2025 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: JANUARY 14, 2025 TO DECEMBER 31, 2025

2025 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement Health Equity Committee Chair:

7/17/2025

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

3/12/25

Jose Mayorga, M.D. **Date**

Board of Directors Chair:

4/3/25

Isabel Becerra **Date**

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CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

CalOptima Health is in the process of developing a strategic plan for 2025-2028 that may go into effect this year pending adoption for our Board of Directors.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home- or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement

a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.
b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American people by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual can "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

To strengthen our commitment to advancing health equity, we revised our prior health equity framework to integrate comprehensive stakeholder feedback, current research and best practices. Our new health equity framework prioritizes the identification and dismantling of systemic barriers to health access, ensures culturally competent service delivery and promotes active community engagement. Our goal is to create a more inclusive, responsive and sustainable approach that effectively addresses the diverse health needs of our members by concentrating on five areas of focus:

- **Reduce Health Disparities:** Mitigate racial, ethnic, gender and socioeconomic disparities in health outcomes.
- **Leadership and Advocacy for Equity:** Drive health equity initiatives through advocacy, partnership and continuous quality improvement.
- **Member-Centered Care:** Provide equitable, culturally responsive and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.
- **Community Engagement and Partnership:** Empower and collaborate with community stakeholders to co-create equitable health solutions that include prevention.
- **Empowering Change Through Data-Driven Strategies:** Leverage data to discover gaps, strengths and assets to co-design strategies that improve health outcomes with the community.

Program Structure

"Better. Together." is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

Medi-Cal — also known as Medicaid — is a public health insurance program for low-income people offered by the state. It covers families with children, seniors, people with disabilities, foster care children, pregnant women, and low-income people with specific diseases. CalOptima Health provides health care coverage for Orange County residents who are eligible for full Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home, or getting support in the home.

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Pharmacy benefits and services are provided fee-for-service by the Department of Health Care Services through a pharmacy benefit manager
  - Outpatient drugs (prescription and over-the-counter), including Physician-Administered Drugs (PADs)
  - Enteral nutrition products
  - Medical supplies
- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health has developed care management (CM) services. These care management services are designed to ensure coordination and continuity of care and are

described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both

Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

Starting on January 1, 2025, OneCare offers two plan benefit packages, OneCare Complete and OneCare Flex Plus. Each plan offers comprehensive Medicare and Medi-Cal benefits coupled with supplemental benefit options to fit members' needs. Supplemental benefits include a flexible benefit card for over the counter drugs and groceries, vision, hearing, dental, transportation, and fitness benefits.

Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program

8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CHCN). Providers also have the option to contract directly with one of our delegated health networks. CalOptima Health members can choose CHCN or one of nine health networks representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CHCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a health network and members residing outside of Orange County.

CalOptima Health Community Network (CHCN)

CHCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CHCN is administered directly by CalOptima Health and available for health network-eligible members to select, supplementing the existing delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated health networks through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortium (PHC)
- Shared-Risk Group (SRG)

Through our delegated health networks, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 6,000 specialists, 40 acute and rehabilitative hospitals, 70 community health centers and 207 long-term care facilities.

CalOptima Health contracts with the following:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	HMO	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	not participating
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	—	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of October 31, 2024)

Total CalOptima Health Membership

910,063

Program	Members
Medi-Cal	895,392
OneCare (HMO D-SNP)	17,173
Program of All-Inclusive Care for the Elderly (PACE)	498

***Based on unaudited financial report and includes prior period adjustment**

Membership Demographics (as of October 31, 2024)

Member Age

0 to 5	8%
6 to 18	23%
19 to 44	35%
45 to 64	20%

Language Preference

English	54%
Spanish	31%
Vietnamese	10%
Other	2%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	37%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	11%

65+	14%	Korean	1%
		Farsi	1%
		Chinese	<1%
		Arabic	<1%

People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. This program integrates health equity into quality improvement initiatives by leveraging data-driven insights, evidence-based practices, and community engagement strategies.

