [Covered California (Effective 2027), Medi-Cal, OneCare, PACE]*** describes the process by which CalOptima Health evaluates and determines whether to approve or decline Organizational Providers (OPs) for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's annual review process, and revisions include the following:

Policy Section	Change
Section II.F.22	Adds Qualified Autism Services (QAS) providers, also known as Applied Behavior Analysis providers, as a provider type required to be Medi-Cal enrolled and fully credentialed.
Section II.K.1-2	Clarifies the Organizational Provider (OP) types that are required to be enrolled with the Medicare Program.

Fiscal Impact
The recommended action is operational in nature. Staff included and will include any anticipated costs in current and future operating budgets.

Rationale for Recommendation
The recommended action will ensure CalOptima Health is compliant with contractual and regulatory guidance from its regulators (*e.g.*, Department of Health Care Services, Centers for Medicare & Medicaid Services, and Department of Managed Health Care). The updated policies will supersede the prior versions.

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

Attachments
1. GG.1650: Credentialing and Recredentialing of Practitioners Final Policy Packet
2. GG.1651: Assessment and Reassessment of Organizational Providers Final Policy Packet

/s/ Michael Hunn *10/03/2025*
Authorized Signature **Date**

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Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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1. Credentialing delegated entities shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health.

F. CalOptima Health and delegated entities shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing providers, is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal~~,~~ but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

H. CalOptima Health and Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

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1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

    b. CalOptima Health and Delegated shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

    a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

    a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

    b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD).

2. Doctor of Osteopathy (DO).

3. Doctor of Chiropractic Medicine (DC).

4. Doctor of Dental Surgery (DDS).

5. Doctor of Podiatric Medicine (DPM)

6. Nurse Practitioners (NP).

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant).

   a. Behavioral health practitioners, including but not limited to:

      i. Psychiatrists and other physicians.

      ii. Addiction medicine specialists.

      iii. Doctoral or master's level psychologists.

      iv. Master's-level clinical social workers.

      v. ~~-~~Master's-level clinical nurse specialists or psychiatric nurse practitioners.

      vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors~~)~~, qualified autism services (QAS) providers also known as applied behavior analysis providers, etc.).

K. CalOptima Health and Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

   a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

      i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104.

   b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

   c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

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L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, ~~including but not limited to Behavior Management Technicians (BMT), Behavior Health Technicians (BHT), and Behavior Management Associates (BMA),~~ CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners ~~that~~who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering practitioners who do not have an independent relationship with CalOptima Health;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer);

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

7. Students, residents, and fellows, where applicable;

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and does not credential or recredential practitioners who practice exclusively

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within a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.

~~N.~~O. CalOptima Health and Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36~~)~~) month cycle to the month, not to the day.

~~O.~~P. CalOptima Health and Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

~~P.~~Q. CalOptima Health and Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

~~Q.~~R. CalOptima Health and Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

    a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

    b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

    c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

~~R.~~S. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information

~~S.~~T. CalOptima Health and Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

~~T.~~U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and

coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   d. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   f. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL: 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

   g. Practitioners shall attest to:

      i. Any work history gap that exceeds six (6) months and include written clarification;

      ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

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v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

h. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

i. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

j. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

k. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

l. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

m. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

n. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary

source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days); and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training.

d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). ~~CalOptima Health may use a signed attestation to validate these qualifications.~~ This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

i. History of any suspension or curtailment of hospital and clinic privileges.

ii. Any alternative admitting arrangements must be documented in the Credentialing file.

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written

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description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

   i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

   iii. A felony conviction related to health care fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

~~i. Current (within last three (3) years) full scope FSR/MRR, and PARS for primary care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;~~

~~j. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required;~~

~~k. Active enrollment status with Medicare for OneCare, as required (*i.e.*, has not opted-out of Medicare program); and~~

~~l.~~i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

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a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

   a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

   b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

      iii. Information from quality review activities;

      iv. Member satisfaction, if applicable; and

      v. Compliance with the terms of the practitioner's contract.

   c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

   a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

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b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

~~Email: mycredentialingupdates@caloptima.org~~
Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

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iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via ~~a~~ fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.
b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding ~~Assessment~~credentialing and ~~Reassessment~~recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

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i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

   a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

   a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

      i. Acceptance;

      ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

      iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

   b. CalOptima Health shall render a final Credentialing decision within one hundred eighty (180) calendar days from the date of the signed attestation that confirms the correctness and completeness of the application.

      i. If CalOptima Health is unable to render a decision within one hundred eighty (180) calendar days from the date of the signed attestation for any practitioner, during the practitioner's Credentialing or Recredentialing process, the practitioner must attest that the information on the application remains correct and complete, by resigning and redating the attestation.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30)

calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

   a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

   b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

   c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

   d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

      i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

         a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

         b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

         c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

         d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

      ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

      iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

      iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

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v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and,

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509

Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

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a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

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IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
B. California Evidence Code § 1157
C. California Health & Safety Code § 1374.197
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreements
I. CalOptima Health Policy GG.1213: Community Health Worker Services
J. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
~~L.~~A. ~~CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information~~
~~M.~~L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
~~N.~~M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
~~O.~~N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
~~P.~~O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
~~Q.~~P. CalOptima Health Policy GG.1619: Delegation Oversight
~~R.~~Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
~~S.~~R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
~~T.~~S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.9006: Provider Complaint Process
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS-) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 08/24/2022)
V. Department of Health Care Services (DHCS-) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. ~~DHCS APL~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS-) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS-) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. ~~NCQA~~National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service;

Term	Definition
	4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
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 or an entity'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. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC

Term	Definition
	meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima'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 to make an authorization decision. 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.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A ~~physician hospital consortium~~Physician Hospital Consortium (PHC), physician group under a shared risk contract, ~~or~~ health care service plan, such as a ~~health maintenance~~Health Maintenance Organization (HMO~~)~~), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide ~~covered services~~Covered Services to ~~members assigned to that health network~~Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

Term	Definition
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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1. Credentialing delegated entities shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health.

F. CalOptima Health and delegated entities shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing providers, is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

H. CalOptima Health and Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

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1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

    b. CalOptima Health and Delegated shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

    a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

    a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

    b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD).

2. Doctor of Osteopathy (DO).

3. Doctor of Chiropractic Medicine (DC).

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4. Doctor of Dental Surgery (DDS).

5. Doctor of Podiatric Medicine (DPM)

6. Nurse Practitioners (NP).

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant).

   a. Behavioral health practitioners, including but not limited to:

      i. Psychiatrists and other physicians.

      ii. Addiction medicine specialists.

      iii. Doctoral or master's level psychologists.

      iv. Master's-level clinical social workers.

      v. Master's-level clinical nurse specialists or psychiatric nurse practitioners.

      vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis providers, etc.).

K. CalOptima Health and Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

   a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

      i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104.

   b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

   c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

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L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering practitioners who do not have an independent relationship with CalOptima Health;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer);

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

7. Students, residents, and fellows, where applicable;

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and does not credential or recredential practitioners who practice exclusively within a FQHC and who provide care for a Member only as a result of the Member being directed to the FQHC.

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O. CalOptima Health and Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

P. CalOptima Health and Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

Q. CalOptima Health and Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

R. CalOptima Health and Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

S. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information

T. CalOptima Health and Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

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III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   d. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   f. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL: 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

   g. Practitioners shall attest to:

      i. Any work history gap that exceeds six (6) months and include written clarification;

      ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

      v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

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h. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

i. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

j. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

k. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

l. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

    i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

m. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

n. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

    i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

    ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

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b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days); and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training.

d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

i. History of any suspension or curtailment of hospital and clinic privileges.

ii. Any alternative admitting arrangements must be documented in the Credentialing file.

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

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b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

iii. Information from quality review activities;

iv. Member satisfaction, if applicable; and

v. Compliance with the terms of the practitioner's contract.

c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

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b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

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1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

        i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

        ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

        iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

    a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

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6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

    a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

        i. Acceptance;

        ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima Health shall render a final Credentialing decision within one hundred eighty (180) calendar days from the date of the signed attestation that confirms the correctness and completeness of the application.

        i. If CalOptima Health is unable to render a decision within one hundred eighty (180) calendar days from the date of the signed attestation for any practitioner, during the practitioner's Credentialing or Recredentialing process, the practitioner must attest that the information on the application remains correct and complete, by resigning and redating the attestation.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

    a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

    a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

    b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

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c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

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a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and,

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

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i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

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vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

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ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
B. California Evidence Code § 1157
C. California Health & Safety Code § 1374.197
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Covered California
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreements
I. CalOptima Health Policy GG.1213: Community Health Worker Services

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J. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1619: Delegation Oversight
Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.9006: Provider Complaint Process
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 08/24/2022)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service;

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Term	Definition
	4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
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 or an entity'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. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC

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Term	Definition
	meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima'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 to make an authorization decision. 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.

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Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.

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Term	Definition
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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CalOptima Health Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs. Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – DEA

Source of Verification	Method of Verification

CalOptima Health Primary Source Verification Table

DEA	https://apps.deadiversion.usdoj.gov/RDA/ **Login and Password required	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Nursing Board	Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Midwifery	American Midwifery Certification Board (AMCB) http://www.amcbmidwife.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physician Assistant	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

	National Student Clearing House http://nscverifications.org/welcome-toverification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

State & Federal Sanctions and Other Sources	Medi-Cal Suspended & Ineligible List https://files.medi Provider Suspended and Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction, https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/ Provider-EnrollmentandCertification/MedicareProviderSupEnroll/OptOutAffidavits.html	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

	For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider opt-out-affidavits-look-up-tool https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits/data	

Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Screening and Enrollment

Sanction Information	Source of Verification	Method of Verification
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web.	**Social Security Death Master File (DMF) Website** https://evoconportal.com/dmfportal/login.php **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

National Plan and Provider Enumeration System (NPPES)	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
List of Excluded Individuals/Entities (LEIE)	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
System for Award Management (SAM)	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
CMS' Medicare Exclusion Database (MED)	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/ Receive from IS Dept	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DHCS' Suspended and Ineligible Provider List	Medi-Cal Suspended & Ineligible List - c Provider Suspended and Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Restricted Provider Database (RPD)	Department of Health Care Service (DHCS)- Restricted Provider Database Receive from IS Dept	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
CHHS Open Data Portal (Medical Enrollment)	Medi Cal FFS Provider Listing | Medi Cal FFS Provider Listing | DHCS GIS Data Hub (arcgis.com)	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Ordering, referring, and prescribing (ORP)	https://mcweb.apps.prd.cammis.medi-cal.ca.gov/orp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network.

F. CalOptima Health shall assess or reassess ~~Ops~~OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Clinic;
12. Free Clinic;
13. Health Access Program;
14. Home Health Agencies;
15. Hospice and Palliative Care Providers;
16. Hospitals;
17. Indian Health Care Providers or Facilities;
18. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
19. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

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i. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

20. Non-Emergency Medical Transportation;

21. Prosthetics and Orthotics;

22. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

~~22.~~23. Radiology Center (Free Standing);

~~23.~~24. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

~~24.~~25. Religious Non-Medical Health Care Institution;

~~25.~~26. Residential Care Facilities for the Elderly;

~~26.~~27. Rural Health Clinic;

~~27.~~28. Skilled Nursing Facilities/Long Term Care Facility;

~~28.~~29. Surgical Center (Free Standing);

~~29.~~30. Transplant Programs (Organ Procurement Organization); and

~~30.~~31. Urgent Care Center (Free Standing).

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing Providers, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), ~~Applied Behavioral Analysis Providers,~~ and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and

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CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and Delegates shall confirm ~~the Medi-Cal and Medicare participation status of the OP.~~ :

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

   a. Hospitals;

b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural health Clinic (RHCs); and

m. Federally Qualified Health Center (FQHCs).

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

M. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

i. CalOptima Health and Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

ii. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

iii. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

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xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

   a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

   b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

      i. Completion of the CalOptima Health Provider training within the last two (2) years;

      ii. A facility site audit from a state agency;

      iii. No change in five percent (5%) ownership disclosure;

      iv. Possession of an active CDPH license and CMS certification; and

      v. In good standing as a Regional Center vendor.

   c. W-9 request for taxpayer identification number and certification.

   d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

   e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

   a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to:

         a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

         b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

         c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

         d) Review of medical records, as applicable.

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ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. Provider files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

a. The CMO or Designee shall review each file for Providers who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For Provider files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance; or

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

5. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Evidence Code, §1157
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

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D. CalOptima Health Contract with Covered California
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1355: CalAIM Community Supports
H. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
L. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
M. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
T. Title 42, United States Code, §1320a-7(a)
U. Title 45, Code of Federal Regulations, Part 455
V. Title XVIII and XIV of the Social Security Act
W. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
X. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Term	Definition
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
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 or an entity'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. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Durable medical equipment means equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim,

Term	Definition
	and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. 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. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A ~~physician hospital consortium~~Physician Hospital Consortium (PHC), physician group under a shared risk contract, ~~or~~ health care service plan, such as a ~~health maintenance organization~~Health Maintenance Organization (HMO~~)~~), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members ~~assigned to that health network~~.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: 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), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.

Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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) 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.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Clinic;
12. Free Clinic;
13. Health Access Program;
14. Home Health Agencies;
15. Hospice and Palliative Care Providers;
16. Hospitals;
17. Indian Health Care Providers or Facilities;
18. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
19. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

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i. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

20. Non-Emergency Medical Transportation;

21. Prosthetics and Orthotics;

22. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

23. Radiology Center (Free Standing);

24. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

25. Religious Non-Medical Health Care Institution;

26. Residential Care Facilities for the Elderly;

27. Rural Health Clinic;

28. Skilled Nursing Facilities/Long Term Care Facility;

29. Surgical Center (Free Standing);

30. Transplant Programs (Organ Procurement Organization); and

31. Urgent Care Center (Free Standing).

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing Providers, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not

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required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and Delegates shall confirm:

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

   a. Hospitals;

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b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural health Clinic (RHCs); and

m. Federally Qualified Health Center (FQHCs).

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

M. CalOptima Health and Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

i. CalOptima Health and Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

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ii. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

iii. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

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xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

    a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

    b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

        i. Completion of the CalOptima Health Provider training within the last two (2) years;

        ii. A facility site audit from a state agency;

        iii. No change in five percent (5%) ownership disclosure;

        iv. Possession of an active CDPH license and CMS certification; and

        v. In good standing as a Regional Center vendor.

    c. W-9 request for taxpayer identification number and certification.

    d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

    e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

    a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

    b. Incorporate the following data in the decision-making process:

        i. Quality review activities, including but not limited to:

            a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

            b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

            c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

            d) Review of medical records, as applicable.

        ii. Member experience, if applicable;

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iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. Provider files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

   a. The CMO or Designee shall review each file for Providers who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For Provider files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

   a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

      i. Acceptance; or

      ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

5. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

   a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

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b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

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iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

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iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Evidence Code, §1157
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Covered California

E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1355: CalAIM Community Supports
H. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
L. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
M. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
T. Title 42, United States Code, §1320a-7(a)
U. Title 45, Code of Federal Regulations, Part 455
V. Title XVIII and XIV of the Social Security Act
W. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
X. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	08/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

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Term	Definition
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
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 or an entity'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. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Durable medical equipment means equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration

Term	Definition
	or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. 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. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: 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), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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) 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.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 8, 2025
Regular Meeting of the CalOptima Health Board of Directors
Quality Assurance Committee

Report Item

5. Recommend that the Board of Directors Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

Contact

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

Recommended Actions

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1. ~~Approve CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Delegated Health Network Pay For Value Performance Programs effective January 1, 2026, through December 31, 2026.~~
2. Approve CalOptima Health Measurement Year 2027 Covered CA Health Network Pay for Value Performance Program effective January 1, 2027, through December 31, 2027.
3. Approve Measurement Year 2026 Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs, one-time provider incentives for digital technology improvements and utilization of physician incentive software to provide a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Background

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

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and CHCN PCPs for demonstrating quality performance;
2. Drive improvement in quality outcomes and processes through monetary incentives and penalties
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and CHCN PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and CHCN PCPs on their quality improvement efforts.

CalOptima Health staff have obtained feedback from HN and CHCN physician partners on recommendations to refine and improve the P4V Program to drive improvement and achieve quality goals. Feedback includes increasing incentive amounts, phasing-in programmatic changes, and shifting from a retrospective pay for performance model to a real-time, point-of-care approach that rewards physicians, and potentially physician staff, for the completion of specific value-based care actions.

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These recommendations are incorporated into the Calendar Year 2026 program elements discussed below.

Discussion

Measurement Process

~~CalOptima Health staff calculates the quality rating score for each HN annually. For Measurement Year (MY) 2026, staff will use the Integrated Healthcare Association (IHA) methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPs), and Centers for Medicare & Medicaid Services (CMS) Star measure data~~. The Covered California P4V Program will be based on comparison to benchmarks only since prior year rates will not be available.

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~~Medi-Cal Delegated Health Network P4V Program~~

~~Staff recommends implementing MY 2026 Delegated Health Network Medi-Cal P4V Program with the following program components:~~

1. ~~Maintain IHA pay for performance methodology to assess performance.~~
    - ~~The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.~~
    - ~~The greater of either the attainment or improvement score will be used to calculate incentive payments.~~
    - ~~The total quality score determines the percentage of incentive pool earned.~~

2. ~~Staff recommends basing the Medi-Cal incentive earned on both the total Medi-Cal quality score and the OneCare quality score. Since the pay for value incentive pools are based on membership, Medi-Cal draws focus and has performed higher than OneCare. CalOptima Health must maintain a OneCare Star rating of at least 3.0 stars. For MY2023/Star Rating Display year (SY) 2025, the total OneCare Star rating was 2.5 stars. This is below CMS' minimum star threshold. Staff recommends that HN performance on OneCare determines the allowable Medi-Cal incentive pool as follows:~~

	~~**Medi-Cal P4V Incentive Percentages**~~		
~~**OneCare Delegated Health Network P4V Star Performance**~~	~~**Year 1 MY2026 SY2028**~~	~~**Year 2 MY2027 SY2029**~~	~~**Year 3 MY2028 SY2030**~~
~~Below 3.0 stars~~	~~80%~~	~~70%~~	~~60%~~
~~3 Stars~~	~~90%~~	~~85%~~	~~75%~~
~~3.5 Stars~~	~~100%~~	~~100%~~	~~95%~~

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	~~Medi-Cal P4V Incentive Percentages~~		
~~OneCare Delegated Health Network P4V Star Performance~~	~~Year 1 MY2026 SY2028~~	~~Year 2 MY2027 SY2029~~	~~Year 3 MY2028 SY2030~~
~~4.0 Stars~~	~~110%~~	~~105%~~	~~100%~~
~~4.5 Stars~~	~~115%~~	~~110%~~	~~105%~~
~~5.0 Stars~~	~~125%~~	~~115%~~	~~110%~~

~~The amount of Medi-Cal incentive earned remains based on performance on Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) Minimum Performance Level (MPL) measures compared to benchmarks.~~

3. ~~Utilize the MY 2026 DHCS MCAS measures held to MPL for the HEDIS measurement set. Based on preliminary notice from DHCS, the MY 2026 Medi-Cal P4V Program will have a total of 20 quality measures. CalOptima Health's P4V Program will adopt the final MY 2026 MCAS MPL measure set upon availability by DHCS.~~

4. ~~Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.~~

5. ~~Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks. For MY 2026, MY 2025 Medicaid percentiles will be used as benchmarks.~~

6. ~~Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).~~

7. ~~Corrective Action:~~
   ~~HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.~~

8. ~~Application of DHCS Quality Withhold:~~
   ~~DHCS will maintain its quality withhold and incentive program for managed care plans. For calendar year 2026, the quality withhold percent will remain 1.0% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.~~

   ~~Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of~~

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withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

9. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives such as the member health reward program, mobile or at-home health screenings, digital measure improvements, etc.

OneCare Delegated Health Network P4V Program

Staff recommends implementing MY 2026 OneCare P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology, as described in the Medi-Cal section above, to assess performance. Performance will be calculated on a Star rating scale based on CMS Star ratings. The percentage of OneCare incentive earned will be determined as follows:

Current OneCare P4V Program		**Proposed OneCare P4V**
OneCare P4V Performance	**MY2025 Incentive Percent SY2027**	**MY2026 Incentive Percent SY2028**
Below 3.0 stars	0%	0%
3 Stars	20%	40%
3.5 Stars	40%	60%
4.0 Stars	60%	80%
4.5 Stars	80%	100%
5.0 Stars	100%	120%

Note: MY = measurement year, SY= Star rating display year

2. Utilize select CMS Part C and D measures for the P4V measurement set. Selected measures are those that are directly aligned with HN responsibilities

3. Utilize CMS Star cut-points as benchmarks. For MY 2026, the 2028 Star Rating cut points will be used.

4. Maintain program funding at $20 per member per month (PMPM).

5. HNs that score below the 3-Stars will be required to submit an improvement plan for that measure to CalOptima Health.

6. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives.

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~~**Additional Health Network Penalties**~~

~~***Panel Closure***~~

~~CalOptima Health proposes implementing a quality penalty for low-performing Medi-Cal and OneCare HNs where a HN Star at or below 2.5 stars will result in panel closure for one quarter. Performance for this indicator will be assessed quarterly to allow for re-opening of panels once a HN's Star rating improved to a minimum of 3.0 stars. Staff will return to the Board of Directors (Board) at a later date to request authorization of this quality penalty and to modify CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process and MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification.~~

Covered California Health Network P4V Program

Covered California values continuous improvement in the quality of care provided to its enrollees. To encourage quality improvement, Covered California maintains a Quality Transformation Initiative (QTI) program to provide financial incentives to Qualified Health Plans (QHP) participating in Covered California. Performance measures in QTI are based on CMS Quality Rating System (QRS) and NCQA HEDIS measures.

Staff recommends initiating a MY 2027 HN Covered California P4V Program with the following program components:

1. Adopt the Covered California QTI performance measures. For MY 2027, the calendar year 2027 QTI measures will be used.
2. Utilize NCQA Quality Compass National Exchange (NCQA Exchange) percentiles as benchmarks. For MY 2027, the MY 2026 NCQA Exchange percentiles will be used.
3. Performance will be assessed by comparing HN measure rates to the NQCA Exchange percentiles as follows:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

4. Fund the Covered California P4V Program at ten percent (10%) of professional capitation (base rate only).

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MY 2026 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider P4V Programs and One-time Provider Incentives for Digital Technology Improvements

Staff recommends moving from an annual, retrospective physician pay for performance model to a real-time approach for HN and CHCN Primary Care Providers (PCP) to achieve:

1. **Timely Feedback:** Real-time data will allow physicians to receive immediate feedback on their performance. This can help them quickly identify areas needing improvement and make necessary adjustments, leading to better patient outcomes and an overall improvement in CalOptima Health's quality performance.

2. **Continuous Improvement:** With real-time monitoring, physicians can continuously track their performance against quality measures. This ongoing process encourages a culture of continuous improvement rather than waiting for an annual review.

3. **Enhanced Patient Care:** Real-time data can highlight care gaps as they occur, enabling physicians to address these issues promptly. This proactive approach can lead to more timely interventions and better overall patient care.

4. **Increased Engagement:** Physicians are more likely to be engaged and motivated when they can see the immediate impact of their actions.

5. **Reduced Administrative Burden:** Annual reviews often require significant administrative work to compile and analyze data. A real-time approach can streamline this process, reducing the administrative burden on staff.

Staff recommends utilizing a software vendor to deliver the PCP P4V Program. The physician incentive software will be used by CalOptima Health contracted providers to view and close quality care gaps and earn corresponding P4V incentive dollars. The physician incentive software will:

1. Provide a single view of health-promoting behaviors and corresponding incentive values (*e.g.*, complete breast cancer screening) through a simple user interface that engages PCPs and office staff.

2. Support real-time updates to care gap closure status upon the physician/office staff taking action.

3. Ensure timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

4. Support the ability to share rewards across physician office staff to engage all levels of the provider practice/clinic.

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PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps, including the following activities:

- Calling members to schedule an appointment;
- Referring members for services such as mammograms, retinal eye exams, colonoscopy, etc.;
- Ordering laboratory tests;
- Reviewing test results with members;
- Conducting medication review; and
- Providing preventive services (*i.e.*, annual wellness visits, assessments, etc.).

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from $5 to $50 depending on the action taken and care gap closed.

One-time Provider Incentives for Digital Technology Improvements: This program will also include one-time incentives of $1,000 per type per provider for adopting the following digital technology improvements:

- Conversion from paper checks to electronic fund transfer
- Provider Portal adoption
- Provider electronic medical record (EMR) adoption

Staff will initiate the PCP P4V Program with OneCare and add Medi-Cal after an initial pilot period during Quarter 1 of 2026. Funding for this program and the one-time incentives to support provider adoption of digital technology improvements will draw from MY 2024 unearned P4V funds.

MY 2026 Unearned Incentive Dollars

MY 2026 P4V funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Total grant funds to an individual HN will not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withhold application. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

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CalOptima Health will utilize a portion of the unearned HN P4V funds for the MY 2026 PCP P4V programs.

Unearned incentive funds will be used as described herein. Staff will finalize expenditures from the MY 2026 P4V programs by Quarter 4 of 2028 and report back to the Board.

Eligibility for Incentive Payments
Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN must be contracted with CalOptima Health during the entire measurement period (January 1, 2026, through December 31, 2026), the calculation period (January 1, 2027, through December 30, 2027), and at the time of disbursement of payment. HNs and PCPs must also be in good standing with CalOptima Health at the time of disbursement of payment. Good standing includes the provider having an active contract, including contract amendments; being free of contract sanctions and limitations; and not having substantive corrective action, as determined by the Audit and Oversight department. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Fiscal Impact

~~Medi-Cal P4V Program~~
~~Staff estimates that the fiscal impact for the MY 2026 P4V Program will be no more than ten percent (10%) of the professional capitation (base rate only) or approximately $73.9 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2026-27 Operating Budget.~~

~~OneCare P4V Program~~
~~Staff estimates that the fiscal impact for the MY 2026 OneCare P4V Program will be no more than $20 PMPM or approximately $4.3 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the FY 2026-27 Operating Budget.~~

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Covered California P4V Program
Staff estimates that the fiscal impact for the MY 2027 Covered California P4V Program will be no more than 10% of the final professional capitation. Staff will include estimated pool funding for the MY 2027 Covered California P4V Program initiatives in future operating budgets.

MY2026 CalOptima Health Community Network Medi-Cal and OneCare PCP P4V Programs and One-time Provider Incentives for Digital Technology Improvements
Staff estimates that the fiscal impact for the MY 2026 Medi-Cal PCP P4V Program will not exceed $10.0 million, and the OneCare PCP P4V Program will not exceed $1.0 million. The fiscal impact for the one-time incentives to support provider adoption of digital technology improvements is estimated at $6.0 million for Medi-Cal and $1.0 million for OneCare. Staff anticipates that the estimated remaining balances in unearned funds from the MY 2024 Medi-Cal and OneCare P4V Programs will be sufficient to fund these initiatives.