CalOptima Health develops programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity, equity and inclusion in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias, diversity, equity and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of the service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organization wide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.

- Recommending delivery system reform to ensure high-quality and equitable health care.

- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, the Population Health Management Strategy and the Culturally and Linguistically Appropriate Services Program, including the work plans and the annual evaluations of these programs/strategies.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted health networks, including CHCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description, Population Health Programs, the Culturally and Linguistically Appropriate Services (CLAS) Program and Work Plans, and other relevant documents.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted health networks.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions are not unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually.

The QIHETP is based on the ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

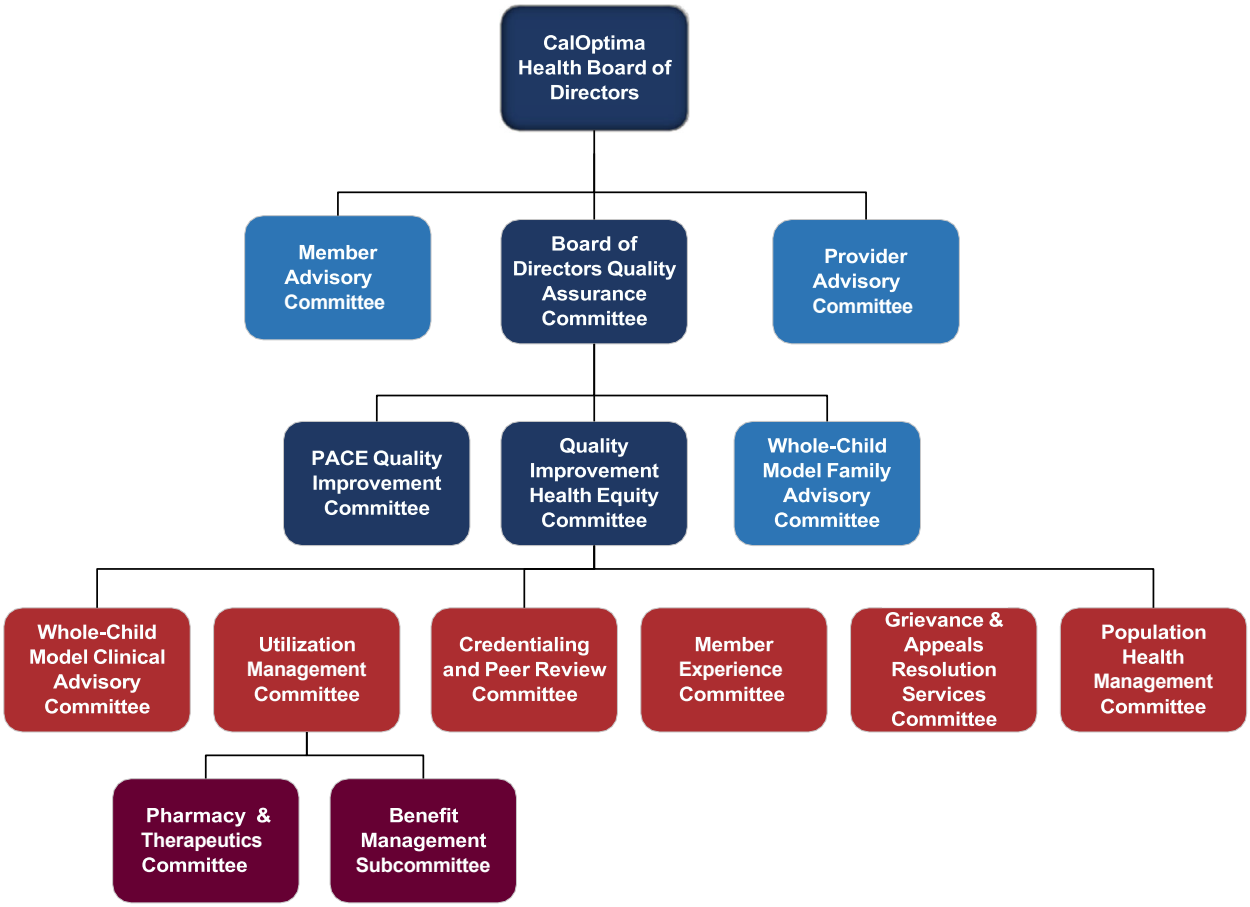
- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to ensure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and people with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address the integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The QIHEC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QIHETP projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. Performance measurement and improvement activities and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

Responsibilities of the QIHEC include:

- Review, contribute to and approve the QI Health Equity Transformation Program, UM Program, CLAS Program, and PHM Strategy annually
- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow-up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated health networks, including over/under-utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards
- Review and assess compliance of the Diversity, Equity and Inclusion (DEI) training program.
- Provide a written summary of the QIHEC activities publicly available on CalOptima Health's website

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan

addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for the dissemination of all study results to CalOptima Health-contracted providers and practitioners and delegated health networks.

The QIHEC composition is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer or Designee (Chair or Designee)
- CalOptima Health Chief Health Equity Officer or Designee (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, Equity and Community Health
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

QI-related committees or QIHEC charted subcommittees report quarterly to QIHEC:

- Utilization Management Committee (UMC)
    - Pharmacy & Therapeutics Committee (P&T)
    - Benefit Management Subcommittee (BMSC)
- Grievance and Appeals Resolution Services (GARS) Committee
- Credentialing and Peer Review Committee (CPRC)
- Member Experience Committee
- Population Health Management Committee (PHMC)
- Whole-Child Model Clinical Advisory Committee (WCM CAC)

The QIHEC is supported by CalOptima Health staff including but not limited to:

- Executive Director, Behavioral Health Integration
- Executive Director, Medi-Cal/CalAIM
- Sr. Director, Case Management
- Director, Equity and Community Health
- Director, Behavioral Health Integration
- Director, Case Management
- Director, Clinical Operations
- Director, Clinical Pharmacy
- Director, Customer Service
- Director, Grievance and Appeals
- Director, Long-Term Care
- Director, Operations Management – Quality Analytics
- Director, Operations Management – Medi-Cal/CalAIM
- Director, Provider Relations

- Director, Provider Data Management Service
- Director, Quality Improvement
- Director, Quality Analytics
- Director, Utilization Management
- Manager, Behavioral Health
- Manager, Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members, of whom at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIHEC and all QIHE subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QIHEC proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Term of Membership
Terms are a function of employment and job responsibility. Participating physicians and practitioners will serve a two-year term and may serve unlimited consecutive terms.

External participants must report changes in membership status (i.e., retired, left their place of work, quit, etc.) to the Committee Chair.

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are kept confidential. Minutes are maintained in electronic format and produced only for committee approval, if needed.

The QIHEC provides the QAC with quarterly written progress reports that describe actions taken, progress in meeting QIHETP objectives and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health provider selection process and determines corrective actions, as necessary, to ensure that all providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and/or performance of all providers every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated health networks and organizational providers to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CHCN and health networks. Physician participants represent a range of practitioners and specialties from CalOptima Health's provider network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM/CM Integrated Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost-effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CHCN and delegated health networks to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as the development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly

and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T Committee is a forum for an evidence-based formulary review process. The committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving an interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T Committee includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T Committee provides written decisions regarding all formulary development decisions and revisions. The P&T Committee meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T Committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impact the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC, health network CCS providers, Regional Center Orange County, and the County of Orange Social Services Agency. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure a strategic focus on the issues and factors that influence the member's

experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is on improving customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability to get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and health network level (including CHCN), where appropriate. The MEMX committee, which includes the Access and Availability Workgroups, meets at least quarterly and is accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also ensures that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommending evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima Health employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflicts of Interest

CalOptima Health maintains a Conflict-of-Interest Policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima Health information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QIHEC and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

2025 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health
   - Close racial/ethnic disparities in well-child visits and immunizations by 50%
   - Close maternity care disparity for Black and Native American people by 50%