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Rationale for Recommendation

CalOptima Health strives to continuously improve the quality of care and outcomes for all members. CalOptima Health is committed to demonstrating breakthrough improvement in quality measures, achieving high performing managed care plan status and achieving a 5-Star rating status. To achieve optimal quality performance and more fully engage the physician network, it is critical that CalOptima Health shift from a retrospective P4V model to a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Measurement Year 2026 Pay for Value Programs
2. Measurement Year 2026 Pay for Value Program

/s/ Michael Hunn *10/03/2025*
Authorized Signature **Date**

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Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

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MY 2026 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers are eligible to participate in the Medi-Cal P4V program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow-Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow-Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 1-10 points

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- ~~Points based on performance between 50th percentile and 95th percentile.~~
- ~~$1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$~~

- ~~Improvement Points~~
  - ~~Scale of 1-10 points~~
  - ~~Points reflect performance in the prior year compared to the current year.~~
  - ~~$\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$~~

3. ~~Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.~~
4. ~~Measure weighting~~
   - ~~HEDIS measures weighted 1.0~~
   - ~~CAHPS measures weighted 1.5~~
5. ~~Maintain program funding at ten percent (10%) of professional capitation (base rate only).~~
6. ~~Available Incentive Pool: OneCare performance will determine the total available incentive fund available for Medi-Cal based on OneCare Star performance. Actual Medi-Cal P4V incentives will be based on Medi-Cal performance as described in this section.~~

	~~Medi-Cal P4V Incentive Percentages~~		
~~OneCare P4V Performance~~	~~Year 1 MY2026~~	~~Year 2 MY2027~~	~~Year 3 MY2028~~
~~Below 3.0 stars~~	~~80%~~	~~70%~~	~~60%~~
~~3 Stars~~	~~90%~~	~~85%~~	~~75%~~
~~3.5 Stars~~	~~100%~~	~~100%~~	~~95%~~
~~4.0 Stars~~	~~110%~~	~~105%~~	~~100%~~
~~4.5 Stars~~	~~115%~~	~~110%~~	~~105%~~
~~5.0 Stars~~	~~125%~~	~~115%~~	~~110%~~

7. ~~Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.~~
8. ~~HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.~~
9. ~~DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.~~

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

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~~OneCare Pay for Value Program (P4V)~~

~~The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.~~

~~MY 2026 OneCare P4V Program Components~~

~~Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:~~

~~1. Utilize a subset of CMS Star measures~~

~~MY 2026 OneCare Pay for Value Program Measurement Set~~	
~~**Measure Category**~~	~~**Measure**~~
~~**Part C HEDIS**~~	~~Breast Cancer Screening~~
	~~Colorectal Cancer Screening~~
	~~Care for Older Adults- Medication Review~~
	~~Care for Older Adults- Functional Status Assessment~~
	~~Osteoporosis Management in Women who had a Fracture~~
	~~Comprehensive Diabetes Care – Eye Exam~~
	~~Comprehensive Diabetes Care – Blood Sugar Controlled~~
	~~Kidney Health Evaluation for Patients with Diabetes~~
	~~Controlling Blood Pressure~~
	~~Transitions of Care~~
	~~Follow-Up After ED Visit for Patients with Multiple Chronic Conditions~~
	~~Plan All-Cause Readmission~~
	~~Statin Therapy for Patients with Cardiovascular Disease~~
~~**Part C Member Experience**~~	~~Care Coordination~~
	~~Getting Care Quickly~~
	~~Getting Needed Care~~
	~~Customer Service~~
	~~Rating of Health Network Quality~~
	~~Rating of Health Network~~
~~**Part D**~~	~~Medication Adherence for Diabetes~~
	~~Medication Adherence for Hypertension~~
	~~Medication Adherence for Cholesterol~~
	~~Statin Use in Persons with Diabetes~~
	~~Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults~~
	~~Concurrent Use of Opioids and Benzodiazepines~~

~~2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN~~

- ~~Attainment and Improvement score calculated for each measure. The better of the two scores is used.~~

- ~~Scoring~~
  - ~~Attainment Points~~

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- ~~Scale of 1-5 points~~
- ~~Points based on performance between 3-Star and 5-Star cut points.~~
- ~~$1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$~~

- ~~Improvement Points~~
  - ~~Scale of 1-5 points~~
  - ~~Points reflect performance in the prior year compared to the current year.~~
  - ~~$\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$~~

2. ~~MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.~~
3. ~~Measure weighting~~
   - ~~HEDIS process measures weighted 1~~
   - ~~CAHPS measures weighted 2~~
   - ~~Outcome measures weighted 3~~
4. ~~Apply a program funding methodology of $20 PMPM~~
5. ~~Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V incentives will be based on performance as described in this section.~~

~~Current OneCare P4V Program~~		~~Proposed OneCare P4V~~
~~OneCare P4V Performance~~	~~MY2025 Incentive Percentage~~ **~~SY2027~~**	~~MY2026 Incentive Percentage~~ **~~SY2028~~**
~~Below 3.0 stars~~	~~0%~~	~~0%~~
~~3 Stars~~	~~20%~~	~~40%~~
~~3.5 Stars~~	~~40%~~	~~60%~~
~~4.0 Stars~~	~~60%~~	~~80%~~
~~4.5 Stars~~	~~80%~~	~~100%~~
~~5.0 Stars~~	~~100%~~	~~120%~~

~~*Note: MY = measurement year, SY= Star rating display year*~~

6. ~~Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance~~
7. ~~HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.~~

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs
Covered California Pay for Value Program (P4V)

The Covered California P4V program focuses on measures included in the Quality Transformation Initiative. Health networks (HNs) are eligible to participate in the Covered CA P4V program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components:

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

Measurement Year (MY) 2026 Pay for Value Program

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.

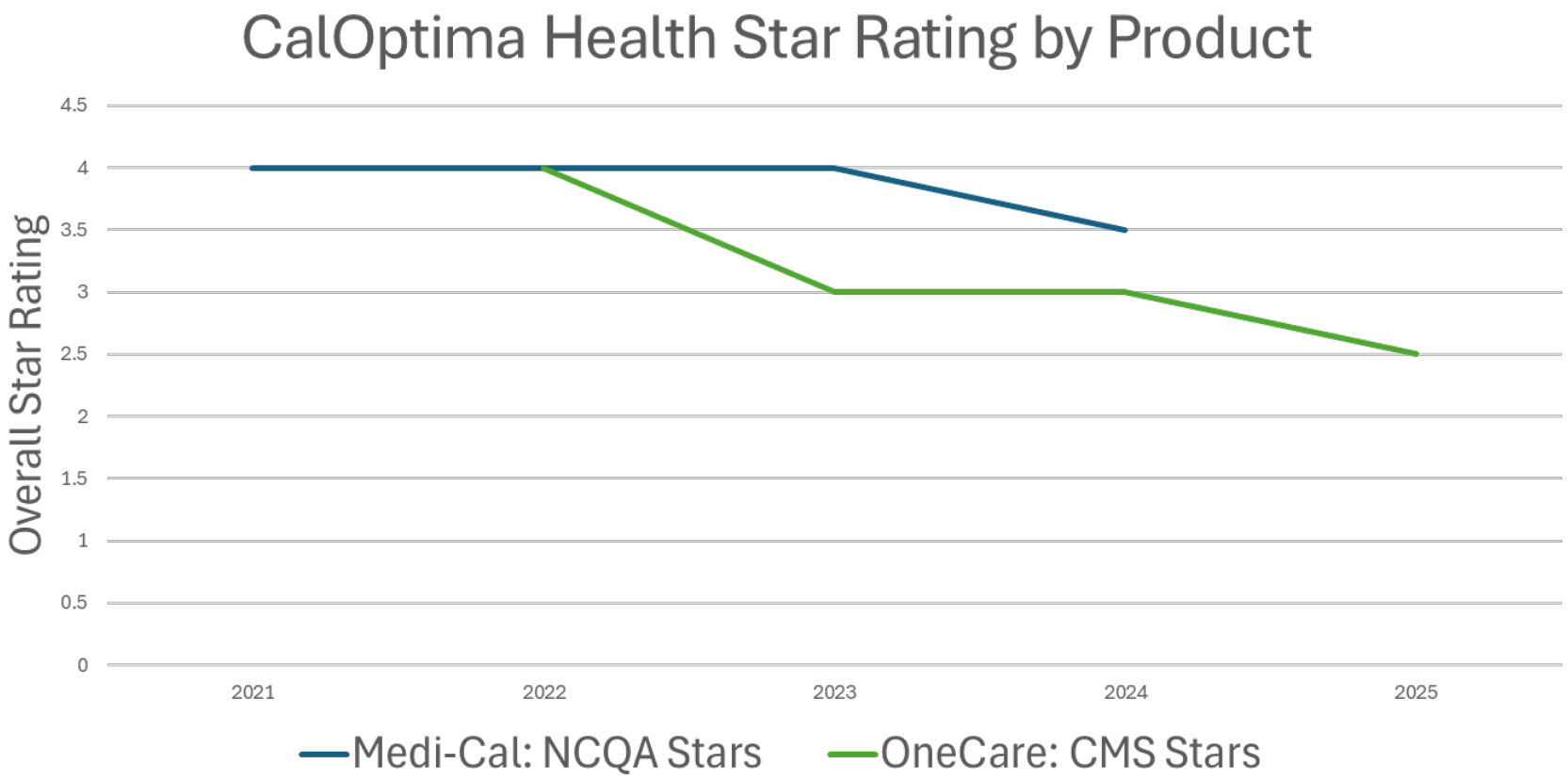
Background

- CalOptima Health has implemented a Pay for Value Program (P4V) to reward high performing Health Networks
- CalOptima Health's P4V program has historically provided upside incentives and no downside penalties
- The P4V program has resulted in mixed performance across products and at the Health Network level

Medi-Cal's Membership Draws Quality Focus

- Since CalOptima Health's P4V incentive pool is based on membership, the Medi-Cal program draws significant attention due to the large membership and corresponding larger incentive pool
- This leaves less attention on smaller products such as OneCare
- The impact is lower performance compared to industry standards for OneCare compared to Medi-Cal

OneCare Performance Lags Behind Medi-Cal



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MY2026 Delegated Health Network P4V Program Components

OneCare P4V Gateway: Medi-Cal P4V Percentages

OneCare performance impacts Medi-Cal with both upside and downside impacts

	Medi-Cal P4V Incentive Percentages		
OneCare P4V Performance	**Year 1 MY2026**	**Year 2 MY2027**	**Year 3 MY2028**
Below 3.0 stars	80%	70%	60%
3 Stars	90%	85%	75%
3.5 Stars	100%	100%	95%
4.0 Stars	110%	105%	100%
4.5 Stars	115%	110%	105%
5.0 Stars	125%	115%	110%

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OneCare P4V Incentive Percentages

OneCare performance compared to star cut-points can earn bonus incentives above 100% of P4V allocation

Current OneCare P4V Program		Proposed OneCare P4V
OneCare P4V Performance	**MY2025 Incentive Percent**	**MY2026 Incentive Percent**
Below 3.0 stars	0%	0%
3 Stars	20%	40%
3.5 Stars	40%	60%
4.0 Stars	60%	80%
4.5 Stars	80%	100%
5.0 Stars	100%	120%

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MY2026 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize HEDIS and DHCS clinical measures
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with CMS Star measures most impactable by HNs
    - Utilize Part C HEDIS and CAHPS measures
    - Utilize Part D measures

MY2026 P4V Program Elements

- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring method
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile for Medi-Cal and 3-Stars for OneCare
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on CMS Star cut points

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Health Network Corrective Action

- Corrective action: HN scoring below the MPL on Medi-Cal or below 3.0 Stars on Medicare must submit a corrective action plan

Additional Health Network Penalties

- Panel closure
  - Overall performance at or below 2.5 stars results in panel closure for one quarter
  - Performance will be reassessed quarterly
- CalOptima Health will pass down any impact of the DHCS quality withhold program.
  - For MY2026, the withhold is 1.0% of capitation
  - Any unearned withhold will be deducted from each HN's PV4 program payment

MY2026 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $73 million

- OneCare:
  - $20pmpm
  - Estimated at $4.3 million

Unearned Incentive Dollars

- Issue quality grants using unearned dollars
- Grants will be used to improve individual or groups of measures
- Funds used for quality improvement efforts including staff directly involved with quality initiatives
- HNs submit a plan, subject to quarterly monitoring
  - Must meet implementation requirements to continue to access improvement funds
- CalOptima Health will implement delivery system-wide interventions

MY2027 Covered CA P4V Program

MY2027 Covered CA Program Components

- Utilized Covered CA Quality Transformation Initiative (QTI) measure set
- Measures will be equally weighted
- Utilize NCQA Exchange National Percentiles as benchmarks
- Performance assessed on attainment of benchmarks
  - P4V program budgeted at ten percent of professional capitation (base rate only)

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MY2027 Covered CA P4V Incentive Percentages

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

MY2026 Primary Care Provider P4V Program Components

Primary Care Provider P4V

- Carve-out a portion of Health Network P4V for primary care provider (PCP) incentives to drive improvement at the point of care
- CalOptima Health issued an RFP in August 2025 to acquire a vendor to implement this program
- PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps
  - Call members to schedule an appointment
  - Refer members for services
  - Review results with members
  - Provide services i.e. annual wellness visits, assessments, etc.

One-Time Provider Incentives for Digital Technology Improvements

- Conversion from paper checks to electronic fund transfer
  - One-time incentive of $1000 per provider
- Provider Portal adoption
  - One-time incentive of $1000 per provider
- Provider EMR adoption
  - One-time incentive of $1000 per provider

CalOptima Health Investments

- CalOptima Health is in the process of implementing Cozeva PayerOne
  - Direct access to provider EMR
  - Provides a data system for providers to update care gap closure
  - Provides a data system for providers to submit supplemental data

Next Steps

- Discuss modified program at:
  - CEO Meeting- early October
  - October QAC 10/8/2025
  - November Board Meeting 11/6/2025
- Create program policy to include in 2026 QI program
- Create 2026 P4V provider manual

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APPENDIX

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Breast Cancer Screening
HEDIS	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Care Coordination
Member Experience	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

MY2027 Covered CA P4V Measurement Set

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

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CalOptima Health Board Action Agenda Referral

Action To Be Taken October 8, 2025
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

6. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2026 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 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 are historically 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.

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 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

Attachment

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

/s/ Michael Hunn *10/03/2025*
Authorized Signature **Date**

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

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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Credentialing Update

Quality Assurance Committee Meeting

October 8, 2025

Linda Lee, Executive Director, Quality Improvement

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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.

Credential Backlog Mitigation Plan (April to June 2025)

- In April 2025, CalOptima Health implemented the following to clear the backlog of credentialing files:
  - Hired and trained temporary staff to assist with credentialing
  - Initiated overtime for staff to support credentialing
    - Overtime shifts occur before/after work hours Monday to Friday and Saturdays
- By June 30, 2025, CalOptima Health cleared the backlog of credentialing files.

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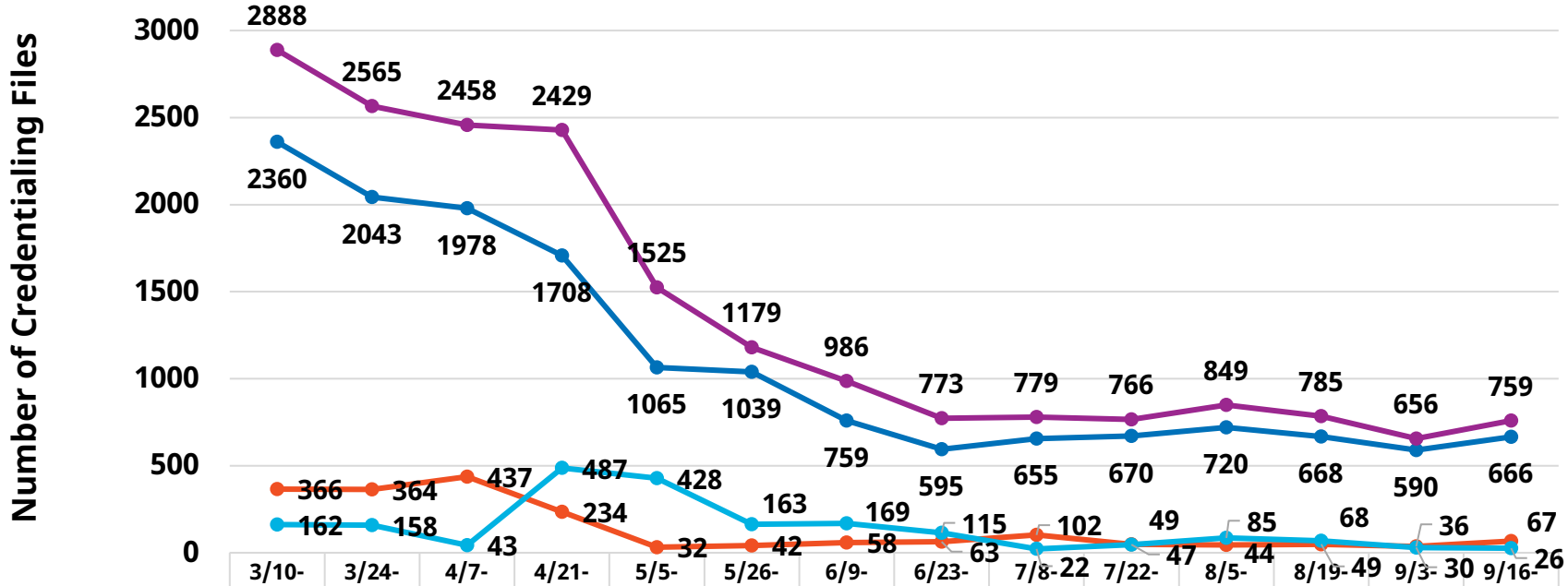
Providers Credentialing Files

of Files By Credentialing Status Per Week



	3/10-3/16	3/24-3/30	4/7-4/13	4/21-4/27	5/5-5/18	5/26-6/1	6/9-6/15	6/23-6/30	7/8-7/14	7/22-7/28	8/5-8/11	8/19-8/25	9/3-9/9	9/16-9/22
Received*	366	364	437	234	32	42	58	63	102	49	44	49	36	67
Pending	2360	2043	1978	1708	1065	1039	759	595	655	670	720	668	590	666
Closed	162	158	43	487	428	163	169	115	22	47	85	68	30	26
Total Inventory	2888	2565	2458	2429	1525	1179	986	773	779	766	849	785	656	759

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Additional Credentialing Efforts

- Hired a Director of Credentialing and two full-time staff to support credentialing
- CalOptima Health is focused on making improvements in the following areas:
  - Tracking of credentialing applications throughout the process
  - Reducing provider onboarding times
  - Reducing manual work via automation

REGULATORY UPDATE

Qualified Autism Service Provider Medi-Cal Enrollment Update

- Starting on May 5, 2025, DHCS implemented a method for Qualified Autism Service (QAS) provider organizations, individuals, and community-based organizations to apply for Medi-Cal enrollment.
- Existing providers who were contracted with CalOptima Health prior to May 5, 2025 must become Medi-Cal enrolled.
- Providers who have not initiated the Medi-Cal enrollment process by 10/1/25 will face contract termination.

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Qualified Autism Service Provider Notification and Process Update

- To ensure compliance with Medi-Cal enrollment, CalOptima Health has taken the following steps to notify all currently contracted QAS providers
  - Sent an email communication on 6/3/2025, 8/15/2025 and 9/23/25.
  - Discussed the Medi-Cal enrollment process at the June 18th ABA provider webinar.
  - Sent a letter via certified mail on 9/22/25.
  - Conducted reminder phone calls during the week of 9/22/25.

Qualified Autism Service Provider Notification and Process Update

- CalOptima Health is monitoring current QAS providers to ensure timely Medi-Cal enrollment
- All newly contracted QAS providers are required to be Medi-Cal enrolled prior to contract execution

Qualified Autism Service Provider Medi-Cal Enrollment Update

- On 9/30/2025, DHCS held a webinar to discuss updates on the Medi-Cal Enrollment requirements for QAS providers including
  - Individual Board-Certified Behavioral Analyst (BCBA) that only bill Medi-Cal for themselves may report their residential address as their administration location
  - This change goes into effect on November 17, 2025

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National Committee for Quality Assurance (NCQA) Accreditation Update

Quality Assurance Committee Meeting

October 8, 2025

Linda Lee, Executive Director, Quality Improvement

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NCQA Accreditation Timeline

Survey	Review Time Period	File Review	Submission Dates
Health Plan Accreditation (HPA)	April 06, 2025-April 06, 2027 (24 months)	April 6, 2026-April 6, 2027 (UM Denials, Appeals, Complex Case) April 6, 2024-April 6, 2027 (Credentialing)	April 6, 2027
Health Equity Accreditation (HEA)	April 07, 2025-October 07, 2025 (6 months)	Not applicable	October 7, 2025

NCQA Health Plan Resurvey Progress

Status	Actions	Timeline
Completed	• All policies and Annual Programs, evaluations, and work plans were reviewed and approved by the consultants. • NCQA Team conducted training with stakeholders that write analytical reports and set due dates. • Audit period kick-off meeting	• July 2024-ongoing • 12/6/2024 • 3/24/2025
In-Progress	• Continue to submit year one documents for consultant review. • 2026 NCQA standards released and NCQA Team is conducting trainings with internal and external stakeholders.	• April 2025-ongoing
Next Steps	• CalOptima Health to conduct file review audits (UM Denials, Appeals, Complex Case, and Credentialing)	• November 2025

NCQA Health Equity Accreditation Progress

Status	Actions	Timeline
Completed	• Consultants reviewed: policies and procedures, desk-top level procedures, training materials, survey materials, language service contracts, reports, program descriptions, program evaluation(s), and minutes. • Consultants provided a revised GAP Assessment which was shared with workgroups and executives • Current Assessment is 89.29% out of a possible 100 points.	• January 2025-August 2025
In-Progress	• Consultants will continue to review the documents as they become available and/or finalize, guiding the team until identified gaps are closed. • CalOptima Health to revise and finalize all documents and share with HMA for review.	• Ongoing until submission
Next Steps	• NCQA Team to upload all documents to the NCQA's Interactive Review Tool (IRT) for submission. • NCQA Health Equity Survey Submission	• September 2025 • By October 7, 2025

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Summary and Next Steps

- NCQA Team will train stakeholders on 2026 Standards.
- CalOptima Health to conduct file review audit (UM Denials, Appeals, Complex Case, and Credentialing)
- Health Plan accreditation is on track for year one of the lookback period (4/6/2025-4/6/2026)
- **Health Equity accreditation documents submitted on 10/6/2025**

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Utilization Management Committee and Clinical Operations Updates Q2 2025

Quality Assurance Committee Meeting
October 8, 2025

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 Committee Sub-Workgroups
- Over/Under Utilization Goals
- Health Network Oversight
- Inpatient / Hospital Facility Supports

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Utilization Management Committee Sub-Workgroups

Kelly Giardina, Executive Director, Clinical Operations

UM Sub-Workgroups – Q2 2025 Accomplishments

- **High-Risk Care:**
  - Enhanced Usher text campaign
  - Launched Urgent Care technology, tools and resources
- **Transitional Care Services workgroup:**
  - 7.58% improved member engagement from Q1 2025
- **Over/Under Utilization:**
  - Remove PA for Medi-Cal preventive screenings
  - Expanded Auto Approval Trend Dashboard
  - Enhanced clinical oversight and retraining on criteria review for specialty imaging
- **Gender Affirming Care**
  - Published transgender health care resources to the CalOptima Health website

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UM Sub-Workgroups – Q2 2025 Accomplishments

- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
  - UM resource tool developed for home health agencies who staff sub-specialty private duty nursing (PDN) services.
  - Launched preventive screening text campaign.
- **Enhanced Care Management (ECM) Clinical Oversight**
  - Implemented ECM audit framework and provided targeted education for ECM providers with the highest volume of members with ER admissions.
    - Provided education on the TCS requirements.
    - Clinical consultations from CalAIM medical director to address complex medical needs.
  - Ongoing analysis to identify ECM providers to engage for clinical conference meetings and education.