2. Children's Preventive Care
   - Exceed the 50th percentile for all children's preventive care measures

3. Behavioral Health Care
   - Improve maternal and adolescent depression screening by 50%
   - Improve follow-up for mental health and substance disorder by 50%

4. Program Goals
   - Medi-Cal: Exceed the Minimum Performance Levels (MPLs) for the Medi-Cal Managed Care Accountability Set (MCAS)
   - OneCare: Attain a Four-Star Rating for Medicare
   - Attain NCQA Health Equity Accreditation

Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- Health equity
- Culturally and linguistically appropriate services
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2025 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access to care, the delivery of services, quality of care, over and under-utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported

to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan is also publicly available on the CalOptima Health website.

For more details on the 2025 QIHETP Work Plan, see Appendix A: 2025 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by QIHEC and/or subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.
  - Performance Improvement Projects (PIPs) required by CMS or DHCS.
- Measures aligned with the following programs:
  - DHCS Managed Care Accountability Set and Quality Withhold and Incentive Program
  - CMS Stars Rating Program
  - NCQA Health Plan and Health Equity Accreditation
  - NCQA Health Plan Rating
- Areas for improvement identified from the following reports:
  - Comprehensive Quality Strategy Report
  - Technical Report
  - Health Disparities Report
  - Preventive Services Report
  - Focus Studies
  - Encounter Data Validation Report

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services

- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., depending on the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
    - Health Network Forums – Monthly
    - Health Network Collaborative Quality Forums – Quarterly
    - Joint Operation Meetings (JOM) with Health Networks – Biannually
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

Methods for the identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used.

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when the target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline

3) Describe root cause(s) including barrier analysis
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate the result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs, to improve processes and member outcomes.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIHEC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of the target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly to facilitate communication along the continuum of care. The QIHEC reports activities to the Board of Directors' QAC, through the CMO or designee, on a quarterly basis. Communication of QIHE trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- Health Network Forums, Medical Directors' Meetings, Health Network Collaborative Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

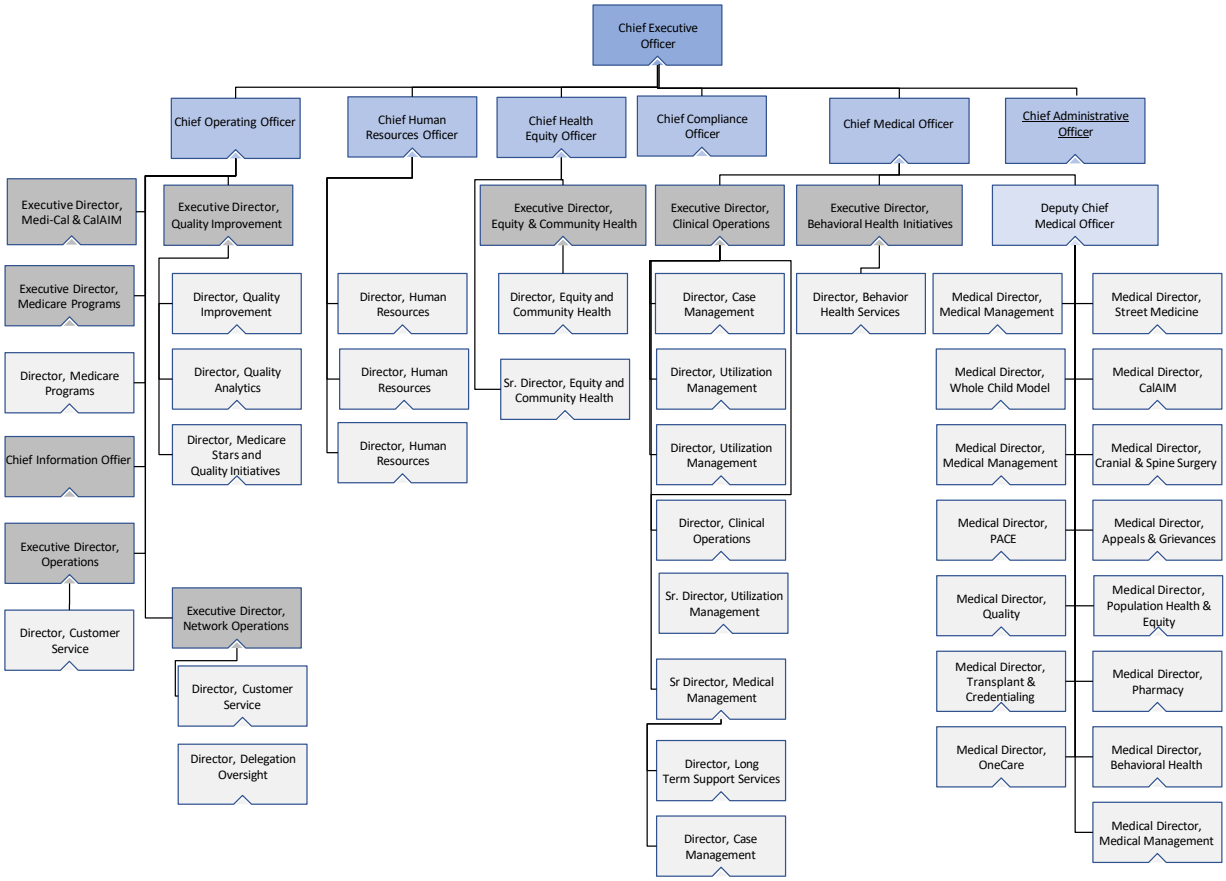
- A description of completed and ongoing QIHE activities that address the quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of December 2024



This organizational chart represents the positions and structure that directly support the QIHETP and does not represent the organizational structure for the entire CalOptima Health organization.

Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below are the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes

certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' QAC.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its health networks and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and the Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of health networks and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures related to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Equity and Community Health, Pharmacy Management, LTSS and other medical management programs.

Chief Administrative Officer (CAO) has overall responsibility and accountability for the activities of the Clerk of the Board, Communications & Marketing, Government Affairs, Strategic Development, and Enterprise Project Management. The CAO creates a shared sense of purpose to achieve an aligned mission and vision executed through CalOptima Health's strategic plan and CEO initiatives. The CAO is expected to lead by example and influence others by exhibiting the highest professional and ethical behaviors.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who participates in the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives,which include clinical programs and related services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (Equity and Community Health) [ECH] is the designated physician who chairs the Population Health Management Committee and oversees the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health ECH staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization, and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole-Child Model) is the physician designee who chairs the Whole-Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole-Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member

of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the Executive Team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal/CalAIM is responsible for implementing and overseeing CalAIM, a whole-system, person-centered delivery system reform to improve quality and care for members.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO, ED BHI and ED ECH makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the health networks and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima Health's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) oversees and guides Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima Health's CMO and ED QI, the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading the collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure the effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics
- Supervisor, Quality Analytics
- Data Analysts
- Project Managers
- Program Specialists
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading the implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization-wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:

- Manager, Quality Analytics
- Supervisor, Quality Analytics
- Project Managers
- Program Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Improvement Specialists
- Program Assistant

Sr. Director, Equity and Community Health (ECH)
Responsible for the development, implementation of community outreach and member engagement strategies designed to address identified health inequities. The Dr. Director of Equity and Community Health assists the CHEO in developing, implementing, analyzing, and refining CalOptima Health goals and objectives related to health equity. This is a leadership role, collaborating with the CalOptima Health Executive Officer, Executive Director of Equity and Community Health and other leaders to strengthen the organization's commitment and strategy to advance health equity and reduce health disparities of our member population, as well as to remain a diverse, equitable, and inclusive organization.

Director, Equity and Community Health (ECH)
Responsible for program development and implementation of the PHM program and strategies for comprehensive health initiatives. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Integration (BHI)
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures

departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management (UM)
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions of key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Sr. Director, Clinical Operations
Responsible for overseeing the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima Health to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct.