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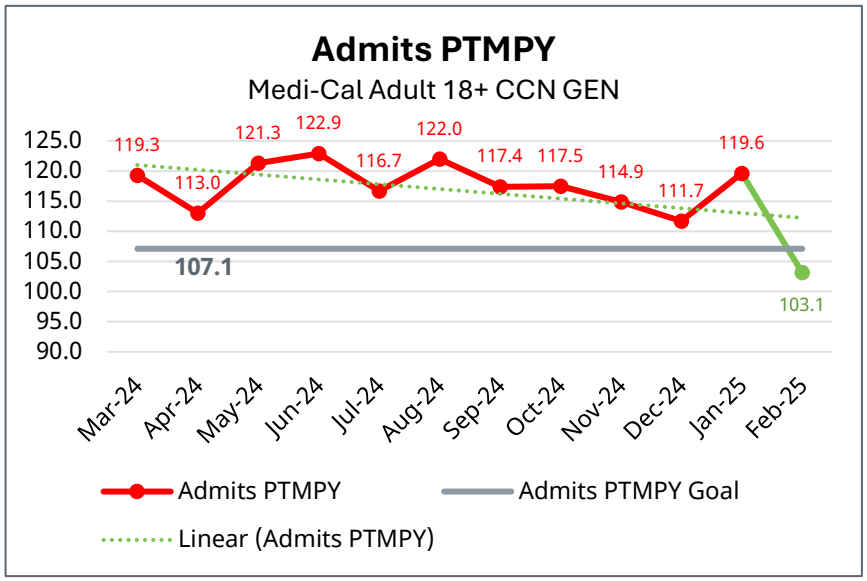
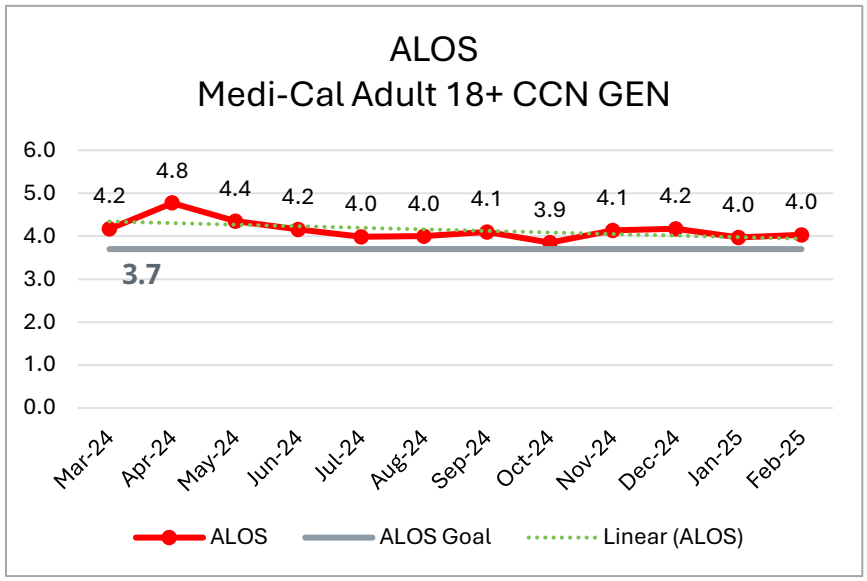
Over/Under Utilization: Utilization Goal Tracking

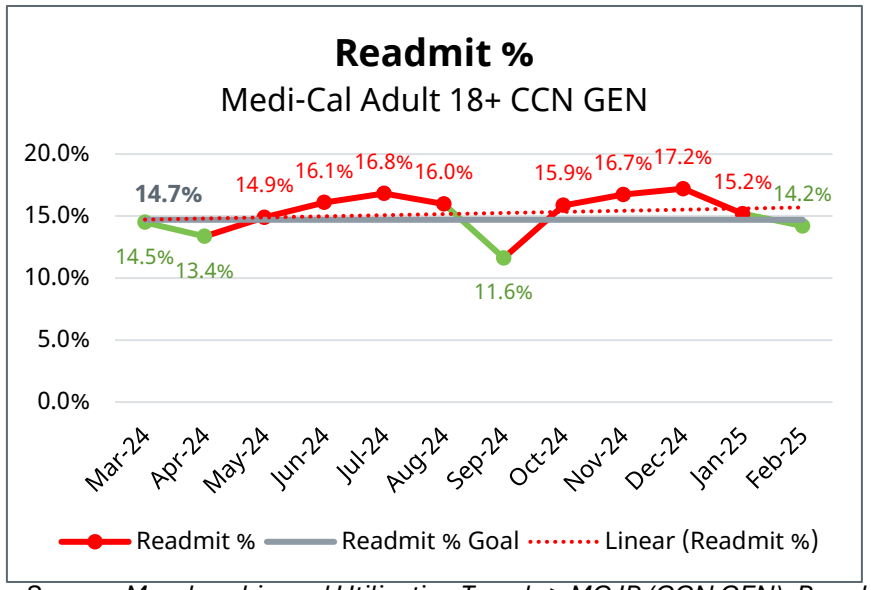
Kelly Giardina, Executive Director Clinical Operations

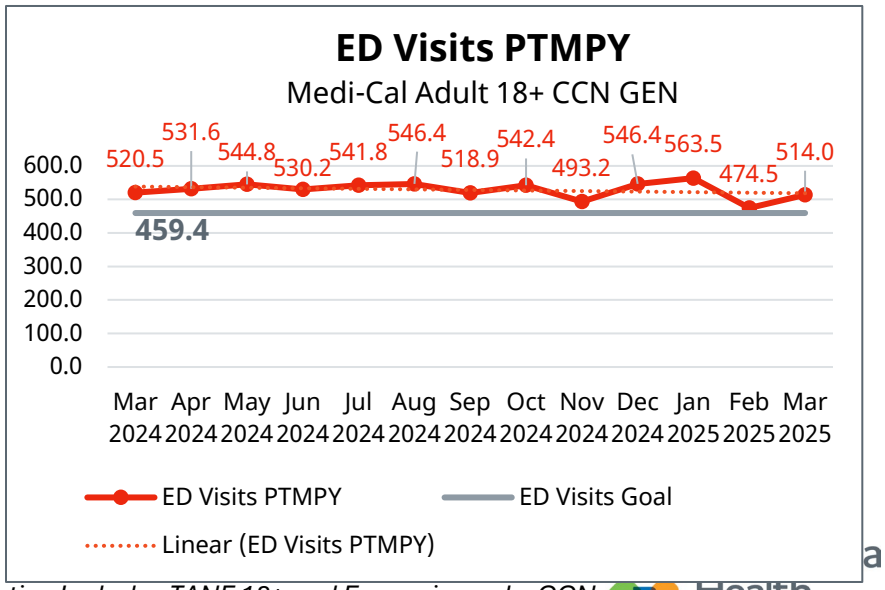
Medi-Cal Adults 18+

Members / Month	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
	108,956	110,904	112,777	114,164	114,487	117,220	118,233	119,278	120,553	121,842	123,148	124,662







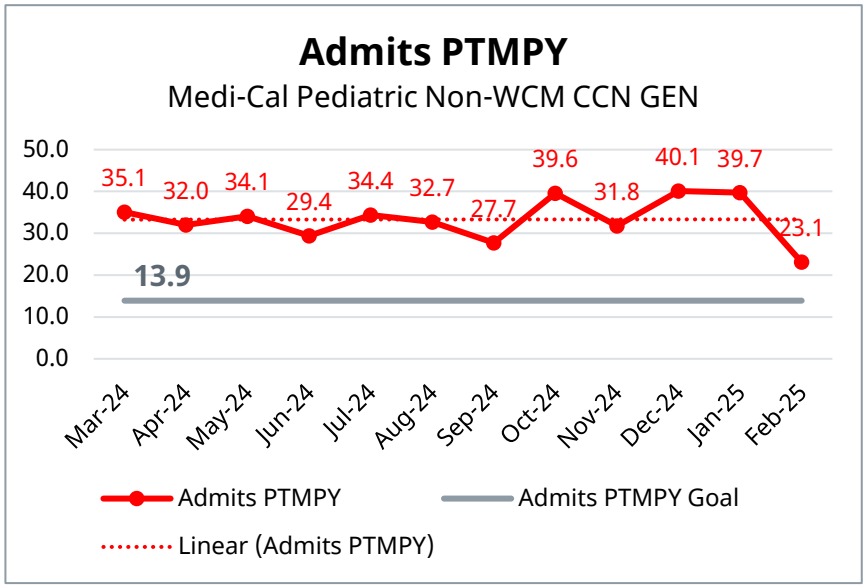


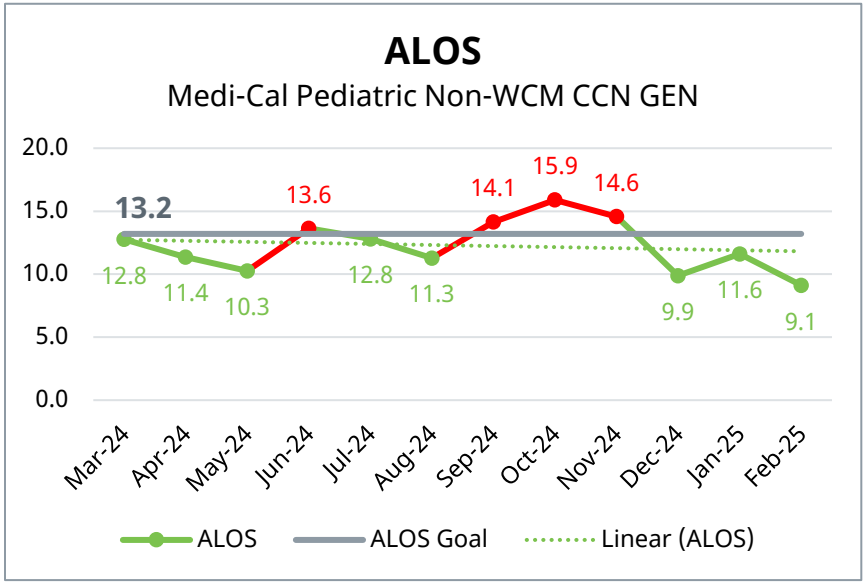
Source: Membership and Utilization Trends > MC IP (CCN GEN). Population Includes TANF 18+ and Expansion only. CCN General only. Population excludes Dual, WCM, LTAC, and Acute Rehab. Date 032024-022025, LOB: Medi-Cal. Data pulled 9/9/2025. ED Utilization: Membership and Utilization Trends dashboard. Medi-Cal Data excludes Duals and WCM. Data looking at 032024-022025. Data pulled 9/9/2025

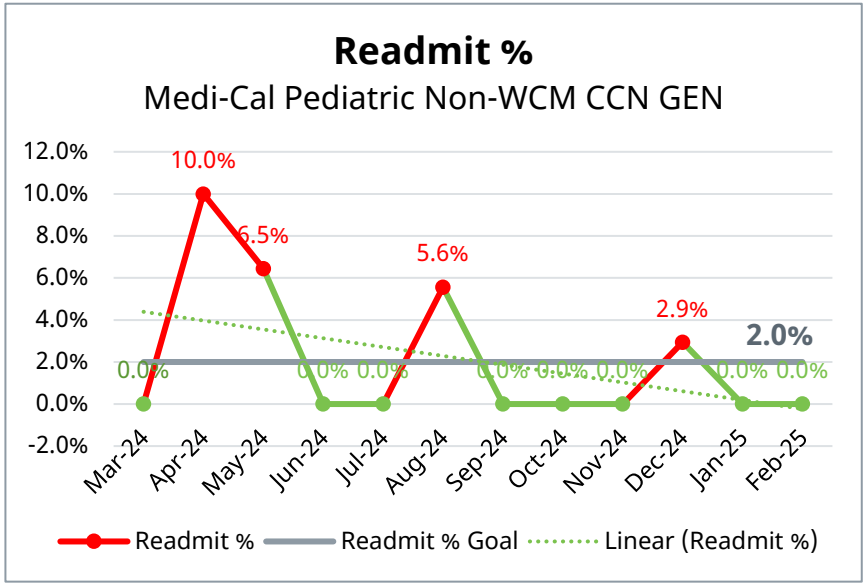
Back to Agenda

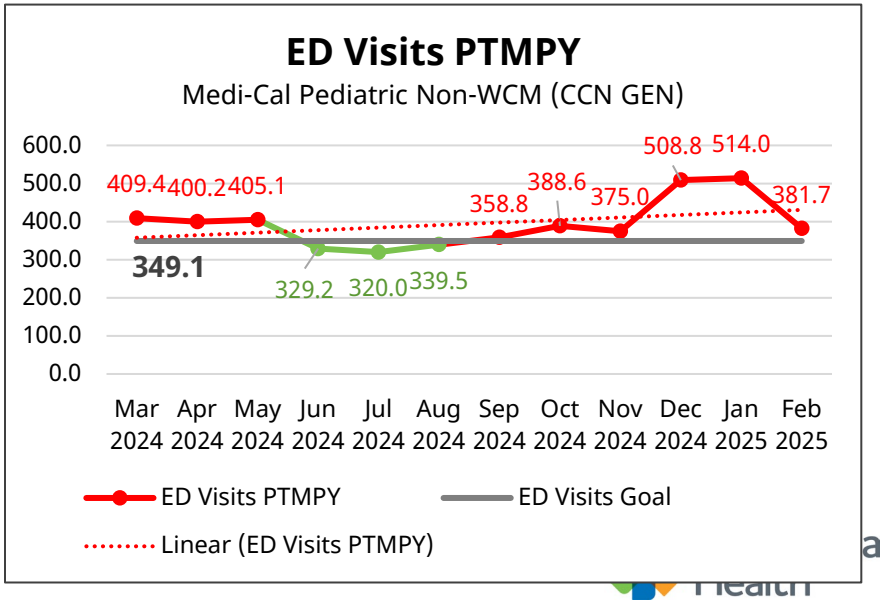
Medi-Cal Pediatric Non-WCM

Members / Month	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
	24,301	24,407	24,645	24,863	25,089	25,343	25,521	25,756	26,019	26,319	26,616	27,066







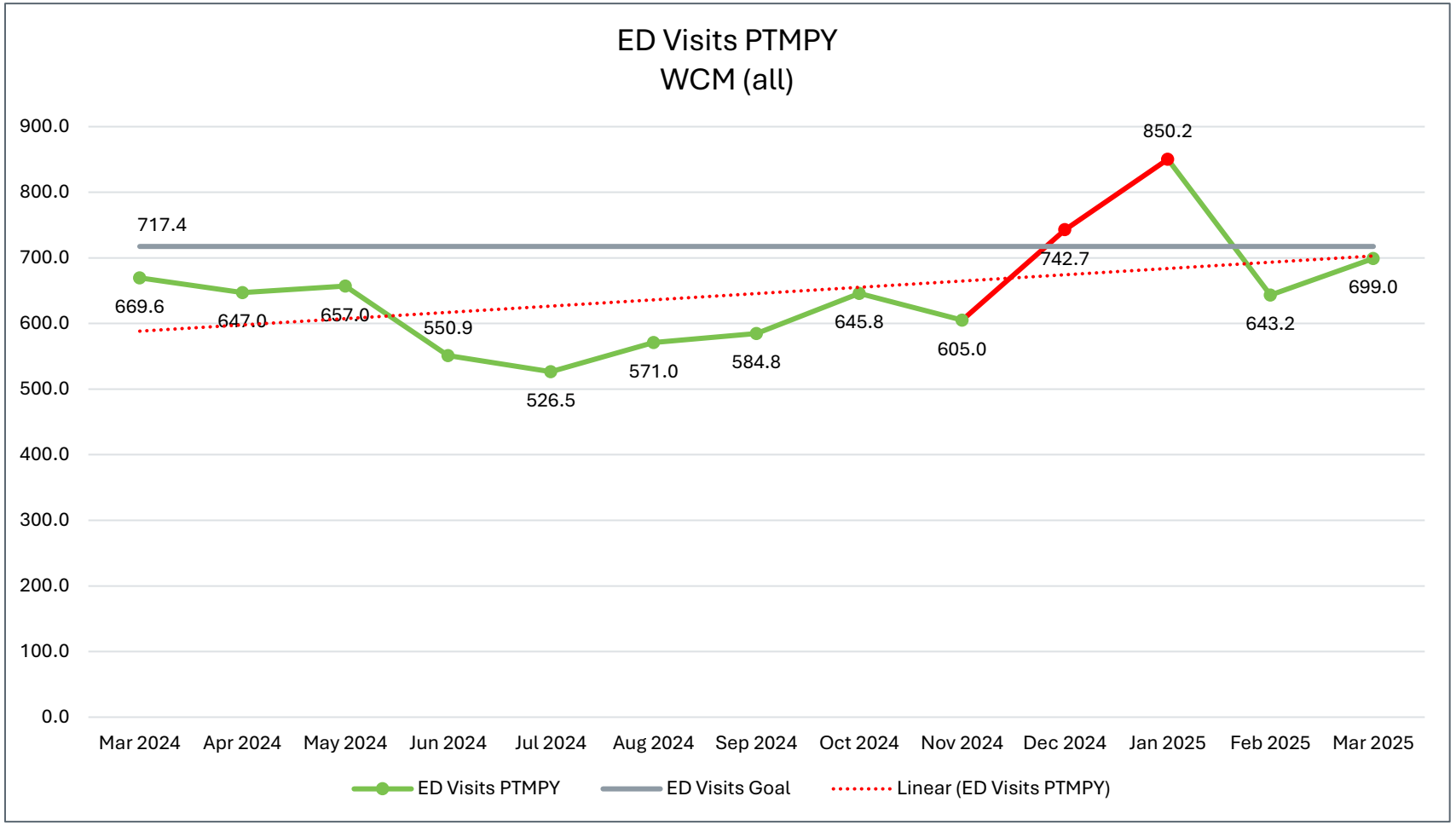


Source: Membership and Utilization Trends > MC IP (CCN GEN). Population Includes CCN General only. Population excludes Dual, WCM, LTAC, and Acute Rehab. Date 032024-022025, LOB: Medi-Cal. Data pulled 9/9/2025 ED Utilization: Membership and Utilization Trends dashboard. Medi-Cal Data excludes Duals and WCM. Data looking at 032024-022025. Data pulled 9/9/2025

Whole Child Model

ED Visits PTMPY

Members / Month	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
	9,857	9,738	9,736	9,649	9,596	9,541	9,460	9,403	9,362	9,388	9,344	9,291



Due to the high-touch management of our WCM members the only metric tracked for this population is ED Visits PTMPY.

Source: Membership and Utilization Trends dashboard. Medi-Cal Data excludes Duals and WCM. Data looking at 032024-022025. Data pulled 9/9/2025

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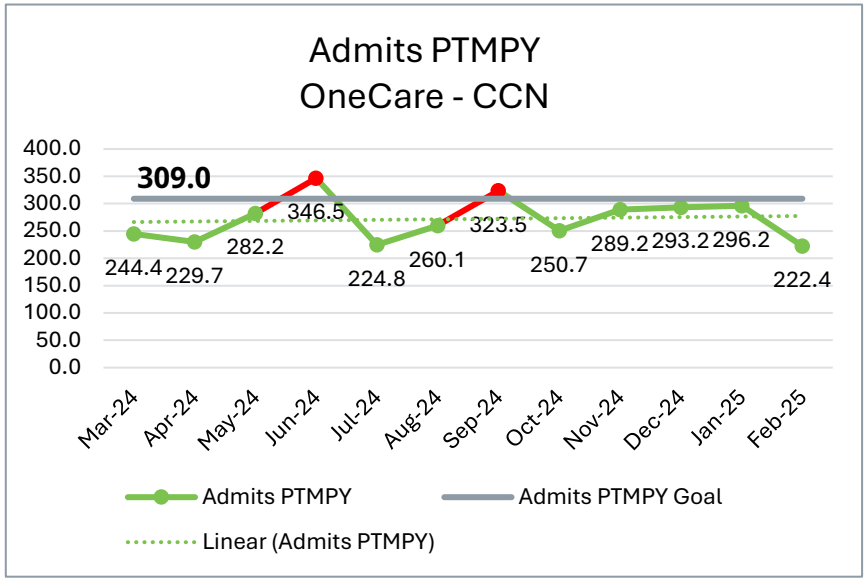
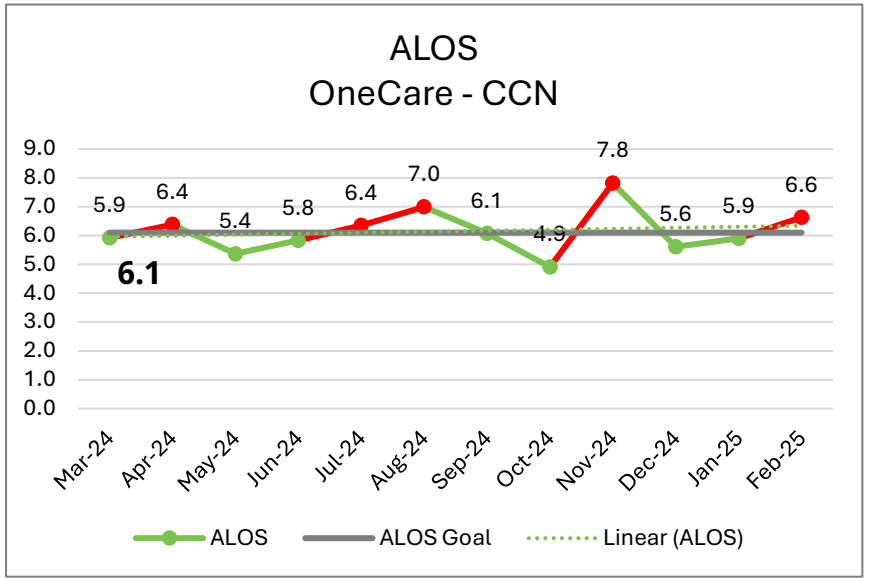
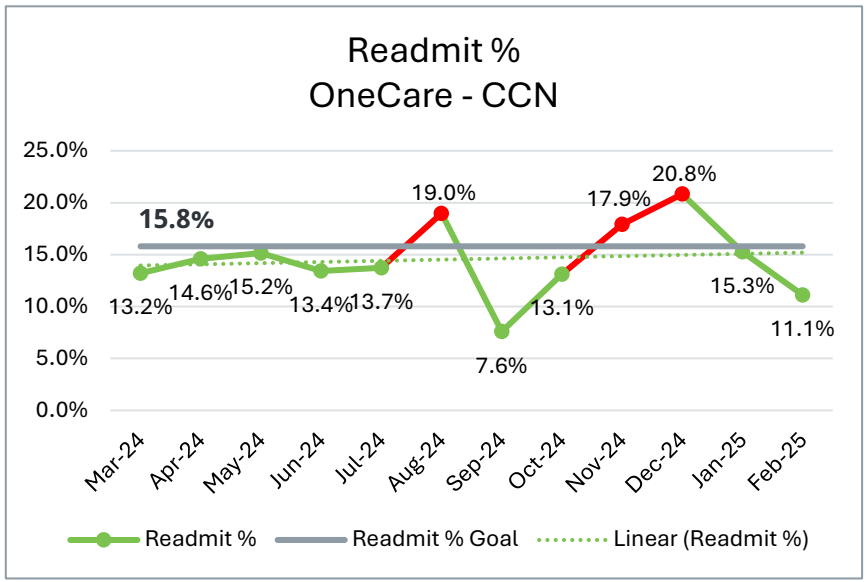
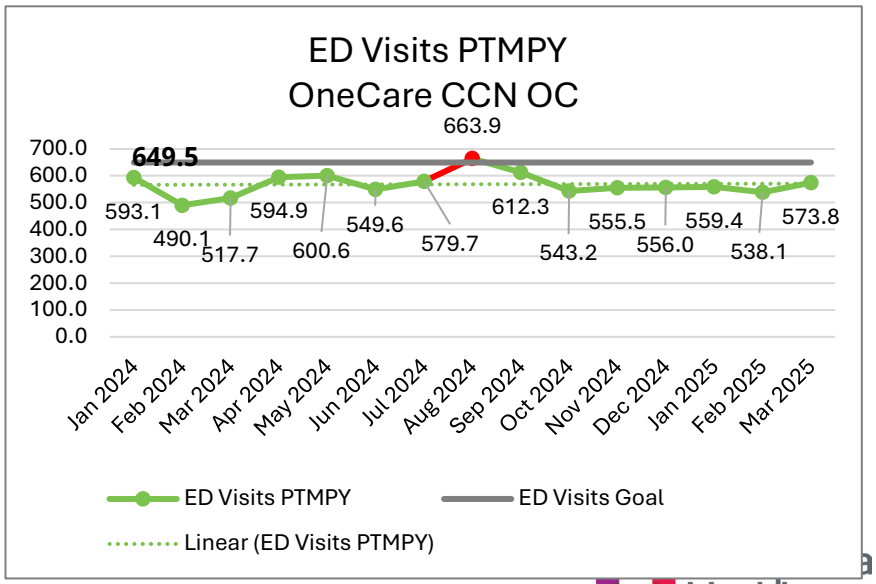
OneCare

Members / Month	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
	2,898	2,925	2,977	3,013	3,043	3,091	3,116	3,159	3,154	3,151	3,282	3,345









Source: Cost & Utilization: IP Acute Claims by Month Date 032024-022025, LOB: OneCare. CalOptima- CCN OC. Data pulled 9/9/2025
ED Utilization: Membership and Utilization Trends dashboard. Data looking at 032024-022025. Data pulled 9/9/2025

Health Network Oversight

Dr. Robin Hatam, Medical Director

Health Network Clinical Oversight

- Health network Dashboard results monitored by Business Units monthly. Reported monthly to Delegation Oversight Committee and quarterly at clinical meetings.
- GARS trends integrated into quarterly clinical meetings
- Delegation annual report card created and distributed for CY 2024 summarizing performance in delegated domains.

Inpatient / Hospital Facility Supports

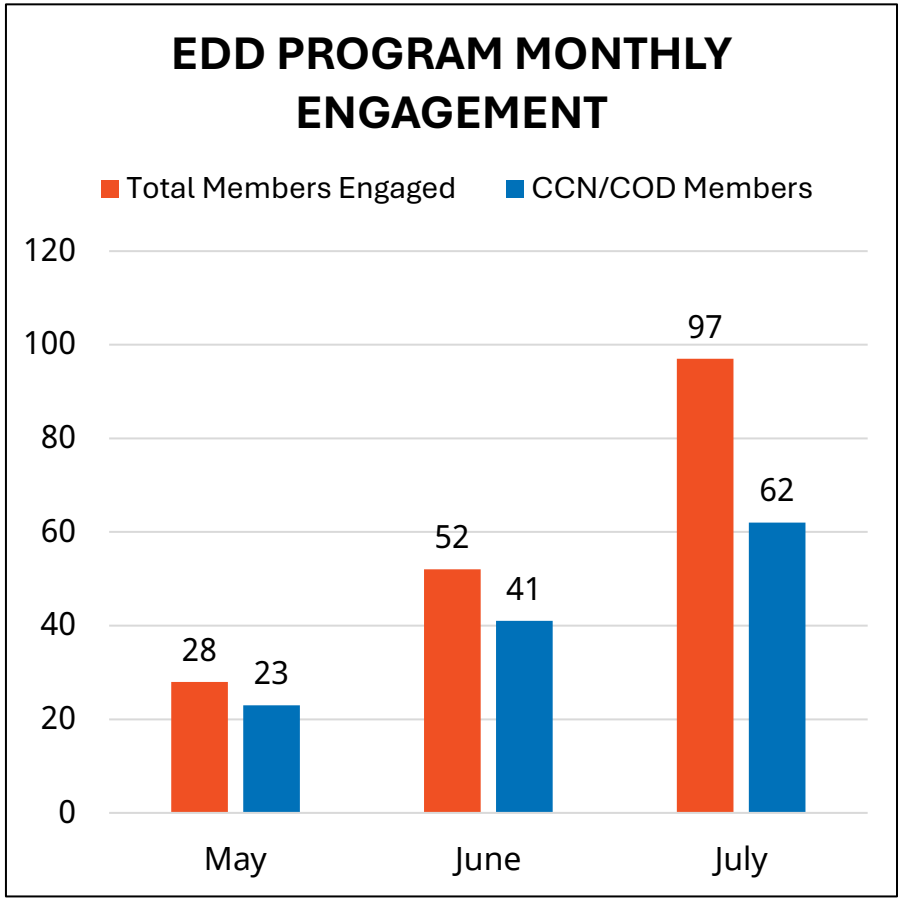
Dr. Robin Hatam, Medical Director

Inpatient / Hospital Facility Supports

- Hospital Rounds and LTACH Rounds
- SNF Partner Engagement

Emergency Department Diversion Program

- Increased engagement month over month
- Enhancements:
  - Weekly workgroup meeting
  - Weekly “Tips & Tricks” education with ED CM team
  - Warm handoff to CCN and Delegated networks
  - Assist with SNF placement of members transitioning out of ED
  - Referrals to TCS, CM, ECM, and Community Supports/CalAIM



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Second Quarter 2025 Summary of the Quality Improvement Health Equity Committee (QIHEC)

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.

QIHEC Actions in Second Quarter 2025

- QIHEC oversees and monitors the Quality Improvement Health Equity Transformation Program (QIHETP) Annual Work Plan
- In Quarter 2, 2025, QIHEC evaluated the following topics:
  - QIHEC 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

QIHEC Actions in Second Quarter 2025

- QIHEC evaluated the following topics:
  - Quality oversight functions including 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, data from member experience surveys
  - Coordination of care

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QIHEC Actions: Program Oversight

- QIHEC reviewed and approved the following:
  - March 11, 2025; April 28, 2025; and May 13, 2025 meeting minutes
  - 2025 QI Work Plan_Quarter 1 update
  - 2026 Pay for Value Program

QIHEC Actions: Policy Review

- QIHEC reviewed and approved the following policies:
  - Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
  - Policy GG.1629: Quality Improvement and Health Equity Transformation Program (QIHETP)
  - GG.1655_Reporting Provider Preventable Conditions

QIHEC Findings/Outcomes

- Interaction voice response (IVR) system conducted over 1,000 calls to improve medication adherence that resulted in 283 prescriptions for 19 members.
- 100-Day Supply Conversion Program extended 54 prescriptions for 34 members.
- To meet California Department of Health Care Services (DHCS) requirements, Russian is being added as a threshold language for translation services by August 11, 2025

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QIHEC Findings/Outcomes

- Preliminary HEDIS[1] 2024 results for Medi-Cal MCAS measures indicate that measures in the Children and Reproductive Health and Cancer Prevention domains exceeded the Minimum Performance Level (MPL)
- Measures in the Behavioral Health and Chronic Care domains did not reach MPL:
  - Asthma Medication Ratio (AMR) measure did not exceed MPL.
  - Behavioral Health measures (FUA[2] and FUM[3]) remained below MPL and continue to be a priority area.