Director, Human Resources
Responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs and processes.

Director, Customer Service (Medi-Cal)
Responsible for day-to-day management, strategic direction and support to CalOptima Health's Medi-Cal Customer Service operations; Medi-Cal Call Center, Behavioral Health Call Center, Member Liaison, Customer Service Data Analysts, and CalOptima Health Member Portal.

Director, Customer Service (OneCare)
Responsible for day-to-day management, strategic direction and support to CalOptima Health's OneCare Customer Service call center, Cultural & Linguistics, Non-Medical Transportation/Non-Emergency Medical Transportation, Member Communication and Enrollment & Reconciliation.

Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- DEI Training Program
    - Disability Awareness
    - Health Equity
    - Seniors and Persons with Disabilities Awareness training
    - Diversity, Equity, Inclusion and Unconscious Bias
    - Cultural Competency
- Transgender, Gender Diverse, Intersex (TGI) Cultural Competency Training Program

Employees are required to complete an annual compliance training course on the topics listed above. The frequency of the training varies by topic and depends on the employee's job position.

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process and includes interactive and web-based platforms as well as paper format, if needed.

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive physical and behavioral health care services based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima Health model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Services and Supports
- Enhanced Care Management
- Community Supports

- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under-utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* related to quality of care

* CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Health program.

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and ensuring that site review and credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department is also responsible for ensuring compliance and timely submission of NCQA Health Plan and Health Equity Accreditation Survey. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
    - Drive improvement of quality of care received
    - Minimize rework and unnecessary costs
    - Empower staff to be more effective
    - Coordinate and communicate organizational information, both department-specific and organization-wide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organization-wide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents cases, determined to be quality-of-care, to CPRC and upon discussion, CPRC provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the case, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of quality-of-care reviews and tracking and trending of quality-of-service issues are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality-of-care case referrals are referred to the QI department from departments throughout CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers, health networks and regulatory agencies.

The QI department provides training and guidance for non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality-of -care grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima Health contracted delivery system. It is also designed to provide ongoing monitoring of providers' good standing, ensuring providers are able to participate in the Medicare and/or Medi-Cal program and do not have any limitations to participate in the provider network. CalOptima Health contracts with an NCQA-certified Credentialing Verification Organization (CVO) to credential or vet our providers and practitioners.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists as well as their group entity, where applicable, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CHCN are performed at CalOptima Health and delegated to health networks and other subdelegates for their providers.

CalOptima Health performs credentialing and recredentialing of organizational providers, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that

these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalOptima Health performs credentialing or vetting of providers who provide support services to our members, which includes but is not limited to CalAIM providers and doulas. CalOptima Health ensures that these providers are qualified to provide Enhanced Care Management, Community Supports and doula services, respectively, to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medically tailored meals providers, and personal care and homemaker services providers.

CalOptima Health recredentials all credentialed providers every three years. Between recredentialing cycles, CalOptima Health conducts ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints. At recredentialing, CalOptima Health takes QI activities and other performance monitoring activities into consideration during the recredentialing approval process.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical record reviews to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated health networks. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with the Department of Health Care Services (DHCS) APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An initial medical record review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete a review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues.

If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated health networks make certain that each member's medical record is maintained in an accurate, current, detailed, organized, and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Delegation Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner/provider, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2024, CalOptima Health completed a triannual renewal survey for NCQA Health Plan Accreditation and received 135.50 out of 140 of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 10, 2027.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee, which provides all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima Health has acquired NCQA consulting services to support document review and survey readiness before submission for both Health Plan and Health Equity Accreditation.