1. Healthcare Effectiveness Data and Information Set
2. Follow-Up After Emergency Department visit for Substance Use Disorder
3. Follow-Up After Emergency Department visit for Mental Illness

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QIHEC Findings/Outcomes

- Preliminary HEDIS 2024 results for Medicare measures indicate Care for Older Adult and Transitions of Care measures are below a 3-Star.
- In Q4 2024, 84% of new D-SNP members completed Health Risk Assessments (HRAs).
- The Individual Care Plan (ICP) completion rate within 90 days rose to 82% in Q4 2024, up from 27% in Q3 2024.
- 95% of members surveyed reported that the complex case management program helped meet care goals.

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QIHEC Findings/Outcomes

- Race Ethnicity and Language data now displayed in the provider directory with 67 languages reported.
- CalOptima Health conducted two surveys to assess staff and member experience of languages services.
- Member experience efforts include a “voice of member” campaign and after-call surveys, with satisfaction scores exceeding 92% for both Medi-Cal and OneCare.

QIHEC Recommendations in First Quarter 2025

- QIHEC made the following requests and/or recommendations:
  - A communication to be sent to members emphasizing the importance of vaccinations, specifically Measles, Mumps, and Rubella (MMR) vaccinations.
  - Staff to investigate barriers to interpreter services availability, particularly the interpreter scheduling process.

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QIHEC Actions: Sub-Committee Oversight

- QIHEC accepted and filed subcommittee minutes
  - Grievance and Resolutions Services (GARS) Committee February 19, 2025
  - Population Health Management Committee (PHMC) February 20, 2025
  - Utilization Management Committee (UMC) January 23, 2025 and February 20, 2025
  - Whole Child Model Clinical Advisory Committee (WCM CAC) February 18, 2025

QIHEC Sub-Committee Report

Back to Agenda

Subcommittee Actions in First Quarter 2025: Credentialing and Peer Review

- Approved seven policies related to credentialing
- Two preventable provider conditions were reported to DHCS.
- Three primary care physicians failed MRRs and were terminated, per DHCS requirements.
- Two closed session meetings were held to discuss two separate cases related to Fair Hearings.
- CRPC approved the credentialing clean/closure list

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Subcommittee Actions in First Quarter 2025: Member Experience

- MemX issued corrective action plans to health networks based on Q4 2024 network adequacy performance as part of the Subcontractor Network Certification (SNC) process.

Subcommittee Actions in First Quarter 2025: Population Health Management

- Approved the 2025 Population Needs Assessment (PNA)
- PHMC recommendations:
  - Explore opportunities to host community classes within PCP spaces or local school campuses to increase accessibility and community engagement
  - Revise and shorten the member satisfaction survey to increase response rates
  - Offer the member satisfaction survey via text message, either in place of or alongside telephonic outreach
  - Conduct additional analysis on hyperlipidemia diagnosis among the Vietnamese population

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Subcommittee Actions in First Quarter 2025: Utilization Management

- UMC recommended CalOptima Health focus on improving the collection of post-discharge contacts.
- BMSC approved removal of 97 codes from the prior authorization list.

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APPENDIX

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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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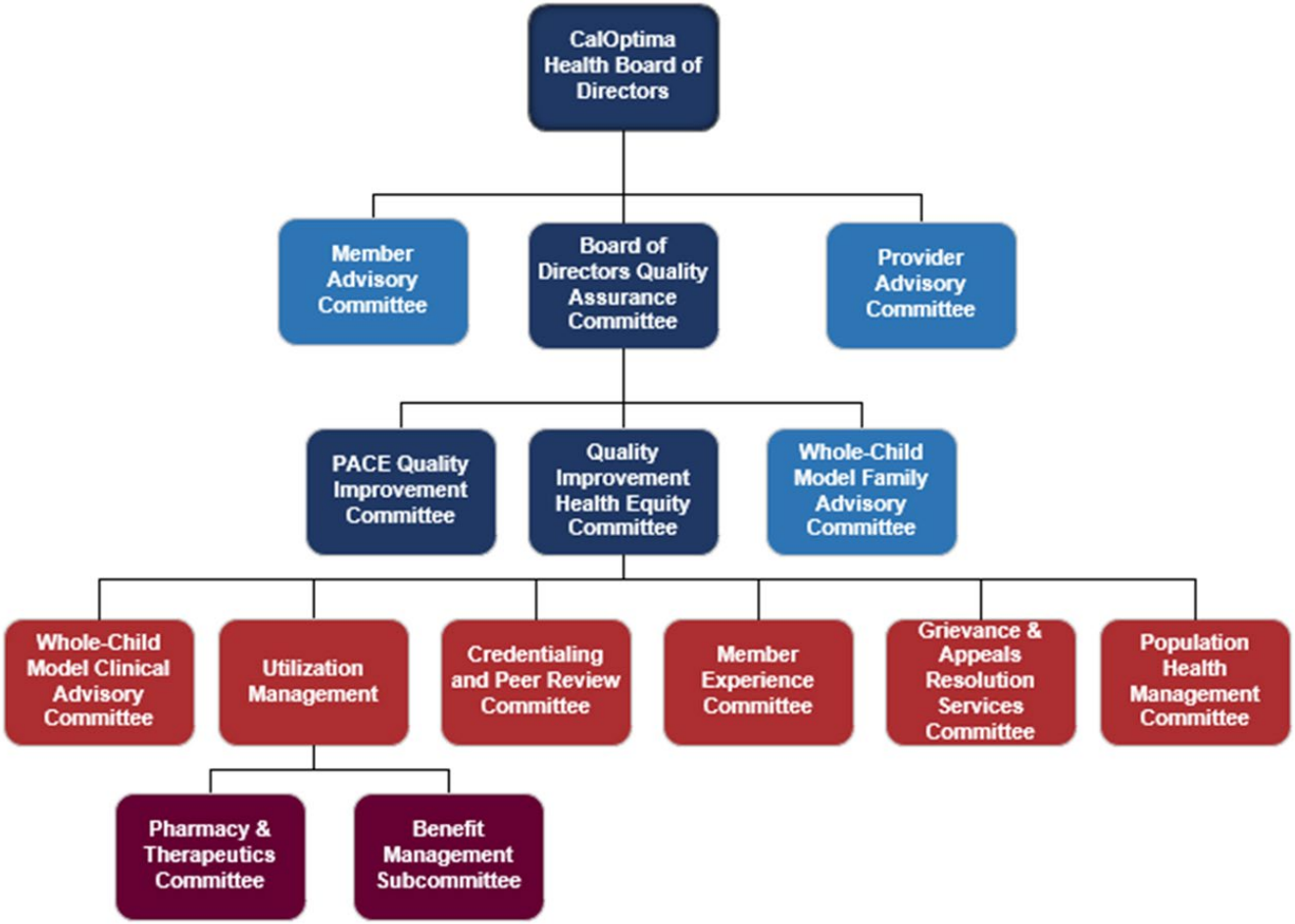
Quality Improvement and Health Equity Governance



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Board of Directors'

Quality Assurance Committee Meeting

October 8, 2025

Quality Improvement Health Equity Committee (QIHEC) Second Quarter 2025 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer	
Reporting Period	Quarter 2, 2025	
QIHEC Meeting Dates	April 8, 2025, May 13, 2025, June 10, 2025	
Topics Presented and Discussed in QIHEC or subcommittees during the reporting period	• Access and Availability • Adolescent Care • Adult Wellness and Prevention • Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) • Behavioral Health Integration (BHI) • Benefit Management Subcommittee (BMSC) • CalAIM • Case Management (CM) program • Comprehensive Community Cancer Screening Program • Consumer Assessment of Healthcare Providers and Systems (CAHPS) • Care Management and Care Coordination • Chronic Conditions Management • Continuity & Coordination of Care • Credentialing and Recredentialing • Cultural and Linguistics Appropriate Services Program • Customer Service • Delegation Oversight • Demographic Data Collection • Department of Health Care Services (DHCS) Non-Clinical Performance Improvement Project (PIP)	• Health Education • Healthcare Effectiveness Data and Information Set (HEDIS) • Hospital Quality Program • Initial Health Appointment • Language Accessibility • Managed Care Accountability Set (MCAS) • Medicare Advantage Star Program Rating • Medication Adherence • Medication Management • Member Experience (MemX) • National Committee for Quality Assurance (NCQA) Accreditation • OneCare Model of Care • Pay for Value (P4V) • Pediatric Wellness and Prevention • Performance Improvement Projects • Pharmacy • Plan All Cause Readmission (PCR) • Policy • Population Health Management (PHM) • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Preventive and Screening Services • Provider Directory • Maternal Care

	• Depression Screening • Diabetes Care • Diversity, Equity, and Inclusion (DEI) training • Emergency Department Diversion Program • Enhanced Care Management (ECM) • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services (GARS)	• Quality Compliance Report • Quality Improvement Health Equity Work Plan • Quality Metrics • Student Behavioral Health Incentive Program • Transitional Care Services (TCS) • Utilization Management Committee • Whole Child Model (WCM)

QIHEC Actions in Quarter 2, 2025

QIHEC Approved the Following Items:

- March 11, 2025, meeting minutes; April 28, 2025, meeting minutes; May 13, 2025, meeting minutes
- Three Quality Improvement policies:
  - Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
  - Policy GG.1629: Quality Improvement and Health Equity Transformation Program (QIHETP)
  - Policy GG.1655_Reporting Provider Preventable Conditions

Accepted and filed the following items:

- Appendix: National Committee for Quality Assurance (NCQA) Accreditation
- Appendix: Student Behavioral Health Incentive Program (SBHIP)
- 2025 QI Work Plan_Quarter 1 update
- Appendix: Quality Improvement and Credentialing Policies
- PHMC meeting minutes_02.20.25_Final
- GARS meeting minutes_02.19.25_Final
- UMC meeting minutes_01.23.25_Final
- UMC meeting minutes_ 02.20.25_Final
- WCM CAC meeting minutes_02.18.25_Final

QIHEC Quarter 1 2025 Highlights

- Chief Medical Officer (CMO) Updates
  - CMO provided an update on the measles outbreak and immunization rates. High immunization rates in Orange County except in South County.
  - California maintains a 96.5% vaccination rate, but hesitancy is increasing. Emphasis was placed on provider-patient trust to address skepticism.
  - CMO emphasized continued focus on member care despite organizational uncertainties.
- Quality Improvement Compliance Report - Following the compliance issue reported last quarter regarding CalAIM Community Supports authorizations, which failed to meet the 95% benchmark in November and December 2024 due to staff vacancies and an increase in referral volumes, a Corrective Action Plan (CAP) was implemented. This plan included cross-training staff and hiring temporary personnel, leading to improved compliance rates of 99% for both February and March 2025.
- At the March 11, 2025, QIHEC meeting, QIHEC raised concerns about the lack of specificity in CalOptima Health's provider directory and requested an update. Provider Directory enhancements are

QIHEC Quarter 1 2025 Highlights

underway to improve provider data collection and search capabilities, starting with orthopedics. A provider portal link with a specialty spreadsheet is also in development to support clinical staff and referring physicians.

- At the March 11, 2025, meeting, QIHEC discussed member resistance to immunizations, prompting QIHEC to recommend that CalOptima Health send a communication emphasizing the importance of vaccinations. Staff will send member communications using DHCS materials to promote measles, mumps, rubella (MMR) vaccination. Content was submitted for the Fall 2025 newsletter, but the action remains open until publication.
- Prenatal Care Initiative - Staff are developing a women's health text campaign, partnering with community organizations, and planning media outreach to improve early pregnancy identification and prevent delayed prenatal care.
- NCQA Accreditation - Health Equity accreditation submission is due October 7, 2025. Health Plan accreditation is due April 6, 2027. Staff are addressing gaps and preparing documents for submission.
- Comprehensive Community Cancer Screening Program (CCCSP) - A dashboard was developed to track grantee progress. Staff are planning mobile mammography events and refining evaluation scope.
- Behavioral Health Services - Staff focused on improving quality measures such as Follow Up After Emergency Department Visit for Mental Illness (FUM) and Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependance (FUA) by implementing the following: weekly texts and coordinating with a telehealth vendor for follow-up appointments, created a Quick Reference Guide for portal use, and submitted a Fall newsletter article and social media posts.
- Behavioral Health Performance Improvement Projects (PIPs) - The Medi-Cal PIP aims to increase case management enrollment among CalOptima Health Medi-Cal members with specialty mental health diagnoses by 2%. Enrollment declined from 1.71% in 2022 to 1.08% in 2023. PIP data was submitted to DHCS. Staff continue to work with telehealth vendors for member outreach and focus on member data integrity.
- School-Based Mental Health Services - All partners in the DHCS Student Behavioral Health Incentive Program (SBHIP) concluded their program obligations successfully. Key outcomes included increased behavioral health staffing, improved referral and billing systems, and expanded services. Hazel Health now serves 19 districts. CalOptima Health submitted its outcome report and is awaiting DHCS scoring.
- Medication Adherence - Interactive Voice Response (IVR) system to improve medication adherence was implemented, making over 1,000 calls that resulted in 283 prescriptions for 197 members, focusing on triple-weighted Star measures. The 100-Day Supply Conversion Program allowed pharmacists to extend chronic medication supplies with prescriber and member approval, converting 54 prescriptions for 34 members.
- Cultural Responsiveness - Demographic Data Collection - CalOptima Health successfully collected Race/Ethnicity and Language (REL) data for their members; 87% for race/ethnicity and 98% for language. Only 5% of members provided information on their Sexual Orientation and Gender Identity (SOGI) and efforts are focused on increasing data collection in this area.
- Language Services Utilization - Interpreter and translation requests increased in early 2025 due to member awareness and demand. Russian to be added as a threshold language by August 2025.
- Experience with Language Services - CalOptima Health launched two surveys to assess staff and member experience of languages services. The staff survey launched on March 17, 2025, and staff feedback was positive. The member survey is currently being conducted, and results are not yet available

QIHEC Quarter 1 2025 Highlights

- Diversity, Equity, and Inclusion Training - CalOptima Health has developed a new Diversity, Equity, and Inclusion training that covers cultural competency, disability, and unconscious bias. The training was approved by the state and was piloted for new employees and began in April, and a full launch for all employees will be conducted in September.
- Postpartum Depression Screening - At a previous QIHEC meeting, staff were asked to consider postpartum depression screenings during hospital stays. Inpatient screenings do not meet HEDIS criteria. CalOptima Health will continue focusing on outpatient screenings.
- Quality Performance Improvement - Preliminary HEDIS 2024 results for Medi-Cal MCAS measures indicate that measures in the Children and Reproductive Health and Cancer Prevention domains exceeded the Minimum Performance Level (MPL), except Asthma Medication Ratio (AMR) measure. Behavioral Health measures (FUA and FUM) remained below MPL. Preliminary HEDIS 2024 results for Medicare measures indicate Care for Older Adult and Transitions of Care measures are below a 3-Star.
- Value-Based Payment Program - Proposal for the 2026 Pay for Value Program was presented to QIHEC and approved. The proposed program aims to link Medi-Cal incentive eligibility to OneCare STAR performance. Under the proposal, health networks must achieve at least a 3-star rating in OneCare to access the Medi-Cal incentive pool. The proposal is being reviewed in various forums and will be presented to the board's Quality Assurance Committee in October.
- Hospital Quality Program - The program uses a Pay for Value model based on quality, patient experience, and safety, using CMS and Leapfrog data. For non-CMS hospitals, Leapfrog ratings apply. Staff proposed rolling over $12.5M in unearned 2023 funds to 2024, potentially increasing payouts from $18M to $21M. A work group will explore fund use. There was also a request to consider U.S. News rankings to expand participation.
- Special Needs Plan (SNP) Model of Care (MOC) - HRA and ICP completion rates improved; Staff will begin tracking combined initial and renewal HRA rates as requested by the committee.
- Quality Performance Measure Update:
    - Maternal and Child Health: Prenatal (82.16%) and postpartum (59.6%) care rates improved over the previous year, driven by early identification efforts and strong community partnerships. Collaboration with the Equity and Community Health team continues to support these gains.
    - Medication Management: Notable improvements were seen in antibiotic stewardship measures (AAB and CWP). The team is planning targeted provider education and member outreach to close remaining gaps.
    - Pediatric & Adolescent Wellness: Immunization and screening rates are trending upward, though well-child visits remain a challenge. Staff are addressing vaccine hesitancy and expanding access to lead testing equipment.
    - Adult Wellness: Most cancer screening rates improved, except for breast cancer screening, which remains low. Outreach strategies include mobile mammography, culturally tailored messaging, and at-home testing kits.
    - Maternity Care for Black Members: Focused efforts are underway to support Black members through Enhanced Care Management (ECM), doula services, and community outreach. Early engagement shows promise, with 22 members in ECM and 7 receiving doula support.
    - Medi-Cal PIP – Well-Child Visits for Black Members: Outreach continues toward the 55.78% target, despite challenges in member contact.

QIHEC Quarter 1 2025 Highlights

  - OneCare CCIP – Diabetes Emerging Risk: A1C control remains a priority, with the current rate at 21% against a goal of 87%. SMS and phone outreach campaigns are in progress to improve member engagement and outcomes.
- Plan All-Cause Readmission - Medicare rate is at 4 stars. Interventions include discharge summaries, transportation, and text campaigns
- Network Cultural Responsiveness, Provider Demographics – Provider demographic data is being collected and displayed in the provider directories. QIHEC discussed member challenges of obtaining interpreter services and requested staff to investigate interpreter availability concerns, specifically interpreter scheduling process. Staff clarified CalOptima Health's interpreter request process. In-person services require 5–7 business days' notice; phone interpreters are available. Provider and member contact numbers were shared for Cultural and Linguistic Services support.
- Delegation Oversight - In Q1 2025, CalOptima Health conducted audits for Family Choice Medical Group/Family Choice Management Services MSO/Conifer Health Solutions and Children's Hospital of Orange County (CHOC) Health Alliance/Rady's Children MSO, identified multiple findings and issued corrective action plans (CAPs) in the Medi-Cal and OneCare lines of business.
  - FCMG had 1 CAP and 8 findings related to claims processing, provider disputes, and utilization management.
  - CHOC had 1 CAP and 3 findings focused on timely notices, reporting, and pharmaceutical management.
  - Common issues included improper use of decision templates, notification delays, and claims adjudication errors. Most findings are under monitoring, with some already resolved. Committee discussed issues with claims, UM, and notification timelines Remediation with ongoing monitoring and corrective actions.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

Credentialing Peer Review Committee (CPRC)

CPRC met January 12, 2025, February 27, 2025, and March 20, 2025, and approved their previous meeting minutes.

- Approved Policies:
  - GG.1650: Credentialing and Recredentialing of Practitioners
  - GG.1651: Assessment and Reassessment of Organizational Providers
  - GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
  - GG.1607: Monitoring Adverse Actions
  - GG.1611: Potential Quality Issue Review Process
  - GG.1616: Fair Hearing Plan for Practitioners
  - GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
  - GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
- Two closed session meetings were held to discuss two individual cases.
- The committee reviewed PQI trends, noting ongoing issues with two Applied Behavior Analysis (ABA) groups and two hospitals. Two preventable provider conditions were reported to DHCS.
- Three PCPs failed MRRs and were terminated.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- Nursing facility audits increased, and critical incident reporting rose due to improved SNF education and DHCS mandates. Critical incidents in Skilled Nursing Facility (SNF)s increased due to better reporting (46 in 2024 vs. 0 in 2023).
- Credentialing volumes increased in early 2025, especially in Behavioral Health. Delays in initial credentialing were noted, but improvements are underway through a new CVO vendor, staffing, and system upgrades. Staff encouraged providers to use the credentialing updates inbox for status checks. Credentialing delays were improved with CVO vendor, staffing, and system upgrade. Committee asked about credentialing timelines; staff explained the backlog and provided contact email for credentialing status updates and reassured that the credentialing backlog was being addressed.
- One Level 3 PQI was reported in Q1, along with multiple Level 2 issues involving ABA providers. CPRC actions included education and referrals for fraud and abuse.
- Dr. Pitts commended the committee's dedication and long hours in ensuring the quality of physician oversight for CalOptima Health

Grievance & Appeals Resolution Services Committee (GARS)

GARS met May 23, 2025, and approved the February 19, 2025, meeting minutes.

- The committee reviewed Q1 2025 trends. OneCare appeals increased to 59 with a 47% overturn rate, primarily involving inpatient and specialty care. Medi-Cal appeals decreased to 265 with a 26% overturn rate. Grievance rates for both lines of business remained below NCQA thresholds.
- Discrimination-related grievances rose to 53, with most involving race, Americans with Disabilities Act (ADA), and language access. Remediation with internal tracking of overturns; quarterly reviews.
- CalOptima Health continues to monitor transportation-related grievances and provider performance. Staff identified a pattern of appeals related to continuity of care and are educating health networks accordingly. Performance comparing Q1 2024 to Q1 2025 showed overall improvement, with CalOptima Health's grievance rate remaining below the state average.
- Following a request by QIEHC, staff reported Grievance and Appeals rates compared to the benchmark to assess performance. Grievance rates remained below NCQA thresholds.
    - OneCare appeals increased (59 in Q1 vs. 41 in Q4); overturn rate 47%.
    - Medi-Cal appeals decreased (265 in Q1 vs. 346 in Q4); overturn rate 26%.
    - Discrimination grievances rose (53 in Q1 vs. 34 in Q4).
    - Overall grievance rates are below NCQA threshold.
    - Committee closed action item on grievance rate benchmarks.

Member Experience Committee (MemX)

MemX met on April 15, 2025, and approved the July 15, 2025, meeting minutes.

- 14 Medi-Cal Primary Care Physician had closed panels due to hitting member assignment capacity.
- For timely access, CalOptima Health met California Department Health Care Services (DHCS) minimum performance levels (MPL) for non-urgent appointments but not for urgent ones. Corrective action plans (CAPs) were issued to health networks and providers for urgent access, with ongoing reviews.
- The 2023 Annual Network Certification (ANC) gaps were largely resolved, and 2024 assessments are underway. Subcontractor Network Certification CAPs were also issued. Monthly monitoring and weekly termination reports are now in place to support the CMS Triennial Network Adequacy Review.

QIHEC Subcommittee Report Summary in Quarter 1, 2025

- Member experience efforts include a "voice of member" campaign and after-call surveys, with satisfaction scores exceeding 92% for both Medi-Cal and OneCare. Feedback focused on medication access and office visits, helping guide service improvement.
- Member Satisfaction Surveys show >92% satisfaction. Committee discussion with focus on improving survey methodology and enhancing survey tools.

Population Health Management (PHM) Committee

PHMC met on May 15, 2025, and approved February 20, 2025, meeting minutes and the 2025 Population Needs.

- As required by the DHCS and NCQA, CalOptima Health must maintain a robust Complex Case Management (CCM program). CalOptima Health has invested significantly in program enhancements, training, support, and oversight to ensure standardized practices and core competencies across all Health Network partners.
    - CalOptima Health invites feedback and discussion to maintain alignment and continually improve care delivery across all networks
- Carolina Gutierrez-Richau, Director, Behavioral Health & Wellness Department Council on Aging – Southern California, presented on The Aging Divide, including national and local demographic data, older adults' health considerations, an overview of the council and its programs and services.
- Staff focused on expanding Health Education Access and Engagement: gather the committee's input on suggestions to increase access and engagement.
- Ongoing Health Risk Assessments shared with PCP
- Initial Screening/Assessment for Newly Enrolled Medi-Cal Members (within 90 days)
- Complex Case Management Q1 member survey results – 95% reported the program helped meet care goals
    - Next step: Sharing the member satisfaction survey scores with CalOptima Health Community Network **(**CCN) and delegated networks.
- PHMC recommended staff explore opportunities to host community classes within primary care provider (PCP) office spaces and collaborate with local school districts to offer classes on school campuses, increasing accessibility and community engagement
- PHMC suggested revising and shortening the member satisfaction survey to increase response rates. Additionally, they suggested offering the survey via text message, either in place of or alongside telephonic outreach, to enhance accessibility and member engagement.
- Explore additional analysis on data on the hyperlipidemia diagnosis rate amongst the Vietnamese population.

Utilization Management Committee (UMC)

- Benefits Management Subcommittee (BMSC)
- Pharmacy and Therapeutics Committee (P&T)

UMC met on May 22, 2025, and approved February 20, 2025, meeting minutes.

- Committee reviewed Q1 2025 utilization data, including inpatient turnaround times, which met the 95% goal. Prior authorization compliance remained strong. Staff addressed earlier workflow issues with training and updates.
- The committee discussed Emergency Department (ED) utilization, bed days, and readmission rates. The ED Diversion Program at University of California, Irvine (UCI) Medical Center launched in February and is showing increased member engagement. UMC recommended that staff focus on improving the collection of post-discharge contacts.

QIHEC Subcommittee Report Summary in Quarter 1, 2025
• Several workgroups met, including Over/Under Utilization, Gender-Affirming Care, EPSDT, and High-Risk Management. • Pharmacy updates included Centers for Medicare & Medicaid Services (CMS) Star Ratings adherence rates. Behavioral Health is monitoring outpatient trends and investigating increased BHT utilization. • Long-Term Services and Supports (LTSS) regained California Advancing and Innovating Medi-Cal (CalAIM) TAT compliance after staffing and process improvements. • Transitional Care Services (TCS) aims to increase successful post-discharge interactions by 10% in 2025. Staff are now full-time, and outreach efforts include daily calls, support lines, and hospital engagement. Positive feedback has been received from hospitals. • Emergency Department Diversion and Transitional Care Setting are progressing. Benefit Management Subcommittee (BMSC) • The Benefit Management Subcommittee approved removal of 97 codes from the prior authorization list. NEMT/NMT improvements led to a 48% drop in grievances, supported by new scheduling tools and standing orders.
Whole-Child Model Clinical Advisory Committee (WCM CAC)
WCM met May 20, 2025, meeting and approved the February 20, 2025 Meeting Minutes • The committee discussed health network adequacy and Timely Access Survey showed gaps in specialties. While routine appointment compliance was generally good, ENT/otolaryngology, gastroenterology, and infectious disease specialties were non-compliant. The WCM CAC requested that staff address Health Network (HN) Adequacy for specialists serving aging out WCM members, as well as Timely Access issues. As a result, staff will focus on initiative to improve access to identified key specialties. • The committee also raised concerns about care coordination, Enhanced Care Management paperwork, and pediatric formulary changes. • Committee discussed specialist shortages and long wait times for Autism Comprehensive Program at two Health Networks (UCI and CHOC). Remediation with exploring partnerships (e.g., Miller Children's); improve care coordination. CalOptima Health is working with health networks to address specialist shortages and improve access, with updates expected at future meetings.

For more detailed information on the workplan activities, please refer to the Second Quarter of the 2025 QIHETP Work Plan.