In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026. CalOptima Health has a survey submission date of October 7, 2025.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and ECH teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes. It monitors and drives improvements to the quality of care and services and ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include the design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes for both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement

- Coordinate and communicate organizational, health network and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize health networks and providers to meet quality performance targets and deliver quality care
- Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will enable us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated health networks in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Managed Care Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

OneCare STARs Measures Improvement

CalOptima Health's OneCare program is required to participate in the CMS Star Rating program each year. This program consists of more than 40 quality measures including HEDIS measures, member survey measures like CAHPS and HOS, administrative measures, and pharmacy measures. To ensure high quality and continued improvement of these measures, CalOptima Health has extensive strategies and initiatives including a Stars Steering Committee, seven working sessions with various departments, member experience improvement work groups, and regular meetings with health network partners and providers.

Medi-Cal Managed Care Accountability Set MCAS

CalOptima Health annually collects, tracks, and reports all Managed Care Accountability Set (MCAS) measures as required by DHCS. Through various initiatives, CalOptima Health consistently seeks improvement in measure rate performance and improved member health outcomes. These initiatives include regular meetings with health networks and providers, inclusion of MCAS measures held to the minimum performance levels in the CalOptima Health Pay for Value program, and member health rewards. Measure performance is tracked at least monthly and initiatives are launched strategically throughout the year to address performance gaps.

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance 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, including CHCN, and delegated health networks' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on the achievement of benchmarks.

Population Health Management

The Population Health Management (PHM) Program at CalOptima Health aims to deliver whole-person, safe, timely, efficient and equitable care across the member health care continuum and life span. To achieve this, PHM care coordination includes basic population health management, complex care management, Enhanced Care Management and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

The PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

CalOptima Health uses the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The information below outlines the key components used to operationalize the PHM Program, which include:

- Population needs assessment and PHM Strategy that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- Gathering member information on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- Understanding risk to identify opportunities for more efficient and effective interventions.
- Providing services and supports to address members' needs across a continuum of care.

In 2025, the PHM Work Plan will continue to focus on addressing health inequities and meeting members' social needs. CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improve access to preventive screenings and services for all CalOptima Health members.
- Expand in-person health education classes and community events to promote health and wellness.
- Enhance Chronic Condition Care and Self-Management programs to assist members with diabetes and hypertension management.
- Expand CalAIM Community Supports and the Street Medicine Program to connect members with whole-person care approaches and address social drivers of health.
- Enhance follow-up care after Emergency Department visits related to mental health and alcohol and other drug abuse or dependence.
- Improve member satisfaction for members who participate in PHM services like complex case management and disease management.
- Collaborate with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the PHM Program, activities and measurements can be found in the 2025 PHM Strategy and PHM Work Plan (Appendix B).

Health Education and Promotion

In April 2024, the Population Health Management department was renamed Equity and Community Health (ECH). The newly named team continues to support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs, focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission.

The department's primary goals are to increase member wellness and autonomy through advocacy, communication, education, identification of services and resources, and service facilitation throughout the continuum of care. Health education materials are written at the sixth-grade reading level and field-tested with members once designed, to confirm that they are clear and appropriate both culturally and linguistically.

The Equity and Community Health department programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for all members, focusing on health conditions, including chronic diseases. Programs and materials use educational strategies and methods suitable for members, families and caregivers to make informed health decisions or modify health behaviors across the lifespan. Moreover, these programs are structured with an "equity lens" to address mental wellness and the social drivers of health that impact members most. The programs are designed to achieve behavioral change over time and are reviewed annually. Covered topics include the management of asthma, diabetes, hyperlipidemia, prenatal health, proper exercise, nutrition, and weight management, tobacco cessation, immunizations, and well-child visits.

ECH supports CalOptima Health members with customized interventions at no cost, which may include:

- Behavior modification and healthy lifestyle management techniques,
- Health education programs and services virtually and in-person medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Classes tailored to member needs
- Online health educational videos and resources
- Informational booklets about key conditions
- Referrals to community or external resources

Member educational classes are offered in various ways, considering accessibility and adaptability. Members can attend in-person classes at community locations or online via virtual sessions.