Attachment

Approved at QIHEC throughout Q2 2025: Second Quarter 2025 QIHETP Work Plan 2Q

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1. Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Marsha Choo	Gloria Garcia	Quality Improvement	The 2025 QIHETP Description and Annual Work Plan was presented and approval by the BOD on 04/3/2025.	The 2025 QIHETP Description and Annual Work Plan was adopted by BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	None	Implementation and tracking of the QIHETP Description and Work Plan; QIHEC overisight of actiview through regular updates.	On Target
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Marsha Choo	Gloria Garcia	Quality Improvement	2024 QIHETP Description and Work Plan Evaluation was presented and approved at the BOD	Evaluation of the 2024 QIHETP Description and Work Plan was completed and presented to BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	N/A	N/A	On Target

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

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					Q4 of 2025 and approved in Q1 2026.					on 04/3/2025.					
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Kelly Giardina	Stacie Oakley/Jennifer Harlow	Utilization Management	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was presented to the Committee's/BOD as indicated in Column H. Final approval by BOD on 4/3/2025	The 2025 Integrated Uitlization Management and Case Management Program Description was aprpoved by the BOD on 4/3/25	None	N/A	Continue with plan as defined for 2025	On Target

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4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The 2024 Integrated UM CM Program Description was presented to the Committee's/BOD as idnicated in Column H. Final approval by the BOD on 4/3/2025	The 2024 Integrated UM CM Program Evaluation was approved by the BOD on 4/3/2025	None	N/A	Continue with plan as defined for 2025	On Target
5	Program Oversight		2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Katie Balderas	Barbara Kidder	Equity and Community Health	2025 PHM Strategy and Work Plan were approved at the April 3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	Implementation and tracking of the PHM Strategy and Work Plan	On Target

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6	Program Oversight		2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Katie Balderas	Barbara Kidder	Equity and Community Health	2024 PHM Evaluation was approved at the April3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	N/A	On Target
7	Program Oversight		2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The QAC bookmarked version was sent to HMA for review and feedback.	No barriers have been identified.	The QAC bookmarked version was sent to HMA for review and feedback.	On Target

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8	Program Oversight		2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description has been approved by QAC and the Board Of Directors.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	No barriers have been identified.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	On Target
9	Program Oversight		**Population Health Management Committee (PHMC)** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	1.The Q2 2025 PHM Committee Meeting was held on May 15, 2025 which included both internal CalOptima Health updates on the Health Education, Care Management, and Complex Case Management. 2.Community spotlight presentation was from the Council on Aging. 3.Committee reviewed and	Committee recommended: 1. Exploring opportunities to increase accessibility and community engagement: •Host community classes in PCP offices •Collaborate with local school districts 2. Revising and shortening member satisfaction surveys to increase response rates	Continue to assist the committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC.	N/A	Next PHM Committee meeting is scheduled for August 2025.	On Target

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					quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.					approved: • Q1 2025 PHMC Meeting Minutes • 2025 Population Needs Assessment 4.Provided PHM Committee update for QIHEC in May 2025.	3. Explore additional analysis on hyperlipidemia diagnosis amongst Vietnamese population.				
10	Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Laura Guest	Rick Quinones Katy Noyes	Quality Improvement	The Committee met on 04/24/2025, 05/22/2025 and 06/26/2025 .On 04/25/2025, there was a Closed Session meeting for the physicians to meet with a physician as part of the Fair Hearing process.	Three physicians (Ob/Gyn, PM&R & NS) continued under the Fair Hearing process. One physician (PM&R) was changed to Probation after meeting with him. A fourth physician (PM) was started on the Fair Hearing process. Ten PQI cases were presented	PQI and Credentialing implemented plans to reduce it's backlog.	Need to have a new Ob/Gyn physician added to the Committee since an Ob/Gyn was removed from the Committee last year due to his retirement.	A new Provider Life-Cycle system for credentialing will be implemented in Q3.	On Target

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					meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.						to CPRC for leveling and actions; three level 3, seven level 2, no level 1. There were three physicians with issues presented for re-credentialing; three presented for credentialing all for the CCN network.All were recommended for credentialing/recredentialing except for one PM physician who was recommended for termination. Credentialing statistics were presented which showed that close to 1100 providers were credentiale				

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											d in Q1; 3 recreds were > 180 days.The following policies were presented and approved: GG.1605, GG.1607, GG.1611, GG.1616, !!.1651, GG.1657 and GG.1658. The credentialing clean lists and closure lists were presented and approved.				
11	Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee -** Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

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					results are presented by product time to the committee quarterly. 3. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.										
12	Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Vacant	Carol Matthews/Helen Syn	Quality Analytics	Committee met on 4/15/2025. Meeting minutes from the 1/28/25 meeting were deferred. Regulatory updates were presented: annual network certification, subcontracted network certification, network adequacy, timely access, UM and CAHPS improvement update.	QIHEC accepted the MemX update without further questions feedback.	Continue as planned.	Low customer service scores	CS identify ways to gather specific individual member feedback for members giving low ratings for customer service	On Target

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					points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					A MemX update was provided to QIHEC on 6/10/25.					
13	Program Oversight		**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The UMC met on 5/22/25 & reviewed Q1 2025 over/under utilization patterns. Meetings minutes are drafted & will be approved at the 8/21/25 meeting. UM Leadership will report Q1 2025 findings to the QIHEC on 9/9/25	Medi-Cal Expansion & TANF18+ readmits above goal. TANF under 18 bed days & admits above goal. ED utilzation across all aid codes remains stable with little change. Inpatient & prior authorizatio n turn around time goals met, above 95% compliant. NEMT - Since April	Continue to monitor, track and trend utilization.	None	Continue with plan as defined for 2025	On Target

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					quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.						2024 there has been over 2K rides/day.				

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14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Thanh-Tam Nguyen, MD/Hannah Kim	Gloria Garcia	Medical Management	WCM CAC met 5/13/2025. Approved 2/18/25 meeting minutes. Presented follow up on timely Access Data	Met goals for Health Network Adequacy Turn Around Time (TAT) and other Whole Child Model measures except Timely Acess.	Reviewed data and discussed: WCM Network Adequacy,Timely Accesss, Grievances and Appeals, Adverse Childhood Experiences (ACEs), Member Inquiries, Mental Health Utilization, BH Quality Measures, Student Behavioral Health Incentive Program, Pediatric California Advancing & Innovating Medi-Cal, and Pharmacy.	1) Network Adequacy and the lack of certain specialist providers. 2) Whole Child Model case managed members and Enhanced Care Management overlap. 3) Identify challenges related to the reinstitution of prior authorization for Pediatrics	1) Address with CalOptima Health leadership HN Adequacy for specialist serving the aging out WCM members and Timely Access issues. 2) Examine ECM population criteria and Care Coordination; Follow WCM regulatory requirement. 3) Report challenges related to Medi-Cal Rx prior authorization requirement for pediatric Rx. 4) Autism Comprehensive Program	On Target

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														update scheduled for the 8/19/25 meeting.	
15	Program Oversight		Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer/Hannah Kim	Sherry Hickman	Medical Management	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment	Interventions and activities were completed for the quarter.	Report on the following activities: 1. Basic PHM/CM: Ongoing Health Risk Assessments are shared with Primary Care Physician. 2. Early and Periodic	None	Report on the following activities: 1. Basic PHM/CM: Continue sharing Health Risk Assessments with Primary Care	On Target

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										(EPSDT) CM:		Screening, Diagnostic and Treatment (EPSDT) CM: a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Preparation for texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT d. Behavioral Health Integration review of depression and developmental screening codes for oversight needs.		Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT	

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16	Program Oversight	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with all Health Networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Hannah Kim	Diana Tep	(1) Seven out of the nine Health Networks achieved a score of 90% or higher (Goal 1). (2) A total of 51 members were surveyed. All questions from the member satisfaction survey met the 85% benchmark (Goal 2). (3) 98% of the members surveyed found the case management process helped them meet their care plan goals (Goal 3).	Goal 1 did not meet for Q2 as two Health Networks did not achieve a score of 90% or higher. Goal 2 and 3 met.	1) Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/ situations. (Goal 1) a. Element D/E training for WCM CCN on 5/12/2025, 5/14/2025, and 5/20/2025 2) Member Satisfaction s Survey (MSS) scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care,	Goal 1: Staff training needed for Elements D and E.	Conduct and report on the following activities: Goal 1. a. Continue training and provide educational opportunities to all Health Network staff on the 2025 PHM5 Element D and E and complex conditions. Goal 2 a. Member Satisfaction scores will be shared with all Health Networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, and member outcomes, and improve the member experience in CCM program. b. Continue to gather feedback from MSS to strategize on improving outcomes and	Concern	16	Program Oversight

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										member outcomes, and improve the member experience of the CM programs. (Goal 2) a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025. b. Ongoing training and support for new and existing staff. (Goal 2) c Continue to gather feedback from MSS to improve outcomes. (Goal 2) d Meeting held with QI Nurse and		share in quarterly meetings with leadership. c. Continue training and support for new and existing staff. Goal 3 a. Continue Member centric care plan training and support for all Health Network staff.			

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										leadership on 5/5/2025 to discuss Q1 MSS results. Additional meeting held on 5/19/2025 with QI Nurse, Data Analyst, MA, and Leadership to discuss ways to improve the survey and engage the members in completing the MSS. 3) Training and education on member centric care plans. (Goal 3) a. Care plan training for CCN conducted on 4/18/2025, 6/25/2025, 6/27/2025.					

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17	Program Oversight		Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention 3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas/Megan Dankmyer	Barbara Kidder	Equity and Community Health	1. 2025 PNA was presented at the May 15, 2025 PHMC meeting and was approved; submitted 2025 PNA as NCQA accreditation evidence 2. Implementation of 2025 PHM work plan is in progress 3. Quarterly 2025 PHM work plan monitoring is in progress	N/A- work in progress	1. Review and approval of 2025 PNA 2. N/A- work in progress 3. Quarterly reporting and tracking is in progress	N/A	1. Monitor 2025 PNA feedback survey 2. Continue implementing the 2025 PHM work plan 3. Continue monitoring progress	On Target
18	Program Oversight		Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Elisa Mora	Equity and Community Health	1. Two-Way Text Campaign: 18,693 diabetes members and 16,106 asthma members were contacted through two-way text messages. 2.	1. Increased Reach Through Text Campaigns: • Text messages are sent to members with diabetes and asthma, allowing them to opt	1. Continue two-way text message campaigns: For member with diabetes and asthma. 2. Monthly Stratification Criteria Logic Updates: Revisions include removing members already engaged with	There have been ongoing issues with staff not being able to launch the text message satisfaction survey. Issue is	Continue to implement activities and monitor outcomes.	On Target

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					Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					Stratification Criteria Revision to better target low to moderate-risk members and avoid duplicative outreach is in progress. 3. Disease Management Satisfaction Survey: survey is text-based and delivered to members via text after follow-up session. Survey received 119 responses out of 278 texts.	in to health coaching services. This approach has increased enrollment rates compared to traditional cold calls. 2. Real-Time Feedback Improves Response Rate: •The Disease Management Satisfaction survey received responses in just 2 months that accounted for over half of the previous annual total (100), indicating a likely improvement in response rates using this new survey method. Notably, within 4	other departments and improving visibility of care gaps across Disease Management interventions. 3. Expansion of Disease Management Satisfaction Survey: Planning to supplement with a paper survey included in the education packet sent by health coaches following telephonic outreach.	being addressed by vendor. A process has been established to ensure that text messages are not sent to the same members on a monthly basis.		

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											months of implementing the text message-based surveys, the number of responses has already surpassed the total received in previous years, further demonstrating the effectiveness and efficiency of this new approach in engaging participants.				
19	Program Oversight		Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Thanh Mai Dinh	Equity and Community Health	1. 1,536 referrals for health education services were received for Q2. There was as slight drop from 1,566 in Q1. 2. 40 virtual and in person Shape Your Life classes	Pilot results for adult Vietnamese virtual classes yielded no participants despite different days and time options. Virtual classes as a primary referral outcome is not realistic for	1. May: Two-way text campaign inviting members to the new virtual adult hypertension class was launched to 30,799 Medi-Cal members ages 18+ with an email address on file (English-20,657 and Spanish-10,142). 2. Virtual adult classes were scheduled and	Some barriers in referring members to the virtual classes include: •availability of virtual classes are not convenient to some members •some	Pilot 2 text campaign approaches to see which one has a larger engagement rate. In July 2025, 97,000 adult Medi-Cal members will be randomly divided into two	On Target

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					text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).					were completed. 188 participants attended sessions successfully. 3. 10 virtual and in person Adult Healthy Living one-time classes were completed in English, Spanish and Khmer. 117 participants attended sessions successfully. 4. 17 virtual and in person Adult Hypertension one-time classes were completed. 89 participants attended classes successfully.	members with low digital literacy.	launched for monthly hypertension and bi-monthly healthy living one-time classes in both English and Spanish, and added to the Events page on the external website. 3. Two in person presentations on healthy living and heart health were provided in Khmer at Cambodian Family Center in April and June in Santa Ana . 4. One in person presentation on hypertension was provided in Vietnamese and Spanish at Southland Integrated Services clinic in Garden Grove. 5. One in person presentation on adult healthy living was provided at Ready Set OC in Los Alamitos. 6. Two mini	members do not have email addresses •digital literacy fluency is low to none for members who do not have home internet service or smart phones	groups. One group will receive a text with the Zoom link to an adult healthy living virtual one-time class in English or Spanish. The other will receive a two way text inviting them to click the next screen in order to get the link for the virtual class.	

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												hypertension presentations were provided at our May BP Screening event at PACE in English and Spanish.			
20	Program Oversight		CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Mia Arias	Andrew Kilgust	Medi-Cal and CalAIM	1. The CalAIM Team is currently in the process up creating audit templates for the Housing trio of community supports. Most recently, the team created program templates for these services which are required to be utilized as of 7/1. These templates will assist in	No findings to report.	Activities included reasearching and developing a housing assessment and housing support plan template. A draft of these documents were provided to contracted housing providers to collect feedback and input. Much of the feedback was incorporated into the final templates. In addition, the 3rd Cohort of the ECM Academy launched in April 2025 with	None.	Continue to research and develop documents and tools for implemetation of the audit of housing community supports. Use feedback from providers on implemention of the new housing templates to continue to refine	On Target

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										monitoring and auditing these services. 2. From January 1, 2025 - May 31, 2025, 6,984 members have received ECM services.		12 providers which will be contracted in December 2025 to provide ECM services.		and update those documents if neccessary.	

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21	Program Oversight		Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Nicole Garcia	None	Medi-Cal and CalAIM		a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025.	Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to	While all goals were met, affordable, permanent housing opportunities continue to be scarce.	Continue to offer street medicine services in the three identfied service areas.	On Target

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					delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation							and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation			

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22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Scott Robinson	Cathy Osborn	Long Term Support Services	CalAim TAT: 99.28%, CBAS Inquiry to Detrmination: 100%, CBAS TAT 99.76%, LTC TAT 99.40%	All programs are compliant	Continuous monitoring of daily staff capacity and productivity. Workloads are shifted to staff with capacity as needed.	None	Continue daily stand-up meeting to assess and intervene workloads as needed.	On Target
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Stacy Baker	Zulema Gomez John Robertson	Delegation Oversight	Annual oversight audit completed (April 14, 2025) for Children's Hospital Orange County (CHOC)/Rady's Children MSO	Delegate monitored: Children's Hospital Orange County (CHOC)/Rady's Children MSO Areas Assessed: • Case Management • Claims • Compliance • Credentialing	Delegate: • Children's Hospital Orange County (CHOC)/Rady's Children MSO Corrective Action Plan(s) Issued: * Utilization Management (Medi-Cal): Status - Accepted	None	Focused Monitoring for three months until CAP is closed	On Target

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											• Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual •Utilization Management				
24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Marsha Choo	Veronica Gomez Guy Todd Britney Warren	Quality Improvement	**1) Health Plan Accreditation:** **QI:** 2025 QI program ready for submission ; Q1 of QI Work Plan completed (Q2 will be available 8/1), 2024 QI Eval is ready for submission **UM**: We received and approved 2025 UM/CM Program descriptions, 2024 UM Evaluation, 2024 IRR analysis reports, reviewed	Health Equity and Health Plan accreditation document collections are currently underway, with look-back periods starting on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) **HPA Accreditation:** There are 6 domains (QI1A-QI4D), UM (UM1A-UM13D), NET (NET1A-NET6D), PHM	**1) Health Plan Accreditation:** - Continue collecting documents due in 3Q2025. - QI/Consultants: We will conduct CR training with our delegates on July 11, 2025and a second training will be held for those who can't attend. - Perform another internal BH denials mock audit to determine if the findings from the 2024 audit have been addressed. - The Quality	A current barrier has been identified for both Health Equity and Health Plan Accreditation. There may be a minor point loss if this issue is not addressed. Specifically, the Delegation Agreem	**1) Health Plan Accreditation (HPA):** - Continue collecting documents required for Year One (April 2025 - April 2026). - Conduct CR training with our delegates on July 11, 2025. A second training will be held for those who can't attend. - Perform another	On Target

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										and approved articles scheduled to go out in 4Q on Annual Member newsletter, Policies reviewed by consultant, 2Q2025 external board certification consultant review cases, April 2025 CalOptima Health dated screenshots were completed by end of April. **NET:** Report templates and training with stakeholders were held before the start of the look-back period. Several reports were written in June and	(PHM1A-PHM7D), CR (CR1A-CR9D), MEM (ME1A-ME8D). A total of 29 policies are required to meet specific domains for HPA accreditation. All policies have been reviewed by a consultant and are on track to meet the year-one look-back period (April 2025 to April 2026). Required programs, including Quality Improvement (QI), Utilization Management (UM), Care Management (CM), and Population Health Manageme	Improvement Department, Contractingand Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services in the delegation agreements. Policies may need to be updated to fill gaps. 2) **Health Equity Accreditation:** - Continue to work with stakeholders to finalize a few open items. - We will review each domain/area with executive leadership and start uploading final approved documents via the NCQA Submission Tool. Our scheduled submission date is October 7th. - The Quality Improvement	ents are missing provisions for the delegation of Interpreter Services and Translation of Written Materials (Sight). The Quality Improvement team is collaborating with Contracting, Customer Service, and a consultant to make the necessary edits before the Health Equity submission deadline on	internal BH denials mock audit to determine whether the findings from the 2024 audit have been addressed by the end of August 2025. - The 2026 HPA Standards are scheduled to be released in August 2025. Will conduct a webinar to go over changes from 2025 to 2026. **2) Health Equity Accreditation (HEA):** - Close out any open deliverables before the October	

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										are currently going through final revisions. Policies were reviewed by the consultant and the April 2025 CalOptima Health dated screenshots were completed by the end of April. PHM: PHM strategy approved, Multiple Chronic Conditions Program Approved, Population Assessment Approved, Health Appraisals & Managment Tools Approved. Pending delegation currently at 80% completion. **CR:** HMA reviewed and	nt (PHM) Strategy, have been reviewed by a consultant and received final approval by the Board in April 2025. NCQA Program Managers are collaborating with stakeholders to collect the necessary documents to fulfill year one of the look-back period, including reports, DTPand communications for both members and providers. We have several reports that are due by the end of June. 2) HEA Accreditatio	Department, Contracting, and Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services on the delegation agreements. Policies may need to be updated to fill gaps.	October 7th.	submission. - HEA submission is scheduled for October 7, 2025. The final review and document loading should be completed by the end of August 2025 - Introductory call with the Accreditation Survey Coordinator (ASC) is scheduled for July 22, 2025. - Submission of the delegation worksheet, and introductory call form	

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										approved required policies, ongoing monitoring Grid approved by consultant, April CPRC meeting minutes approved by consultant. **MEM: Pending 9 documents & delegation docuements currently completion rate is at 70%** Consultants received 49 additional documents, all of which were reviewed in a timely manner. **2) Health Equity Accreditation:** HE1: Ready for submission; HE2: Pending HEDIS	n: Health Equity Accreditation has seven domains (HE1-HE7). We have a few domains with open items (HE2B/C, HE6 A, and D). HE 2 and HE 3 are almost complete; the HE6 team is waiting for reports in June (HEDIS reports and member and staff surveys).				

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										Reporting. then will be ready for submission ; HE3: Ready for submission . HE3C waiting on one deliverable which is currently under consultant review; HE4: Ready final executive leadership review and submission .; HE5: Ready final executive leadership review and submission ; HE6:Pending HEDIS Reporting. then will be ready for submission ; HE7:Delegation agreements is being reviewed, meeting with consultant, Customer service,					

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										and Contracting to align evidence with the delegation of Interpreter/ Language assistance delegation. The total number of documents reviewed as of June is 79, and the consultant received one additional inquiry. **As of today our NCQA Score is 70.97% out of possible 100%, we must meet 80% be be accredited .**					

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25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 05/13/2025 Q3: 07/08/2025 Q4: 10/07/2025 11/04/2025	Paul Jiang / Vacant	Kelli Glynn	Quality Analytics	1. Prospective rate reports are generated monthly for overall CalOptima Health, CCN-specific performance, for all HN partners, and for CHCN providers. 3. The QA Strategy team reviews changes in rates at the measure level for both lines of business after each monthly refresh and identifies new improvement activities as needed, or collaborates with the HEDIS team if there are suspected data issues.	PJ: FUA-30day is at the 25th percentile and it is at the risk for not meeting the MPL. FUM-30day is at the 25th percentile and it is at the risk for not meeting the MPL. PPC-postpartum is below the 25th percentile and it is at the risk for not meeting the MPL.	Continue with plan as listed	Lack of automation of prospective rate report process, and some delays with CitiusTech refreshing (e.g. May 2025 data not available until July 2025).	Automation of the prospective rate report process. Implementation of Hyperlift to monitor Stars performance.	On Target

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26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Linda Lee	Paul Jiang	Quality Analytics	1. Monthly prospective rate reports provided to all HN partners via email. Member-measure level gap in care reports provided monthly to all HN partners via sFTP.	data collection in progress	Automation of monthly reports in development	1. Lack of automation of HN summary reports requires manual formatting and submission; this process takes one business day to complete across multiple FTEs.	Complete reporting of annual audited plan-level rates. Prepare HN and CHCN provider-level rates.	On Target
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Katy Noyes	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR: Initials FSRs=11; Periodic FSRs=47; On-site Interims=2	FSR/MRR: The number of Periodic and Initial FSRs completed increased slightly from Q1 2025 to Q2 2025. The number of Periodic FSRs completed timely increased slightly from 92% in Q1 2025	Provide extensive educational support and technical assistance to sites. This includes but is not limited to review of DHCS FSR and MRR Tools and Standards, U.S. Preventive Services Task Force (USPSTF) A&B recommendati	N/A	Continue to implement work plan.	On Target

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										9; Failed FSRs=2 B. MRR: Initial MRRs=4; Periodic MRRs=42; Failed MRRs=6 C. CAPs: Critical Element (CE)=42; FSR=51; MRR=55 D. PARS: Completed PARS=63; Basic Access=28 (44%); Limited Access=35 E. CBAS Oversight: Critical Incidents=20 (14 COVID); Non-Critical Incidents=8; Falls=12; Audits Completed =11; CAPs Issued=8; Unannounced Visits=0 F. NF Oversight: Critical Incidents=; On-Site Visits=21;	to 93% in Q2 2025. The number of Periodic and Initial MRRs completed decreased from Q1 2025 and Q2 2025. The number of failed FSRs decreased from 3 in Q1 2025 to 0 in Q2 2025. The number of failed MRRs decreased significantly from 19 in Q1 2025 to 6 in Q2 2025. CAPs: The number of CE CAPs issued increased from 33 in Q1 2025 to 42 in Q2 2025. The number of FSR CAPs issued increased from 43 in Q1 2025 to 51 in Q2 2025. The	ons, the American Acedemy of Pediatrics (AAP) periodicity schedule, most current adult and childhood vaccination recommendations from Advisory Committee on Immunization Practices (ACIP). Additionally, a hard copy provider audit packet it sent out to sites before every periodic audit. The packet includes resources to help providers achieve a safe and effective provision of primary care services, to ensure and support the quality of care and documentation of appropriate clinical services, and to improve overall member health outcomes.			

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										Unannounced Visits=0	number of MRR CAPs decreased from 61 in Q1 2025 to 55 in Q2 2025. PARS: The number of PARS completed increased significantly from 74 in Q1 2025 to 169 in Q2 2025. The number of PARS with BASIC access decreased from 51% in Q1 2025 to 40% Q2 2025. CBAS Oversight: The number of Critical Incidents reported increased significantly from 1 in Q1 2025 to 20 in Q2 2025. The number of Non-Critical Incidents reported decreased greatly from 42 in				

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											Q1 2025 to 20 in Q2 2025. The number of Falls reported decreased slightly from 15 in Q1 2025 to 12 Q2 2025. The number of audits completed increased from 8 in Q1 2025 to 11 in Q2 2025. The number of CAPs issued increased from 6 in Q1 2025 to 8 in Q2 2025. NF Oversight: The number of Critical Incidents reports received increased from 7 in Q1 2025 to 20 in Q2 2025. The number on on-site visits completed increased				

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											from 16 in Q1 2025 to 21 in Q2 2025.				
28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Laura Guest	Quality Improvement	Ten PQI cases were presented to CPRC for leveling and actions; three level 3, seven level 2, no level 1. We closed 321 PQIs in Q2, opened 185 cases and have a total of 363 cases open at the end of Q2.	The number of PQI's closed in Q2 increased significantly due to the PQI Backlog Project in collaboration with the medical directors. We had a higher number (99) of cases opened in April due to Customer Service finding more declined grievances and nursing facilities submitting critical incident	Changes implemented as a result of updates to policy GG.1611 and the Backlog Project: 1)Two nurses may close a PQI to QOS, 2)Nurses are reviewing the provider response to QOC grievances and determining if it is QOS at that time, 3)Nurses are waiting 2 weeks after the grievance closes for the provider's response before opening a PQI, 4)We had the first meeting of the Provider Action Workgroup to address service issues	1)The Provider Action Workgroup is still in development so no actions have been initated as yet, 2)There are still 363 PQIs opened; we'd like to get that number under 200.	1)Hold monthly meetings of the Provider Action Workgroup to develop policy, charter and implement actions on providers reviewed. 2)Implement a nurse in GARS to review grievances when received to determine if QOC to further help to reduce the volume of PQIs	Concern

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											reports in mass.	organizationally. 5)We began presenting a report of all PQIs closed in previous month.		being opened.	
29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Rick Quinones	Quality Improvement	Initial BH Credentialing Q2 = 2291 Initial CCN Credentialing Q2 = 282 BH Recredentialing Q2 = 56 CCN Recredentialing Q2 = 122	Initial/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and recredentialing files. We have also contracted wiith Salesforce, a vendor to support the end to end functions of multiple	We implemented a Backlog project from Feb-June which required help from other depts per leadership's request.	N/A	Hired two FTEs (Program Specialist and Program Coordinator)	Concern

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											departments.				
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Megan Dankmyer	Sherry Hickman	Medical Management	Percent of Members with Completed HRA through 6/30/2025: 49.01% Percent of Members with ICP through 6/30/2025: Initial ICP 73.6% Annual ICP 95.2% DHCS ICP reporting for Q12025 at 79.3%	1. Identified 62 OC members from Q3 2024 through Q2 2025 who did not have ICP completed timely due to	Assess and report the following activities: 1. Network communications: Revised layout for monthly communication Implemented in June 2025. 2. DCHS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q1 2025: 772 of 973 members had ICP developed within 90 days of eligibility for	2. Members who are unable to contact or decline both the HRA and the ICP.	Assess and report the following activities: 1. Ongoing communication with Health Networks on ICP development. 2. Ongoing assessment and reporting of DHCS quarterly ICP reporting (Q2 2025) 3. Ongoing assessment and reporting	Concern

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												79.3% 3. HRA Star Status: Percent of Members with Completed HRA days through 6/30/2025: 49.01% 4. MOC Updates: No updates 5. Face to Face Interactions with PCP or specialist: 67% at end of Q2.		on HRA Star Status. 4. Ongoing assessment and reporting for MOC updates. 5.Ongoing assessment and reporting for Face to Face interactions.	

31	Quality of Clinical Care		Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Vacant	Kelli Glynn/Leslie Vasquez	Quality Analytics	Data through May 2025: CIS: 24.6% IMA: 40.7% W30 (6 or more visits): 29.03% W30 (2 or more visits): 64.12% WCV: 19.03% LSC: 66.58%	CIS: already achieved the 33rd %ile and performing significantly higher as compared to same point in time last year (19.52% in May 2024) IMA: already achieved the 50th %ile and performing higher as compared to same point in time last year (37.66% in May 2024) W30: both sub measures are performing higher as compared to same point in time last year (28.1% and 61.31% respectively, in May 2024) WCV: performing higher as compared	Ongoing outreach to parents / guardians / members via Carenet (telephonic) and Ushur (SMS). Creation of a personalized pediatric mailer. One-time telephonic outreach via Carenet to members that are aging in. Vaccine hesitancy presentation to MAC/PAC.	HEDIS engine does not provide all necessary data elements for personalized outreach; creating in-house reporting with Financial Analysis.	Continue with plan as listed and pursue automation where possible. Leverage the upcoming Cozeva PayerOne solution to provide HN and CHCN provider partners with more detailed data for CIS and W30.	On Target

					complete chart chase efforts year-round 6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap						to same point in time last year (17.43% in May 2024) LSC: already achieved the 50th %ile and performing higher as compared to same point in time last year (63.28% in May 2024)				

					Bridging Remediation for early intervention										

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32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Vacant	Melissa Morales/Dexter Dizon/Kelli Glynn	Quality Analytics	Cervical Cancer Screening (CCS) MC:43.97 % Colorectal Cancer Screening (COL) OC: 59% Breast Cancer Screening (BCS) MC: 47.21% OC:57% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) MC Flu Total: 17.12% OC Flu Total: 42.39% MC Pneumococcal 66+: 38.05% OC Pneumococcal 66+: 47.31% MC Tdap Total: 37.99% OC Tdap Total: 42.84% MC Zoster Total: 17.69% OC Zoster	CCS MC: A 5.7 percent point increase compared to May 2024 COL OC: A 7 percent point increase compared to May 2024 BCS MC: A 34.6 percent point increase compared to May 2024 BCS OC: A 1 percent point increase compared to May 2024 MC Flu Total: A 2.79 percent point increase compared to May 2024 OC Flu Total: A 3.14 percent point increase compared to May 2024	Breast Cancer Screening Text Campaign (MC: 75,000) Cervical Cancer Screening Text Campaign (MC 90,000) Colorectal Cancer Screening Text Campaign (MC 90,000) CareNet Live Call campaign for CCS, MC and OC BCS, MC and OC COL Mobile Mammography Events Flu Thank You Postcard Care gap member outreach to commence Q3 and Q4	None identified.	Continue Mobile Mammography Events Continue CareNet Live Call Campaign Q3/Q4 Initiate 2025 Cologuard Campaign Standing Order telephonic and mailing member outreach for BCS Continue Flu Postcard for members TBD Q3/Q4 Relaunch IVR robocall campaign TBD Q3/Q4 Relaunch Texting Campaign TBD Q3/Q4	On Target

					Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					Total: 25.81%	MC Pneumococcal 66+: A 7.37 percent point increase compared to May 2024 OC Pneumococcal 66+: A 0.33 percent point decrease compared to May 2024 MC Tdap Total: A 19.55 percent point increase compared to May 2024 OC Tdap Total: A 21.89 percent point increase compared to May 2024 MC Zoster Total: A 5.42 percent point increase compared to May 2024				

											OC Zoster Total: A 7.56 percent point increase compared to May 2024				

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33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Dr. Richard Pitts	Joanne Ku	Medical Management	1. Conducted an in-person grantee meeting to review Progress Report #2. 2. With the new HEDIS engine implemented, developed the FQ grantee dashboard showing baseline, progress during the current reporting period, and the number of additional members they need to screen to achieve their grant goal (using prospective data). 3. mPulse (texting campaign): Launched the 2-way texting campaigns: -Breast Cancer Screening	Based on observations and feedback from grantees, the workgroup identified the following challenges: 1. Need to account for "ramp up" and hiring. 2. Most payments are in arrears. 3. Frequent reporting and out of sync with calendar year. 4. Challenge in using HEDIS metrics to evaluate success throughout the process.	Worked with the Senior Director of Grant Programs to identify areas of opportunity and initiated grant amendments to better align with the program's scope: 1. Added a 6-month no-cost extension to the grant program. 2. Increased frequency of payments. 3. Decreased number of reports and sync with calendar year. 4. Added volume of screenings objectives based on attempted HEDIS improvements. Distributed the dashboard to the FQ grantees for monitoring and reference purposes.	1. Identified a data discrepancy during the amendment process. Need to determine the root cause and find a solution to ensure data accuracy. 2. While the workgroup actively worked on refining the scope of work for the Research & Evaluation initiative, the focus has shifted significa	1. Execute grant amendments with all 13 grantees, including a benchmarking table. 2. Conduct an in-person grantee meeting in August 2025 to review the grantees' progress using the newly formatted progress report template. 3. Meet with KCS and the internal Quality Analytics team to resolve the data discrepancy issue. 4. Continue working on the Research & Evaluatio	On Target

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										(unique members: 55,536 | Engagement rate: 22%) -Cervical Cancer Screening (unique members: 81,013 | Engagement rate: 14%) -Colorectal Cancer Screening (unique members: 59,521 | Engagement rate: 14%) Translated trigger responses into threshold languages to obtain more meaningful data.			ntly from the time the initial plan was presented to the Board.	n initiative scope of work and determine the best time to release the RFP.	

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34	Quality of Clinical Care		Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Kelli Glynn	Leslie Vasquez	Quality Analytics	PPC Postpartum Care: 65.39% (data through May 2025) PPC Prenatal Care: 81.86% (data through May 2025)	Both measures are performing higher as compared to same point in time last year (May MY2024)	All planned activities are still in progress.	Resource constraints	Continue to partner with the Maternal Health Team.	Concern

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					6.Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.										

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35	Quality of Clinical Care		Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Ann Mino	Equity and Community Health	1. Provided a maternal mental health training through Postpartum Support International to clinics/providers and community-based partners. 58 providers and partners are registered. 2. Conducted maternal mental health screenings at community-based events including Santa Ana College and Maternal Presentations to 45 members. 3. Implemented stroller walks to include mental health	N/A- work in progress	1. Provided a maternal mental health training opportunity to clinics/providers and community-based partners. 2. Conducted maternal mental health screenings at community-based events. 3. Receive contracted provider list for providers that self-identified as specializing in maternal mental health to assist members with connecting to services. 4. Maternal Health focused TeleMed2U flyer is included in maternal health member mailings.	1. Community Events due to immediate needs when completing mental health screenings that are very difficult in that situation. 2. Community events due to the current community environment and low attendance at events.	N/A	On Target

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										preventative care (physical activity, social interactions, breath work, etc.).					
36	Cultural and Linguistic Appropriate Services		Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Vacant	Kelli Glynn/Katie Balderas	Equity and Community Health/ Cal AIM/Quality Analytics	PPC Postpartum Care: 57.53% compliance rate for Black members compared to 64.41% compliance rate for the entire PPC population (data through May 2025) PPC Prenatal Care: 78.08% compliance rate for Black members compared to 81.06% compliance	Based on May 2025 data, the Black or African American population is trending lower (in terms of compliance rate for both prenatal and postpartum care) as compared to Asian and White members.	1) 24 Black members have open authorization for Enhanced Care Management (ECM) within the Birth Equity Population of Focus in Q2. In that quarter, 3 Black members received doula services, making up 9% of all members who received doula services during the same period. This shows a decrease in utilization compared to Quarter 1 (17.5%). Approval was	1) Limited promotion of Doula Benefit 2) Barriers to data sharing with Black Infant Health and community resources	1) Developing strategy for doula promotion to members. 2) Developing manual workaround until automated data sharing solution is available.	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					resource navigation for pregnant and postpartum members.					rate for the entire PPC population (data through May 2025)		obtained from the CalOptima Health Privacy and Security teams to establish member-level data sharing, which will help OC Black Infant Health program with outreach to eligible members. 2) No activities for this quarter. 3) No activities for this quarter.			

37	Quality of Clinical Care		Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Vacant/Katie Balderas	Melissa Morales/Kelli Glynn/ Elisa Mora	Equity and Community Health and Quality Analytics	Eye Exam for Patients with Diabetes (EED) MC:37.64 % OC: 52% Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) MC Poorly Controlled (Glycemic Status >9%): 62.73% OC Controlled (Glycemic Status <8%):40%	EED MC: A 2.28 percent point increase compared to May 2024 EED OC: A 1 percent point increase compared to May 2024 GSD MC: A 14.61 percent point decrease compared to x 2024 (lower is better) GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign (MC, OC approx. 45,000) CareNet Live Call Campaign for MC and OC HbA1c VSP Eye Exam mailing reminder	None identified.	Continue CareNet Live Call Campaign Q3/Q4 Relaunch Diabetes Texting Campaign Q3/Q4 Exploration of at-home A1c testing with lab partners such as Quest	On Target

					physicians 7. Collaborate with OPH and OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-										

					based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.										

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38	Quality of Clinical Care		Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Elisa Mora/Joanna Hoffnagle	Equity and Community Health	1. In Q2, 345 members were screened for blood pressure and received education on blood pressure management, including how to measure it properly, through various community events. Of these, 160 were OneCare members. 2. Eleven hypertension classes were held in Q2, with a total attendance of 150 members. 3. A standing order process was implemented to increase access to blood pressure	1.Community events are effective engagement points, particularly those centered around cultural identity and inclusion. 2.Members are receptive to health education when delivered through trusted community organizations. 3.There is an ongoing need to reduce equipment access barriers, such as blood pressure monitors, to support chronic condition management. 4.Ongoing training, data	1. Identified OC members with CBP health gap to provide targeted outreach for education and blood pressure screening clinics 2. Finalized hypertension class curriculum 3. A standing order was created to increase access to BP monitor for CalOptima members. Training for CalOptima staff will take place in April. 4. Meeting with providers and community based organizations to schedule blood pressure clinics 5. Increased screening opportunities at community events	A1 Pharmacy initially did not carry the XL blood pressure cuff covered under the medical prescription benefit. To ensure continued support for our members, they established a contract with a different manufacturer that provides the XL cuff under medical Rx coverage.	Continue to track and monitor the use the standing order by CalOptima Health staff.	On Target

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										monitors for CalOptima Health members. A total of 173 CalOptima Health staff were trained on the new process. 4. Since the implementation of the standing order process, a total of 168 blood pressure monitors have been ordered. 5. A presentation on the CBP STAR measure and how to increase blood pressure monitor access for members through the pharmacy and DME benefits took place on 5/1 at the CalOptima	tracking and protocol implementation are necessary steps to operationalize expanded member access.				

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										Health Clinical Ops 2025 Health Network Series (UM/CM) 75 attendees.					

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.ECH to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer/Kelli Glynn	Sherry Hickman Mahmoud Elaraby	Medical Management (Case Management) /Quality Analytics	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	1.Case management to collaborate with Quality to identify members who need follow-up: a. Members with OMW will be added to Key Event report through Point Click Care Data. IT TIcket/RITM0043625 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor: a. ECH researched in home vendors during quarter 2. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide	1. Some in-home vendors do not meet diagnostic criteria for the Star Measure.	1. Case management will continue to collaborate with Quality to identify members who need follow-up: a. Pending Members with OMW to be added to Key Event report through Point Click Care Data. IT Ticket/RITM0043625 2.Case Managementwill continue to outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality to	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					timely data and insight to the member's compliance deadline date to Health Network partners.							education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). Discussion in Stars Workstream Workgroup. 6.Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partner: Ongoing in member - measure level files to Health Networks monthly.		continue timely notifications to the member's PCP via fax. 4. Exploration for education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate) is currently on hold. Quality will continue to explore potential pharmaceutical intervention in support of OMW. 5. Quality and Case Management will continue to coordinate to provide more timely data and	

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														insight to the member's compliance deadline date to Health Network partners	
40	Quality of Clinical Care		Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer	Sherry Hickman	Case Management	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	1. Review and update the Key Events for Emergency Visits: a. IT Ticket RITM0043625 created for additional identification of members who meet chronic condition criteria to be identified as a Key EventType. 2. Continue to share Emergency Visits with Health Networks through Key Event	Key Event reporting lacked visibility for members who met FMC chronic care condition critiera.	1. Review and update the Key Events for Emergency Visits: a. Pending addition of Members who meet FMC criteria as Key Event Type. IT Ticket RITM0043625. 2. Continue to share Emergency Visits with	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
												reporting: Ongoing.		Health Networks through Key Event reporting.	
41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	APM PR HEDIS Rates Q2 (April): MC: 13.08%	APM PR increased from Q1 (March) to Q2 (April) by 1.67%	APM: 1) Prescribing provider letter finalized 06/09/2025. 2) HEDIS Provider tool tip sheet finalized 06/06/2025. 3) Social Media Post, posted on 04/14/2025. 4) Article for the Fall Member Newsletter approved and going through MMA process. 5) Text Campaign sent out a.) 4/10/2025 - 75 texts sent b.) 5/8/2025 - 52 texts sent 6) Created a Quick Reference Guide (QRG) & Power Point	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	APM: 1) Continue Text message campaign. 2) Resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 3) Resume collaboration with Provider Relations to conduct in-person provider outreach	At Risk

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.							Presentation for providers and staff on how to use the Provider Portal. Pending report availability		with top 10 providers on a monthly basis. 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports are availability.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
42	Quality of Clinical Care		Behavioral Health Services: Depression	~~Antidepressant Medication Management (AMM)~~ ~~MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025.~~ ~~MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025.~~ ~~OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025.~~ ~~OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025.~~ Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	~~AMM~~ ~~Goal not met. Continue to assess and report the following activities:~~ ~~1) Educate providers on the importance of medication adherence through outreach.~~ ~~2) Educate members on the importance of medication adherence through newsletters/outreach.~~ ~~3) Track number of educational events on depression treatment adherence.~~ DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR HEDIS Rates Q2 (April): MC: 2.06% OC: 2.48%	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR increased from Q1 (March) to Q2 (April) by 0.02% for MC and for OC there is no data from Q1 to compare findings for Q2.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) HEDIS Provider tool tip sheet finalized 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) Share updated draft of prescriber letter with BHQI workgroup If data is received: a.) Disseminate prescriber tip tool sheet, once Prescriber letter is approved b.) Send out a text message campaign. c.) Resume mailings of Provider materials (Best Practices letter and Provider tip tool	At Risk

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.									sheet) to providers on a monthly basis. d.) Resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports availability.	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
43	Quality of Clinical Care		Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs)	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	SSD PR HEDIS Q2 (April): MC 42.4% SAA PR HEDIS Q2 April PR: MC 0.52% OC 1.70%	SSD PR increased from Q1 to Q2 by 3.39% SAA PR increased from Q1 to Q2 for: MC by 0.52% OC by 1.70%	SSD: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR process on 06/06/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. 4) Article for the Fall Member Newsletter approved and going through MMA process. SAA: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR	Barriers include: 1) Member compliance is a challenge with this population 2) Unable to do member mail out due to lack/delayed data.	SSD: 1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Mail out to all prescribing provider offices the following: a.) Prescribin	At Risk

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					5) Member Health Reward Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.							process on 06/06/2025.. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers & Staff on how to use the Provider Portal. Pending report availability. 4) Article for the Fall Member Newsletter approved and going through MMA process.		g Provider Letter b.) Provider Tool Tip Sheet c.) Member Reward Flyer 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. SAA: 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member follow-up. 2) Discussio	

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														n of implementing a text messaging campaign. 3) Begin mail out to all prescribing provider offices the following: a.) Prescribing Provider letter b.) Provider Tool Tip Sheet 4) Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report avialability.	

44	Quality of Clinical Care		Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz / Valerie Venegas	Behavioral Health Integration	FUM PR HEDIS Rates Q2 (April): 30 day-49.6%, 7 day-29.21% FUA PR HEDIS RATES Q2 (April): 30-day: 29.16%%, 7-day:16.17 % FUI PR HEDIS Rates Q2 (April): 30-day: 26.26% 7-day: 8.42%	FUM PR increased from Q1 (March) to Q2 (April) for 30-day by 30.67% and for the 7-day the rate increased by 19.13%. FUA PR increased from Q1 (March) to Q2 (April) for 30-day by 6.74% and for the 7-day the rate increased by 4.32%. FUI PR increased from Q1(March) to Q2 (April) for 30-day by 6.56% and for the 7-day the rate increased by 1.85%.	FUM: 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM data with HN Networks via sFTP. 5) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with	1) Delay in receiving supplemental 837 data from OC HCA 2) Member engagement is a challenge with this population.	FUM: 1) IVR calls for members who meet FUM criteria to remind them of the importnace of schedling a follow up appointment after an ED visit. 2) Continue Text Campaign 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM HEDIS report data via Provider	Concern

					member text messaging 3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.							NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. FUA: 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication.		portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUA: 1) IVR and text campaign Pilot will replace the current text campaign in July 2025, this will expand member out reach to include landlines 2) Continue Text Campaign 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave	

													4) Continued sharing FUA data with HN Networks via sFTP. 5) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation		the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM HEDIS report data via Provider portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

												for providers and staff on how to use the Provider Portal. Pending report availability. FUI: 1) Monitoring this measure. 2) Created a HEDIS Provider Tool Tip Sheet.06/06/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.			

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45	Quality of Clinical Care		Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jaylene Ramirez	Behavioral Health Integration	APP HEDIS Rates Q2 (April): MC: 43.94% POD HEDIS RATES Q2 (April): MC:3.62%	APP increased from Q1 (March) to Q2 (April) by 16.46%. POD PR increased from Q1 (March) to Q2 (April) by 0.03%.	APP: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability POD: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.	APP: 1) We are not able to send out the provider letters, as we are still awaiting their approval. 2) We are also waiting for Citius to display provider data such as address, so that we can begin to send out letters once approved. POD: 1) The barrier with POD is that pharmacy claims data for Medi-Cal	APP: 1) Send out the provider letters. 2) Work on text message to send out to members, possible barrier new APL regarding minor consent. POD: 1) Meet with county to disscus POD data gap issue at the next county collaboration meeting on July 16, 2025.	At Risk

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													members comes through the state; the state pays for those prescriptions. Sometime the claims are not being billed through the state, so if the member is getting their prescription at county, CalOptima Health does not know the process for members to get thier prescription outside of the states coverage.		

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46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	N/A	N/A	1) There are no activities to report. SBHIP implementation activities and deliverables are all completed; the last incentive payment was received on April 24, 2025. CalOptima Health earned the entire $25M DHCS allotted incentive funding for Orange County.	N/A	1) At this time there are no follow-up actions.	On Target
47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Kelli Glynn	Dexter Dizon	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 52.67% OC Total: 15.82% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.34% OC Total: 25.32%	CWP: A 1.72 percent point increase compared to May 2024 AAB: A 3.03 percent point decrease compared to May 2024	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers.	N/A	Finalize provider communication plan in collaboration with the Quality Medical Director.	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Dr. Nicki Ghazanfarpour	Dr. Susan Vigil	Pharmacy Management	2Q25 Overview: -Count of Member adherence IVRs: 4,473 -Adherence intervention calls to providers, members and pharmacies (ongoing) from January 2025 to date: 2,114 (42.8%) of the 4,938 prescriptions intervened on were filled after the intervention -Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health	CY2025 Star Measure reports unavailable from Acumen for 2Q25. Results of interventions documented in column O.	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements 5) 100-day supply conversion program	1) Members picking up their medications 2) Limited providers signing collaborative practice agreement for 100-day supply program	Continue all interventions outlined.	Concern

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										networks to assist in intervention design -100-day supply conversion program : 230 prescribers outreached, 52 prescribers signed collaborative practice agreement; 67 prescriptions for 42 unique members converted					
49	Cultural and Linguistic Appropriate Services		Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Vacant	Leslie Vasquez/Kelli Glynn	Quality Analytics	10.20% compliance rate for Black members compared to 26.79% compliance rate for the entire W30 population (first 15 months of life) (data through May 2025)	A significant difference in compliance exists for Black members as compared to the performance for the overall population	Telephonic outreach to parents / guardians	1. Contact Information: Bad or disconnected phone numbers continues to be a challenge in the ability to contact members and coordinate care.	To address contact information challenges, outreach staff outreach to the member's assigned primary care doctor and obtain updated contact information, where	Concern

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														feasible. Continue telephonic outreach and explore additional initiatives, such as targeted outreach to pediatricians. Will do so in partnership with health networks and/or primary care providers.	
50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	Baseline Measurement: 01/01/2023 - 12/31/2023 -1.08% Remeasurment 1: 01/01/2024 - 12/31/2024 -2.32%	Percentage has increased by 1.24% during Remeasurment Period 1	1) Continued to receive daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Continue collaboration with telehealth vendor. Vendor to continue ED member outreach and to provide information regarding case managment including ECM and referrals.	1) Coordinating/Engaging internal stakeholder departments due to competing priorities. 2) Given the diagnosis there is difficulty in connecti	1) Continue collaboration with Case Managemnt and Financial Analysis depts to ensure accuracy of internal data and reports. 2) Continue to conduct barrier analysis. 3)	On Target

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					with SMH/SUD.							3) Collaboration with OC HCA and CalOptima Health IT regarding 837 data exchange.	ng with this member populati on. 3) PHI Data Sharing with commun ity partners , for coordina tion of care and outreac h. 4) Lack of data exchang e with the County Mental Health System.	Continue Telehealth member outreach.	

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51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Vacant	Melissa Morales/Kelli Glynn	Quality Analytics	Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) OC Controlled (Glycemic Status <8%):40%	GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign CareNet Live Call Campaign OC HbA1c Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	None identified.	Continue Emerging Risk project in collaboration with Elisa Mora's team. Exploration of at-home A1c testing with lab partners such as Quest.	Concern
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. Gap analysis showed Plan level met time or distance standards. It also closed gastroenterology PMR gap. meets	1. Recruiting outreach for Rheumatology, Urology and Neurology coincides already addressed the new	1. PR completed new provider outreach for Rheumatology, Urology, Neurology outreach. 2. PDO launched a new outreach with PR to connect with	1. PR outreach trended on providers either not interested or no longer at the location	1. Review the results of the CCN contracted groups for specified specialties 2. Review/Approved	On Target

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					2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members					standards except for PMR, which shows gaps in Orthopedic Surgery, LMFT and Urology 2. CCN remains the same at 3 gaps for Time/Distance requirements 3. HNs all had time/distance gaps, and 7 new HNs now have 1 PMR gap in Urology	gap in Urology. The results of the outreach did not yield as many new contracted providers as originally hoped. 2. Urology is a new high volume specialty based on 2024 utilization data which is why it's a new PMR gap at the Plan level and 7 of 10 HNs (includes CCN in the count) 3. PMR Gap trended upward with the inclusion of Urology as a new high volume specialty, therefore creating new standard. Time or	all CCN contracted groups to verify that all providers within the group has been submitted to COH for inclusion 3. COH audited and reviewed all HN CAP responses and opened AAS request/ Telehealth to expand member access to care for the purpose of SNC certification.	listed per DHCS FFS database 2. Network Adequacy Workgroup has identified that certain specialties are seeing COH's rates to be lower and therefore not interested in contracting 3. Contracting new providers take multiple months, therefore HNs are not always able to close the gap within 1 quarter.	AAS/Telehealth request from HNs 3. Network Adequacy Workgroup to discuss other solutions to explanding provider network to address gaps	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
											Distance gap trended downward with HNs decreasing gaps from Q1 to Q2, as a direct result of HNs completing CAPs issued for 2024 SNC.				
53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 4) Continue to educate providers on	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Helen Syn/Karen Jenkins	Quality Analytics	MY-2024 Appointment Access Results: •One-Care Plan- All provider types met MPL •Medi-Cal Plan- All provider types met the MPL with the exception of Psychiatry ○ Urgent at 55% ○Follow-up at 56%:	2024 non-compliance notifications distributed in Q2-2025: •4 HNs were issued a CAP for not meeting 70% MPL •184 Providers were issued a notice of Non-Compliance •74 Providers were issued a CAP (CAP indicates non-compliance of two or more measures)	CareNet Live Call Campaign for MC and OC HbA1c	•Vendor issues with 2024 data quality and reporting •Threshold too high and monitoring of non-regulatory measures •Timely Access analyst resigned at begging of year	Planning for 2025 Timely Access Survey underway. •Targeting initial fielding to start in August •Currently interviewing for new analyst. •Offering access and appointment training to providers and HNs through our contracted vendor, the SullivanL	On Target

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					timely access standards 5) Develop and/or share tools to assist with improving access to services.									uallin Group	
54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. 2024 ANC - DHCS approved and found COH in full compliance with the following requirements: - MPT, Hospital, Cancer Treatment Validation - MPT, LTSS, OB/GYN P7Ps - Provider to Member Ratio (PCP, Total Physician, Outpatient NSMHS) 2. 2024 SNC - All	1. 2024 ANC - the only item remaining to be certified is the outcome of AAS Request for Time or Distance which is still under review 2. 2024 SNC - COH reviewed all HN CAP submissions in April and June. The CAPs closed a considerable amount of gaps across the network	1. 2024 SNC - Telehealth/Alternative Access Request has been authorized to be used by HNs to close remaining gaps and be certified. COH provided office hours to provider an overview and address any questions the HNs may have in completing this step in the SNC process. 2. NAV: PDO operations implemented a workplan to complete the network adequacy validation	1. 2024 SNC - it takes months to recruit providers, which is why some gaps continue to remain open for HNs under Time or Distance requirement. The use of Telehealth/AAS will allow member	1. 2024 SNC - Telehealth /AAS requests are due to COH in July with the goal of certifying all HNs in Q3 to complete this regulatory requirement 2. 2024 NAV Audit package is due to HSAG on 7/17 and Virtual Audit is scheduled for 8/18/25	On Target

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										HNs completed corrective action plan. COH closed the PMR CAP that were issued. Since this is not a DHCS requirements, COH will no longer include it as part of SNC moving forward. Instead it will continue as an internal monitoring standard for NCQA purposes. 3. DHCS retained HSAG for 2024 NAV Audit and HSAG has kicked off the NAV audit process with COH.	however, no HN closed all Time or Distance gaps to be fully certified. All HNs remain with gaps for Time or Distance. 3. NAV - Review of the NAV package showed that the majority of the questions remained the same compared to last year.	package across multiple departments.	s to gain access to care while the HNs continue their contracting efforts to completion.		

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
55	Quality of Service: Access		Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network. 3) Provider and HN education to support new member screening for SDOH screening within 120 days.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Anna Safari/Stephanie Johnson	Equity and Community Health	1) Member communication: •New member text message campaign went live in December 2024 and is sent monthly. •Interactive Voice Response (IVR) campaign goes out to new members twice monthly. 2) Delegation Oversight (DO) Collaboration for HN Compliance Improvement: •ECH & DO Internal Stakeholder Collaborative Meetings: Provider relations and customer service to	1) For April and May 2025, text message campaign member engagement and response rates were both at approximately 10%. 2) N/A; In progress. 3) N/A; In progress.	Presentations: •PHMC 5/15/25 •CLCHC CalOptima Health Quality Meeting: 5/20/25, 6/17/25 •CHCN Virtual Meeting:6/26/25 •DOC Meetings: 5/28/25, 6/24/25 •JOMs: 4/28/25, 5/8/25,6/17/25 •Quality Update Meetings: 5/1/25, 5/6/25, 5/7/25, 5/20/25, 5/22/25 (2), 6/3/25, 6/17/25 •Ad Hoc Meeting with Providence for IHA Onboarding: 6/23/25 •Delegate Health Network Dashboard Monitoring -BU Workgroup: 5/8/25, 7/8/25	N/A	1) Member communication: •Continue with existing member outreach efforts 2) DO Collaboration for HN compliance improvement •Steven Chin, Sr. Director, Provider Relations, to review current IHA interventions and explore best practices to improve the HN IHA completion rate 3) Provider/ HN education Continue educating and supportin	On Target

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										review auto-assignment policies and discuss reducing the timeframe for members to be assigned to HN • ECH participation in the monthly Delegation Oversight Committee (DOC) meetings and Delegate Health Network Dashboard Monitoring Workgroup •ECH participates in DO's monthly Delegate Health Network Dashboard Monitoring -Business Unit Workgroup (listed in Column Q) •ECH provides an				g HNs and Providers with IHA requirements through various presentations. IHA CME scheduled for 8/6/25.	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										IHA data monitoring slide to DO monthly for the DOC 3) Provider/HN Education: ECH presented IHA updates at 18 meetings in Q2, listed in Column Q					

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star Improvement MC: One Star Improvement	Assess and report on the following activities: 1) JIT: Conduct outreach to members in advance of 2025 CAHPS survey (Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively). 2) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 3) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy. 4) Propose mapping of member	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Carol Matthews/Helen Syn	Quality Analytics	1. Closed 2. 2/8 listenting posts active 3. Health Network meetings pending receipt of CAHPS results. 4. Mapping of CAHPS categories is in process. 5. Internal training to CalOptima staff about the DPI platform.	1. 2025 HN CAHPS performance varies for member experience. 2. GARS data difficult to map to one CAHPS meausure for voice of member.	1. Medi-Cal calls were completed in April. 2. Listening posts implementation updates: medication fill within the last month (4/16/2025) and post office visit visit (4/16/2025 and 6/11/2025) 3. HN meetings will be held in Q3 to discuss individual MC HN CAHPS results. 4. Behavioral health categories and GARS data being mapped to CAHPS 5. Training session held July 9.	Lack of time and staffing resources.	Continue with plan as listed.	At Risk

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					responses to CAHPS categories in support of the organization adopting a Voice of Member reporting system. 5) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.										

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 03/11/2025 Q2: 05/13/2025 Q3 08/12/2025 Q4 11/13/2025 Q1: 02/10/2026	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Andrew Tse	Mike Erbe	Customer Service	OneCare Call Center Abandonment Rate: 2.4% OneCare Call Center Average Speed of Answer: 24 seconds Medi-Cal Call Center Average Speed of Answer: 1 minute and 34 seconds		Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	None noted.	Continue with plan as listed	On Target
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 2.. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Michelle Evans	None	Case Management	1st Qtr: MC 1.1440 OC: 15.91% 2nd Qtr: MC Pending data OC: not avail yet-MY2025 Current performance with Data processed through April 2025 is 2 stars. Decrease	MC readmission rates trending upward. OC readmission rate trending down from 17.88% Q4 2024	1) Readmission best practices shared with HN and Facility JOM's 2)Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3)Creating education for 99495 and 99496-TCS codes post	Member engagement; Limited visibility into readmission details - manual readmission audits	**Continue planned activities** 1) Sharing readmission best practices with HN, Facility JOM's, SNF qtrly meetings 2) Sharing TCS flyer and OC PCC flyers for	Concern

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					(UM/CM/TCS) for targeted outreach for member outreach					from 3 stars in March 2025		discharge- higher reimbursement for providers 4) Point Click Care- PAC module added for OneCare- access to Continuing care document, Vital sign, progress notes at SNF partners 5) Impacting readmission and Discharge planning tipsshared at Qtlry SNF meeting and Discharge 6) Shared OC PCC contact flyer for all HN		HN for increased awarenes s how to contact with HN/Facilit y JOM's, SNF qtrly meetings. 3) Provide education for 99495 and 99496 when created with HN/Facilit y JOM's supportin g follow-up after Discharge . 4) Review MC and OC readmissi ons with high risk workgrou p-identify opportunit ies	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Michelle Evans	None	Long Term Support Services	Member engagement shows qtrly improvement. 1st Qtr: 9 members engagement. 2nd Qtr: 101 members engaged with 28 in delegated networks.Successful communication with Member HN with member outreach (27% of members from delegated networks)	Increased member engagement from from first Qtr.	1) Continue onsite activities 2) Weekly workgroup identify trends/opportunities/barriers 3) Program enhancements supporting increased member engagement 4) Warm Handoff to delegated HN/CM/TCS/ECM providers 5) Member resources and referrals (CalAim, housing, TCS, CM)	Decreased engagement from Facility Staff	**Continue planned activities** 1) Weekly onsite resources provided to UCI ED team 2) Continue onsite activities 3) Evaluate Assessement in Jiva as reporting enhancement and workflow enhancement 4) Continue refining workflows and processes 5) Expand into additional ED for support to mitigate barriers from ED discharge	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting. 5) Successful outreach with TCS members within 7 days of outreach.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Michelle Evans	Mimi Cheung	Utilization Management	Internal audit results of total volume of cases and successful outreach w/in 7 days: 1st Qtr audit with 60.69% successful outreach within 7 days. 2nd Qtr audit with 68.27% successful outreach within 7 days.	Results of random sample audit completed monthly showed a 7.58% improvement from first quarter.	1) ContinueTCS Texting campaign. 2) Established TCS phone audit log to capture any missed opportunities to outreach to members 3) Designated staff for TCS maternal health outreach 4) Promotion TCS services at Facility/Hospital JOM's & SNF facilities quarterly meetings. 5) IT support for Jiva Report	Manual audit for successful outreach within 7 days-pending Jiva report.	**Continue planned activities** 1) Usher Text TCS discharge text: Developing a quarterly TCS Ushur report. 2) Continue random sample audits and update KPI report for oversight and monitoring and to address manual audit barrier. 3) Developing Jiva reports for TCS. 4) Continue updating workflows and processes 5) Continue the promotion of TCS	On Target

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
														services at the facility and HN JOMs.	
62	Cultural and Linguistic Appropriate Services		Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	During Quarter 2 of 2025, Cultural and Linguistic Services continued to provide interpreter and translation services for members. The utilization data of interpretations and translations were analyzed, tracked and trended, identified and adjusted when	During Q2 Cultural and Linguistic Services continued to provide interpreter and translation services for members, which experienced an increase in translation and interpreter requests from members.	Throughout Quarter 2, all Member Material were translated accurately and on time to comply with regulatory standards.	Barriers previously identified in Quarter 4 for interpreter services were the shortage/lack of interpreters in various languages such as Khmer/ Cambodian. However, C&L vendors have onboarded more Khmer/	Cultural and Linguistic Services will continued to provide interpreter and translation services for members.	On Target

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										necessary to ensure members received timely and adequate interpreter and translation services. The following is the data for Telephonic and Face-to-Face interpreter requests for Quarter 2 of 2025: • Quarter 2 – 22,759 Telephonic interpreter requests • Quarter 2 – 4,020 Face-to-Face interpreter requests To follow is the translation total for Quarter 2 of 2025: • Quarter 2 – 4,320 Translations			Cambodian interpreters to support this language.		

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
63	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response. • The mailing resulted in a 1.2% response rate, as of July 15th, we have received 2,245 surveys as a result of the mailing. 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings. • Response rate is 13% (7 responses of 56 surveys offered).	1) Response rate continues to be low. • Our overall response rate, based on members surveyed, decreased from 5% to 2.8% due to the low response rate from the mailing. • Our average number of mailing surveys to new members is about 10,000 per month and our average return is 490 so about 5% return rate. • Staff reported members were reluctant to complete the survey due to the type of questions.	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings.	Members reluctant to respond e to the survey.Feedback from staff conducting the New Member Orientations is that members are hesitant to complete the survey stating they do not wish to share this information and possibly and indictation on the reason for the low response rate from the mailing activities.	Continue to monitor and track the collection of all member demographic data and continue to explore additional methods of collection.	Concern

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
64	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Quynh Nguyen	Linda Huynh	Provider Data Management Services	REL data collection is embedded in standard workflows (ACT, LOI, credentialing). No measurable increase in REL data was noted for Q2 because most providers do not submit this information.	No significant increase in REL data was observed in Q2. The 10% goal is an ambitious benchmark, and provider participation remains voluntary. Progress continues through the integration of REL fields into standard workflows, and tracking mechanisms are in place to support ongoing improvement. Continued outreach and education efforts are expected to help drive gradual increases over time.	Standard forms continue to include REL fields. Developed trending report to track provider to member ratio.	Provider submission of race/ethnicity and language fluency data remains voluntary, this limits the completeness of demographic data collection.	1. Implement outreach and reminders to Providers to encourage REL submission. 2. Continue to track response rates.	Concern

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					Health Networks.										

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
65	Cultural and Linguistic Appropriate Services		Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	Cultural and Linguistic Services drafted and initiated a Staff and a Member survey to evaluate language services experience from member and staff. The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive, with only 3 un-favorable responses. CalOptima Health mailed 32,480 member surveys to members via U.S. mail. As of June 30, 2025, we received 1,878	• The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive responses, with only 3 un-favorable responses. • Out of the 32,480 member surveys mailed to members via U.S. mail, we received 1,878 completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction	• Some of the responses from members are in other CalOptima Health threshold languages and need to be translated to assess the satisfaction level of the members.	Lack of response to the member surveys.	Will re-evaluate to determine if an additional survey should be mailed to members in the 3rd or 4th quarter.	On Target

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction level of the members. The target completion date to have a full report/detailed analysis of both the Staff and Member surveys is set for July 24, 2025.	level of the members.				

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
66	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Michaell Rose	Greta Rice/Adriana Ramos	HR and Provider Relations	No new updates	N/A	N/A	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	On Target

Domain abbreviations:
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Member Grievances and Appeals Report Second Quarter 2025

Quality Assurance Committee Meeting

October 8, 2025

Heather Sedillo, 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.

Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Trends
- Appeals Actions Taken

CalOptima Health

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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.

Executive Summary

In Q2, CalOptima Health received 5,056 grievances and 501 appeals for Medi-Cal and OneCare. The average closure rate was 21 days.

Grievances

Medi-Cal: Increased from 3,675 to 4,506 (23% increase). Main issues: Provider/Staff Attitude, Plan Customer Service, referral delays, and appointment availability.

OneCare: Increased from 371 to 550 (48% increase). Main issues: Provider/Staff Attitude, Plan Customer Service, transportation services, and telephone accessibility

Appeals

Medi-Cal: Appeals increased from 265 to 406 (53% increase) with a 28% overturn rate. Main issues: CalAIM Personal Care Hours, Housing Deposits, Day Habilitation services, and specialty care requests related to Out Of Network and UCI Tertiary Level Of Care requests.

OneCare: Appeals increased from 59 to 96 (61% increase) with a decrease in overturn rate from 47% to 33%. Main issues: inpatient hospital care with Non-Contracted Providers, outpatient services related to imaging and labs, and Out Of Network specialty care requests

Grievances

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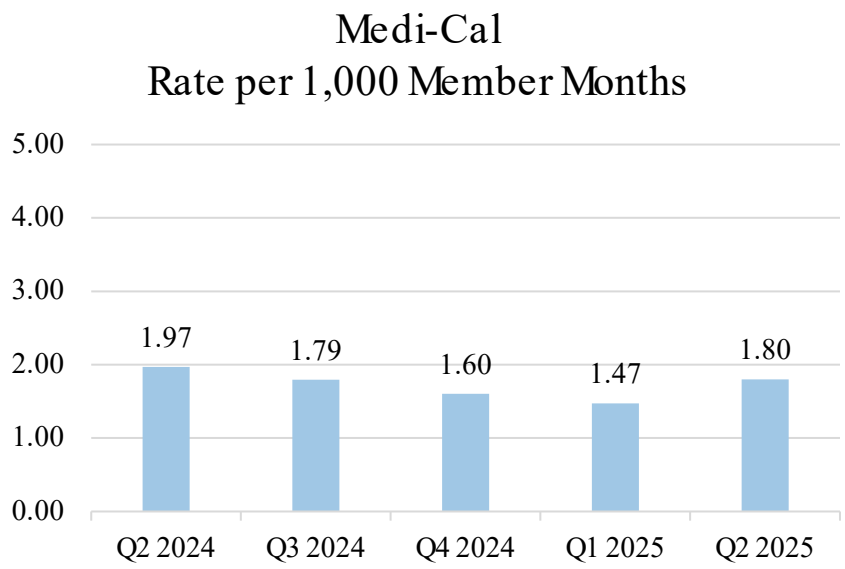
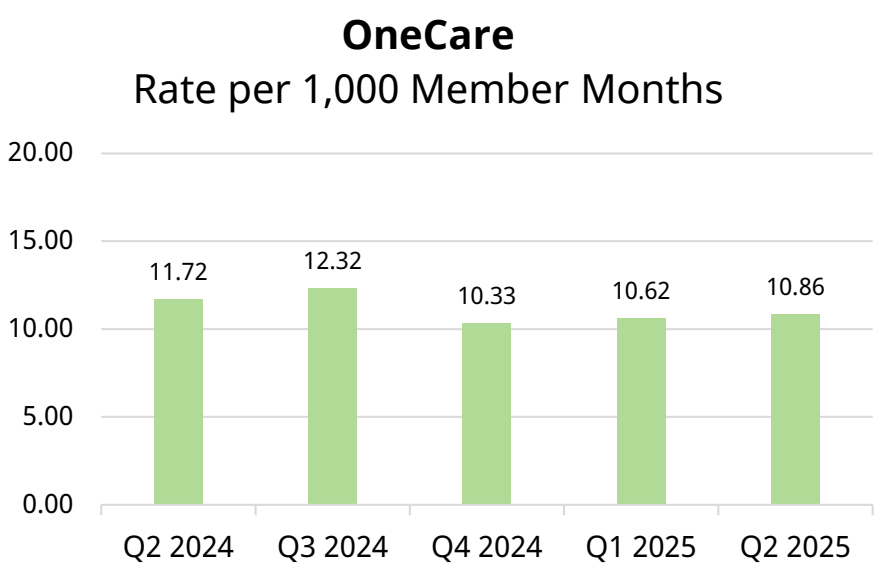
Grievance Volume by Line of Business (LOB)





Total Grievances

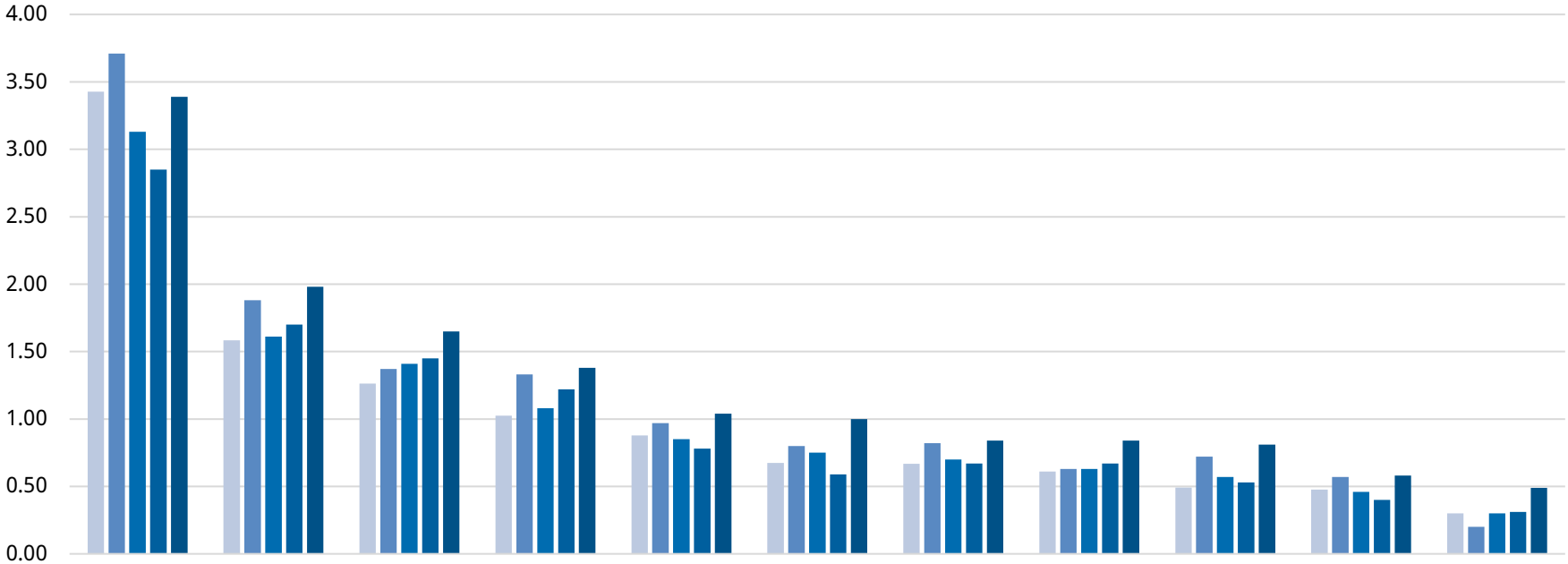
Timeframe	Total Grievances
Q2 2025	4,778
Q1 2025	3,958
Q4 2024	4,298
Q3 2024	4,817
Q2 2024	5,355

Total Grievances

Timeframe	Total Grievances
Q2 2025	574
Q1 2025	552
Q4 2024	531
Q3 2024	639
Q2 2024	607

2024-2025 Complaint Rate per 1,000 Member Months

Q2 2024-Q2 2025
Rate per 1000 MM



	CCN	Heritage	Optum	Prospect	AltaMed	UCMG	COD	Noble	Family Choice	CHA	AMVI
Q2 2025	3.39	1.98	1.65	1.38	1.04	1.00	0.84	0.84	0.81	0.58	0.49
Q1 2025	2.85	1.7	1.45	1.22	0.78	0.59	0.67	0.67	0.53	0.4	0.31
Q4 2024	3.13	1.61	1.41	1.08	0.85	0.75	0.70	0.63	0.57	0.46	0.3
Q3 2024	3.71	1.88	1.37	1.33	0.97	0.8	0.82	0.63	0.72	0.57	0.2
Q2 2024	3.43	1.58	1.26	1.02	0.88	0.67	0.67	0.61	0.49	0.48	0.30

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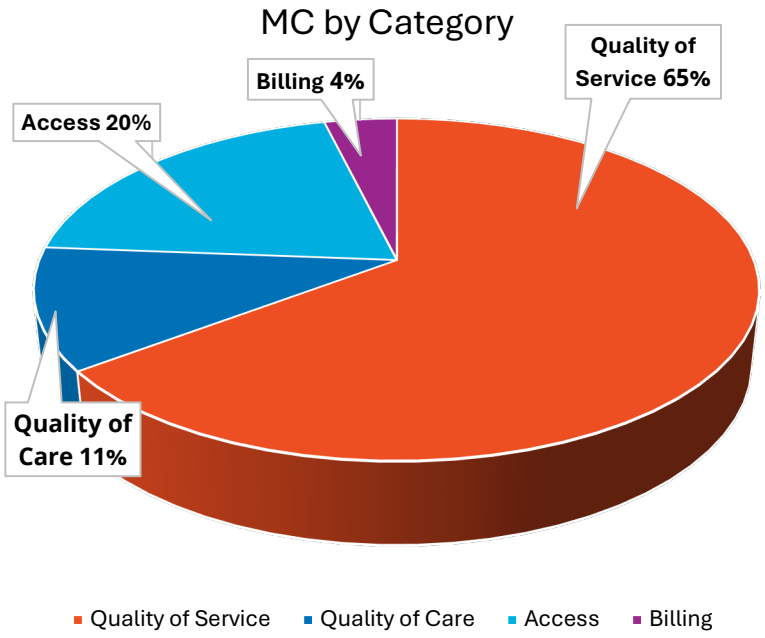
2024-2025 Grievance Type by Category



	MC Grievances				
	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Quality of Service	2,668	2,702	2,485	2,337	2,917
Quality of Care	505	586	480	364	518
Access	789	882	875	821	899
Billing	208	217	178	153	172
TOTAL	**4,170**	**4,387**	**4,018**	**3,675**	**4,506**

Q2 2025 Trends within each Category:

Quality of Care – Inappropriate care/treatment concerns; Authorization

Billing – Provider Direct Member Billing, Balance Billing

Access – Provider Availability, Scheduling

Quality of Service – Provider/Staff Attitude, Plan Customer Service

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Medi-Cal Grievance Trends for Q2

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	24% (698)
Plan Customer Service	15% (442)
Authorization	12% (348)

Quality of Care

Trend	Percentage of Total Volume
Inappropriate Care	34% (176)
Authorization	13% (69)
Referral	11% (56)

Access

Trend	Percentage of Total Volume
Provider Availability	15% (136)
Scheduling	14% (122)
Authorization Related	14% (122)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	65% (112)
Provider Balance Billing	31% (54)
Out of Network	1% (2)

Medi-Cal
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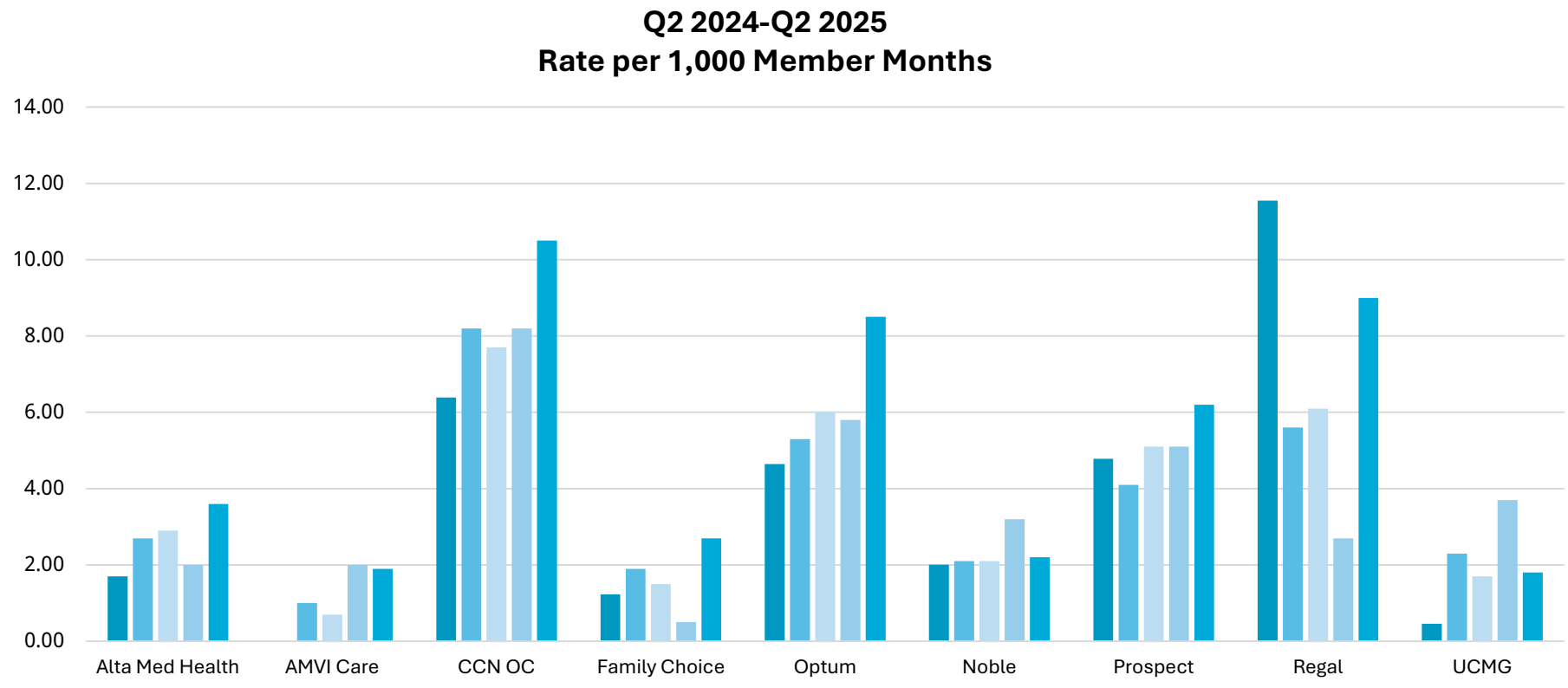
2024-2025 Grievance Rate per 1,000 Member Months



	Alta Med Health	AMVI Care	CCN OC	Family Choice	Optum	Noble	Prospect	Regal	UCMG
Q2 2025	3.60	1.90	10.50	2.70	8.50	2.20	6.20	9.00	1.80
Q1 2025	2.00	2.00	8.20	0.50	5.80	3.20	5.10	2.70	3.70
Q4 2024	2.90	0.70	7.70	1.50	6.00	2.10	5.10	6.10	1.70
Q3 2024	2.70	1.00	8.20	1.90	5.30	2.10	4.10	5.60	2.30
Q2 2024	1.70	0.00	6.39	1.23	4.64	2.01	4.79	11.54	0.46

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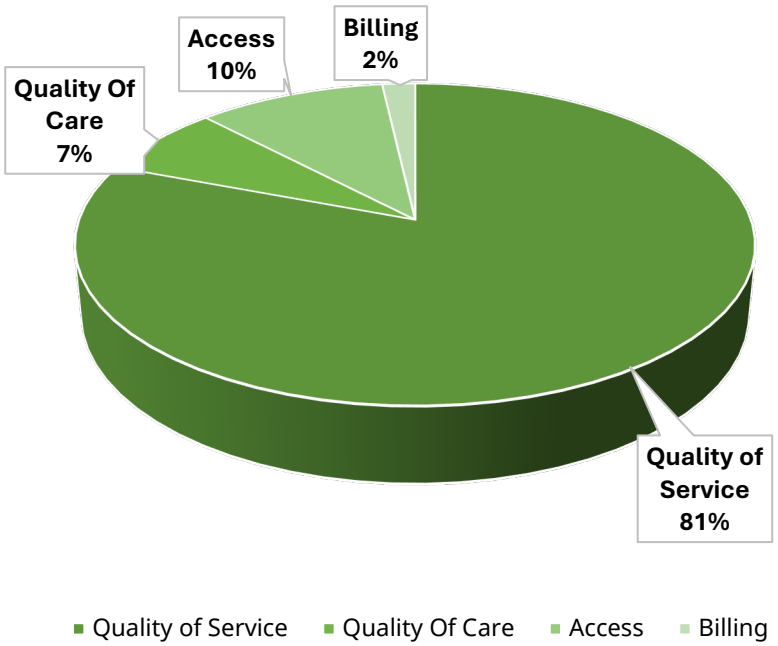
2025 Grievance Type by Category



	OneCare Grievances				
	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Quality of Service	326	371	334	302	444
Quality of Care	34	51	22	25	39
Access	47	49	49	33	57
Billing	16	15	14	11	10
TOTAL	**423**	**486**	**419**	**371**	**550**

Q2 Trends within each Category:

Quality of Service –Provider Staff Attitude, Plan Customer Service

Quality of Care – Inappropriate Care, Provider Staff Attitude

Access – Telephone Issues, Referral, Provider Availability

Billing – Provider Direct Member Billing, Balance Billing

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OneCare Grievance Trends for Q2

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	21% (94)
Plan Customer Service	20% (90)
Driver Punctuality	17% (76)

Quality of Care

Trend	Percentage of Total Volume
Inappropriate Care	62% (24)
Driver Punctuality	15% (6)
Scheduling	5% (2)

Access

Trend	Percentage of Total Volume
Provider Availability	19% (11)
Technology / Telephone	18% (10)
Authorization	11% (6)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	40% (4)
Provider Balance Billing	50% (5)

Actions Taken in Response to Trends

- Q2 trends identified
  - Medi-Cal and OneCare grievances about transportation providers.
  - Medi-Cal and OneCare grievances against staff at Primary Care Physicians and Specialists visits.

- Actions Taken
  - The vendor provided weekly reports on completed rides, focusing on dialysis transportation and improving on-time performance through monitoring and targeted oversight.
  - No provider trends were identified in Q2, but monthly tracking and analysis of provider-specific grievances continue. A collaborative process with Provider Services was established to review trends quarterly and implement corrective actions when needed.

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Appeals

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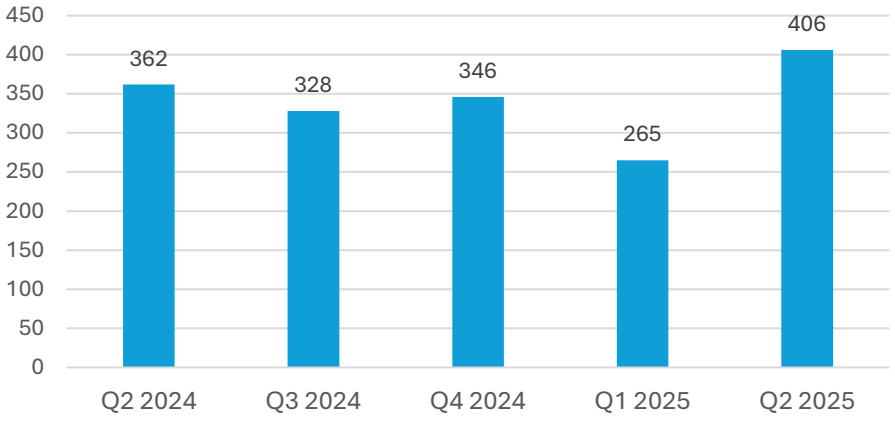
Appeals Volume by Line Of Business (LOB)

Medi-Cal

Total Appeals Volume

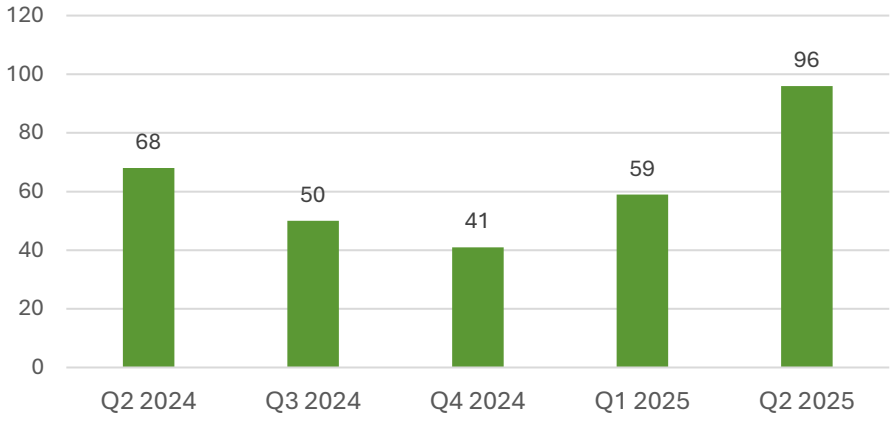


Total Appeals

Q2 2025	406
Q1 2025	265
Q4 2024	346
Q3 2024	328
Q2 2024	362

OneCare

Total Appeals Volume



Total Appeals

Q2 2025	96
Q1 2025	59
Q4 2024	41
Q3 2024	50
Q2 2024	68

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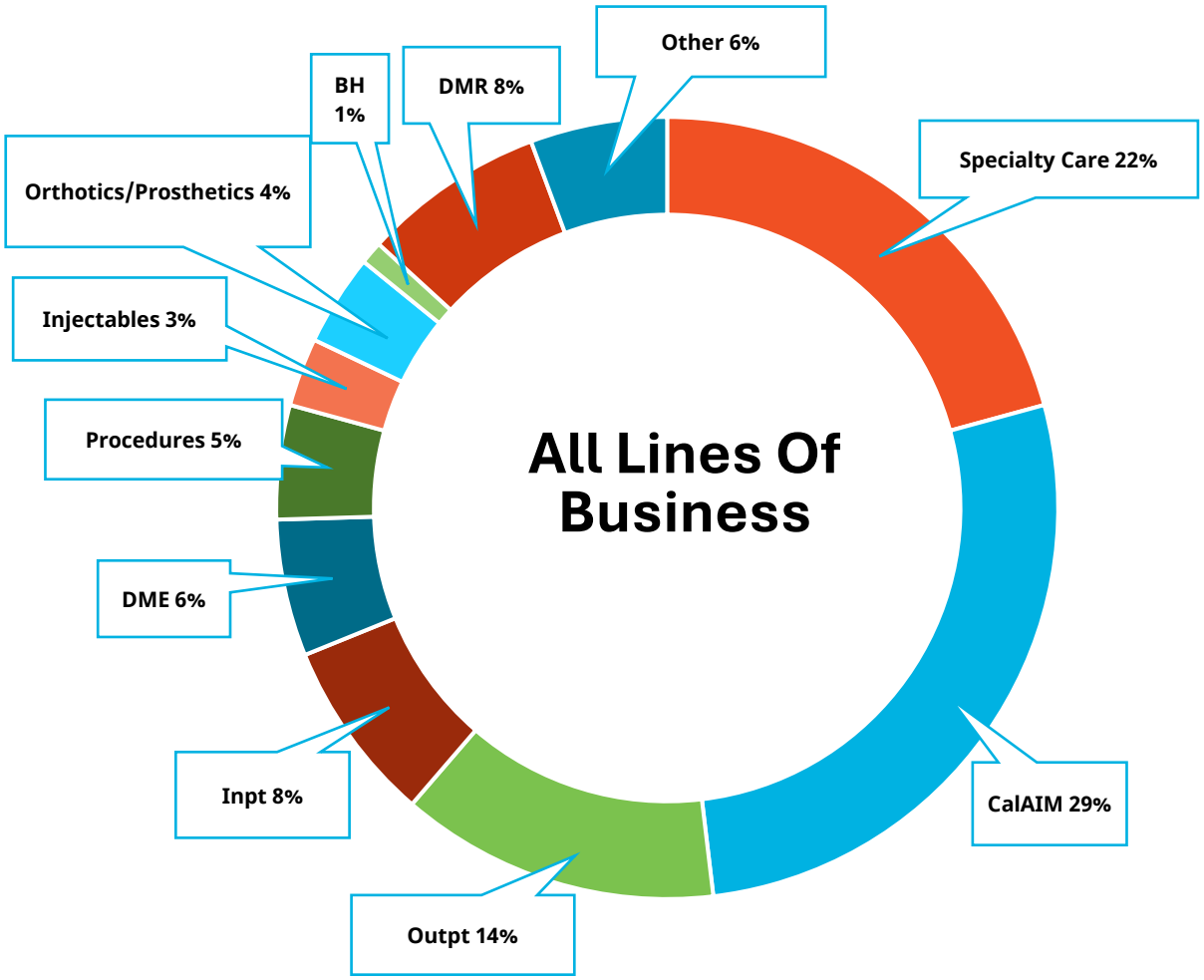
Appeals Overall

Service Types



Services	Qty	%
CalAIM	149	30%
Specialty Care	110	22%
Outpatient	69	14%
Inpatient	40	8%
DME	28	6%
Procedures	27	5%
Orthotics / Prosthetics	19	4%
Injectables	17	3%
DMR	8	2%
BH	6	1%
Other	28	6%

Key Notes: Increases in CalAIM (75), Outpatient (40), Specialty care (20) and Inpatient (13) appeals, and the inclusion of all NCP provider appeals have contributed to the increase in Appeals volume in Q2 compared to Q1.

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Appeal Types by LOB Q2 2025

Service Types	Medi-Cal Q2 2025 Percentage of Total Volume	OneCare Q2 2025 Percentage of Total Volume
CalAIM	34% (139)	9% (9)
Specialty Care	25% (100)	9% (9)
Outpatient Services	12% (51)	18% (17)
Procedures	6% (25)	2% (2)
DME	5% (21)	6% (6)
SNF	5% (19)	2% (2)
Injectables	4% (15)	1% (1)
Hospital Inpatient	3% (13)	34% (32)
Other	6% (23)	19% (18)
TOTAL	406	96

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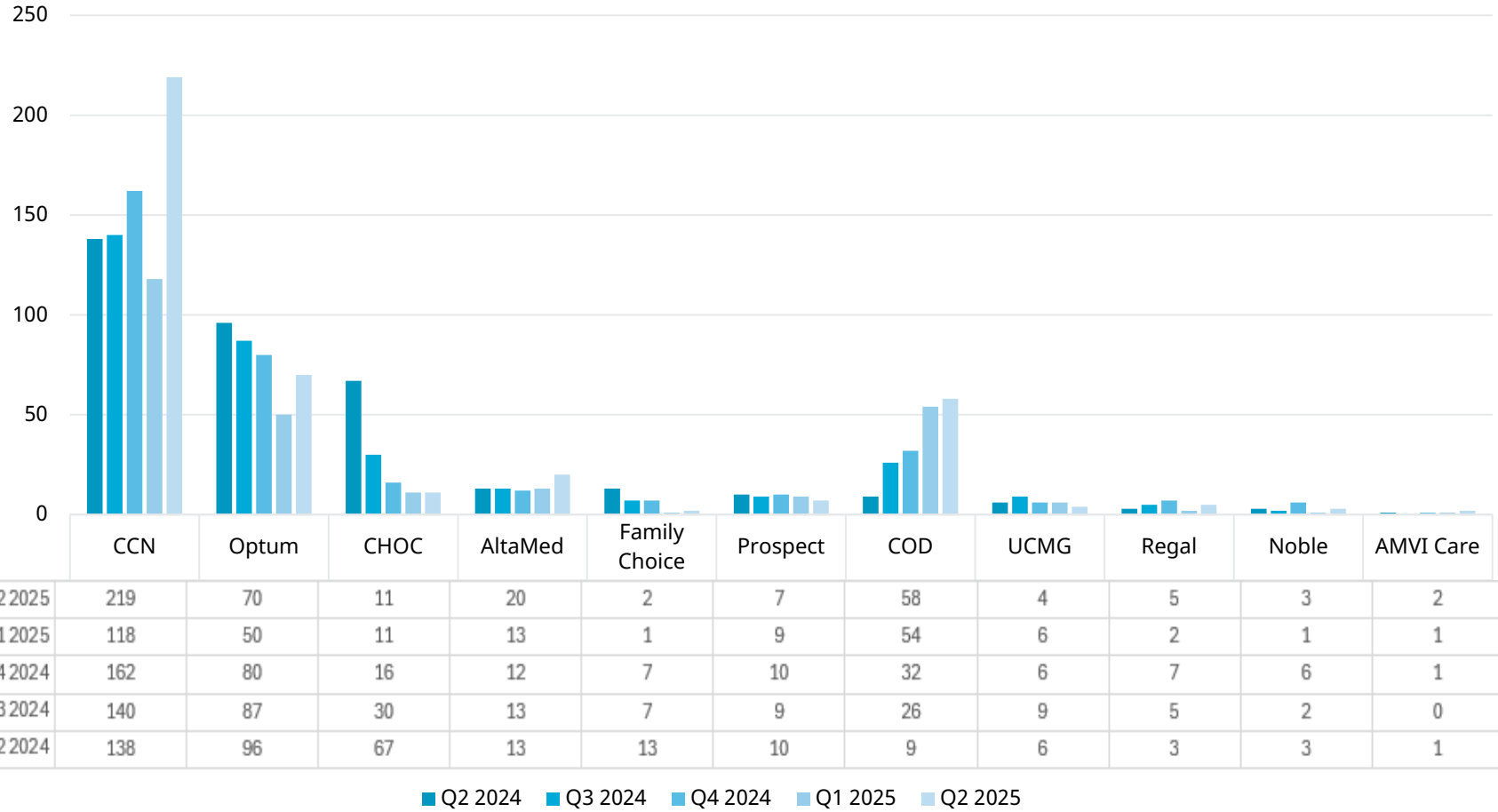
MC Appeals Volume Q2 2024-Q2 2025

Q2 2024-Q2 2025
MC Appeals Volume



	CCN	Optum	CHOC	AltaMed	Family Choice	Prospect	COD	UCMG	Regal	Noble	AMVI Care
Q2 2025	219	70	11	20	2	7	58	4	5	3	2
Q1 2025	118	50	11	13	1	9	54	6	2	1	1
Q4 2024	162	80	16	12	7	10	32	6	7	6	1
Q3 2024	140	87	30	13	7	9	26	9	5	2	0
Q2 2024	138	96	67	13	13	10	9	6	3	3	1

Medi-Cal
CalOptima Health

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Medi-Cal Appeals Trends for Q2

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
CalAIM	111	28	139	20%
Specialty Care	66	34	100	34%
Outpatient Services	34	17	51	33%
Procedures	17	8	25	32%
DME	10	11	21	52%
SNF	18	1	19	5%
Injectables	8	7	15	47%
Hospital Inpatient	9	4	13	31%
Other	18	5	23	22%

Medi-Cal
CalOptima Health

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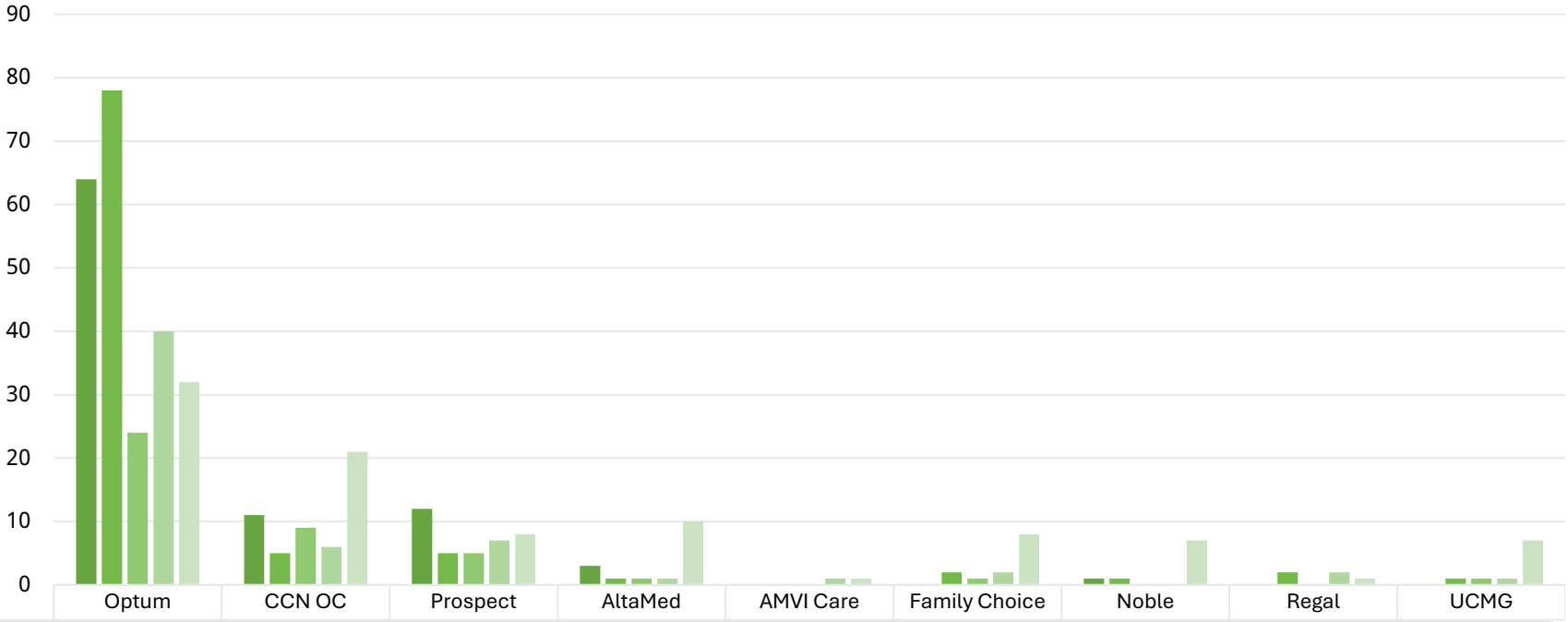
OC Appeals Volume Q2 2024-Q2 2025

Q2 2024-Q2 2025
OC Appeals Volume



	Optum	CCN OC	Prospect	AltaMed	AMVI Care	Family Choice	Noble	Regal	UCMG
Q2 2025	32	21	8	10	1	8	7	1	7
Q1 2025	40	6	7	1	1	2	0	2	1
Q4 2024	24	9	5	1	0	1	0	0	1
Q3 2024	78	5	5	1	0	2	1	2	1
Q2 2024	64	11	12	3	0	0	1	0	0

Q2 2024 Q3 2024 Q4 2024 Q1 2025 Q2 2025

OneCare CalOptima Health

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OneCare Appeals Trends for Q2

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Hospital Inpatient	19	13	32	41%
Outpatient Services	13	4	17	24%
Specialty Care	6	3	9	33%
CalAIM	8	1	9	11%
DMR	4	3	7	43%
DME	4	2	6	33%
Orthotics/Prosthetics	3	3	6	50%
Other	7	1	8	13%

Actions Taken in Response to Trends

- Q2 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.
  - Continuity of Care (COC) based on multidisciplinary care is not considered during initial reviews.

- 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.
  - Trends are also shared with internal departments.

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Second Quarter Summary of the PACE Quality Improvement Committee (PQIC) Meetings

Quality Assurance Committee Meeting

October 8, 2025

Dr. Donna Frisch, PACE Medical Director

Monica Macias-Garcia, PACE Program 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.

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Quarter 2 2025 PQIC Meeting Summary of Quarter 1 Clinical Data

Dr. Donna Frisch, PACE Medical Director

Q2 2025 PQIC Meeting Summary

- Discussion of Q1 **Clinical** Workplan Data
  - Immunizations
    - Influenza- Goal 94%. Q1 rate 90.6%
    - Pneumococcal- Goal 94%. Q1 rate 93%
  - Cancer Screening
    - Colorectal Cancer Screening- Goal >65.21%. Q1 rate 77%
    - Breast Cancer Screening- Goal >82.80%. Q1 rate 86.1%
  - Blood Pressure Control
    - Goal- >85.60% of qualifying participants will have a blood pressure reading <140/90mm. Q1 rate 85.47%

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Q2 2025 PQIC Meeting Summary

- Discussion of Q1 Clinical Workplan Data Cont…
  - Diabetic Monitoring
    - Annual Eye Exams- Goal 88.08%. Q1 rate 91%
    - Blood Sugar Control- Goal <12.24% with HbA1c above 9%. Q1 rate 12.67%
  - Osteoporosis Monitoring
    - Goal 75% of qualifying participants will receive bone density scan. Q1 rate 83%
  - Reducing Falls
    - Goal <72 falls per quarter. Q1 rate 72 falls.
  - Drug Monitoring
    - High Dose Opioid Monitoring- Goal 100% of participants on high dose opioid will have monthly check in with provider. Q1 rate 100%

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Q2 2025 PQIC Meeting Summary

- Discussion of Q1 Clinical Workplan Data Cont…
  - Medication Reconciliation
    - Goal ≥93% of participants will have meds reconciled within 7 calendar days after discharge from Hospital or SNF. Q1 rate 98%
  - Access to Specialty Care
    - Goal >100% of specialty appointments to be scheduled within 7 calendar days of ordering. Q1 rate 76%.
  - Utilization
    - Hospital Days- Goal <3,000 per 1000 per year. Q1 rate 2222
    - ER Visits- Goal <820 per 100 per year. Q1 rate 784
    - All Cause Readmissions- Goal <14% hospital readmissions within 30 days of discharge. Q1 rate 17%
    - Custodial Care Placement- Goal <4% participants in custodial care per quarter. Q1 rate 0.07%.

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Quarter 2 2025 PQIC Meeting Summary of Quarter 1 Non-Clinical Data and PACE Updates

Monica Macias-Garcia, PACE Program Director

Q1 2025 PQIC Meeting Summary

- Discussion of Q1 **Non-Clinical** Workplan Data
  - Enrollment/Disenrollment Data
    - Enrollment Conversion- Q1 goal of 70% conversion from inquiries to enrollments. Rate was 48.78%
    - 3 month disenrollment- Q1 goal of <6% of disenrollments will be within 3 months of enrollment. Rate was 0%
    - Total Attrition- Q1 goal of <8%. Rate was 5.03%
  - Alternative Care Settings
    - Goal ≥10% of participants will use PACE Alternative Care Settings by end of 2025. Q1 Rate was 4%
  - Transportation Performance
    - 60-minute violations- Q1 goal of zero (0) 60-minute violations. January-5, February- 4, March-0.
    - On Time Performance- Q1 goal ≥92% of all rides will be on-time. Rate was 87%

CalOptima Health

New Electronic Health Record System

- PACE is currently in the process of transitioning from TruChart electronic health records software to CareHub by Intus Care
- The PACE Leadership team is working closely with the CalOptima Health Enterprise Project Management Office to finalize transition plans related to data migration, validation, and user trainings
- Current timelines include a “go live” date of 12/10/25 for PACE staff to use Care Hub exclusively

CalOptima Health

2025 Participant Satisfaction Survey

- This year, PACE's annual Integrated Satisfaction Measurement for PACE (I-SAT) survey is scheduled to be partially conducted at the PACE center for the first time since the COVID-19 pandemic.
- The I-SAT survey staff ask our participant questions regarding their satisfaction with PACE services including Medical Care, Meals, Transportation, Home Care, and more
- In person survey dates: September 29th- October 3rd 2025

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Questions?

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Board of Directors'
Quality Assurance Committee Meeting
October 8, 2025

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Second Quarter 2025 Meeting Summaries

April 29, 2025: 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 10 reported participant cases of COVID-19 in Q1 2025.
  - 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 vaccination is still being monitored as a quality initiative.
- Presentation of the Q1 2025 HPMS Elements:
  - Membership data figures presented. Q1 ended with 499 total enrolled.
  - Immunizations
    - Pneumococcal Immunization rate in Q1 was 93% (no exclusions).
    - Influenza Immunization rate in Q1 was 90.6% (no exclusions).
  - Falls without Injury. Q1 ended with 80 falls without injury. Most happened in the bedroom and bathroom, from not using DME. Loss of balance was the main contributing factors.
  - Denials. 2 Denials in Q1, both initiated by DHCS.
  - Grievances. 4 grievances received in Q1.
  - Emergency Room Visits. 92 ER visits, an increase of 11 from Q4 2024. 44 were discharged home and 48 were admitted to hospital. Trends in admission diagnoses: Respiratory Illness, Chest pain and Falls
  - Medication Errors Without Injury. 1 medication error reported in Q1.
    - Error Type: Medication not Administered - Dispensed to wrong participant. Participant did not take the medication- no injury.
  - Quality Incidents with Root Cause Analysis Reported in HPMS.
    - 4 Falls with Injury. Root cause analysis completed for each case and shared with CMS/DHCS.

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- Presentation of the 2025 PACE Quality Initiatives
  - Advanced Health Care Directive
    - Goal: ≥ 55% of participants will have completed AHCD by end of 2025.
    - Q1 ended at 40%. Goal not met at this time.
  - COVID-19 Vaccine
    - Goal: ≥ 50% of participants will have latest recommended COVID-19 vaccine in 2025.
    - Q1 ended at 36.5%. Goal not met at this time.
  - Dental Satisfaction Quality Initiative.
    - Goal: ≤ 1 dental-related grievance per quarter in 2025.
    - 2 dental grievances reported in Q1 2025. Goal was not met.
  - Transportation Satisfaction Quality Initiative
    - Goal is ≤ 3 **valid** transportation related grievances per quarter in 2025.
    - QI received zero (0) total transportation grievances in Q1. Goal was met.

April 29, 2025: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of the Q1 2025 Quality Work Plan Elements
  - *Elements 3 – 4 Immunizations*
    - Pneumococcal Immunization rate in Q1 was 93% (exclusions defined in quality work plan). Goal of 94% was not met at this time.
    - Influenza Immunization rate in Q1 was 90.6% (exclusions defined in quality work plan). Goal of 94% was not met at this time
  - *Element 5: Colorectal Cancer Screening.* Goal > 65.21% will have colorectal cancer screening as defined in quality workplan. Q1 rate was 77%. Goal met.
  - *Elements 6: Breast Cancer Screening.* Goal is >82.80% will have breast cancer screening as defined in quality workplan. Q1 rate was 86.1%. Goal met.
  - *Element 7: Blood Pressure Control.* Goal is >85.60% of qualifying participants will have a blood pressure reading <140/90mm. Q1 rate was 85.47%. Goal not met, but very close.
  - *Elements 8: Diabetic Eye Exams.* Goal is >88.08% of qualifying diabetic enrollees will receive annual eyes exams. Q1 rate was 91%. Goal met.

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- *Elements 9: Diabetic Care – Blood Sugar Control.* Goal is <12.24% of qualifying diabetics will have blood sugar level (HbA1c) measurement of >9%. Q1 rate was 12.67%. Goal not met, but very close.
- *Element 10: Osteoporosis Treatment.* Goal is 75% of qualifying participants receiving osteoporosis monitoring via bone density scan. Q1 rate was 83%. Goal met.
- *Element 11: Reduce Percentage of Falls reported by PACE Enrollees.* Q1 ended with 80 falls, higher than the Goal of <72 falls per quarter in 2025. Goal not met.
- *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. Only 1 participant received a dose greater than 90 MME and had PCP follow up each month in Q1. Goal met.
- *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. Q1 rate was 98%. 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*. Q1 rate was 76%. 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.
- *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 Q1 2025, the rate was 4%. Goal not met- at this time.
- *Element 16: Acute Hospital Days.* Goal of <3,300 per 1000 per year was met with 2,222 hospital days for participants in Q1.
- *Element 17: ER Visits.* Goal of <820 ER visits per 1000 per year. Q1 rate was 784. Goal 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 Q1 was 17%. Goal not met.
- *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 0.7% in Q1. Goal met.
- *Element 20: Enrollment Conversion.* In 2025, the goal is 70% conversion from inquiries to active enrolled participants. Rate in Q1 was 48.78%. Goal not met.

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- *Element 21: 90-Day Disenrollment.* The goal is that <6% of disenrollments are by new enrollees in 2025. Rate in Q1 2025 was 0%. Goal was met.
- *Element 22: Total Attrition Rate.* The goal is a <8% overall attrition rate in 2025. Q1 rate is 5.03%. Goal was met.
- *Element 23: Transportation <60 minutes.* There were five 90 minute violations in January, four in February, and none in March 2025. PACE continues to monitor all violations and investigate whether they are considered controllable (based on poor planning) or uncontrollable (based on traffic incidents).
- *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 ≥92% of all transportation rides will be on-time. Q1 2025 rate was 87%. Goal not met.

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