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of care for members with chronic illnesses. The systemwide, multidisciplinary approach entails forming a partnership between the member, the health care practitioner, and CalOptima Health. The stratification process identifies appropriate interventions based on member needs.

These interventions include coordinating care for members and providing services, resources, and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening and identification of SDOH. It proactively identifies members needing closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business, with the exception of members with more acute needs who receive coordinated care from delegated entities.

Disease Management Program

CalOptima Health offers comprehensive disease management services designed to support members in managing their chronic conditions and improving overall wellness. CalOptima Health has disease management programs for diabetes, asthma, heart failure and maternal depression. These programs are facilitated by registered nurses, registered dietitians and masters trained health coaches. In addition, registered dietitians provide advanced nutritional counseling

to assist members with managing their chronic conditions amongst other nutrition-related health issues. All members are eligible to participate in health and wellness classes, individualized health coaching, and to receive materials to assist with chronic condition prevention and management. Topics include weight management, prediabetes, hyperlipidemia and hypertension among others. Health and Wellness services are available in the members' preferred language and recommendations can be culturally tailored to meet individual needs.

Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is the delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through the use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Case Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care (WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Qualifying members may be referred to Enhanced Care Management (ECM) as appropriate.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the interdisciplinary care team (ICT). Risk assessments are completed in person, virtually, telephonically, through text (SMS) or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments for WCM and OneCare are completed initially and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. If a meeting is required of the care team, the following individuals are always invited to the ICT meeting: the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. Other disciplines are included as needed, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

- ICT meetings occur as appropriate at the health network, or at CalOptima Health for CHCN members.
    - Team Composition: member, caregiver or authorized representative, health network Medical Director, PCP and/or specialist, care manager, BH specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Coordination of ICPs facilitating communication among member, PCP, specialists and vendors
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed based on the needs of the member. The ICP is a member-centric plan of care with prioritization of goals and target dates. The ICP focuses on the needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up. The ICP is updated at least annually and with changes in condition.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS

paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OneCare. The MOC meets the needs of special member populations through strategic activities.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

CalOptima Health's D-SNP care management program includes but is not limited to:

- Complex care management program
- ECM-like program for members who may meet an ECM population of focus criteria
- Transitional care management program Care Coordination program

Monitoring of members for change in condition Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration (BHI)

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QIHETP with direction and guidance from the QIHEC, BHI and other supporting departments continue to monitor the behavioral health care that CalOptima Health provider our members and continues to seek ways to improve BH care.

Medi-Cal Behavioral Health (BH)

CalOptima Health is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, Mental health services include but are not limited to individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima Health covers behavioral health treatment (BHT)/applied behavior analysis (ABA) for members 20 years of age and younger who meet medical necessity criteria. BHT/ABA services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT/ABA services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in DHCS' Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The incentive program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access services by calling the CalOptima Health Behavioral Health Line. Services include psychotherapy, medication management, psychological testing, intensive outpatient program, partial hospitalization program, opioid treatment program, electroconvulsive therapy and transcranial magnetic stimulation.

Utilization Management (UM)

Utilization Management oversees coverage of health care services, treatments and supplies for all lines of business based on the terms of the plan and member eligibility at the time of service. Services, treatments and supplies are available and accessible to all members, including those with Limited English Proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. Decisions are rendered based on medical necessity. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

The use of evidence-based, peer-reviewed and industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2025 Integrated UM and CM Program Description, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2025 Integrated UM/CM Integrated Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under-utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Quality-of-care investigations
- Disease surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with health networks and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to ensure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and organizational providers n at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Quality-of-care issues, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's health networks must submit complete, timely, reasonable and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A health network submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a health network's compliance with performance standards with regard to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the 12-month calendar year. CalOptima Health provides a health network with a Encounter Data Scorecard to report a health network's progress check score and annual score relating to the status of itscompliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child populations.

CalOptima Health conducts comprehensive BH surveys and analyses annually to assess member satisfaction regarding BH services. Two separate surveys are administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The survey questions focus on telehealth services, access to services, treatment experience, and overall experience.
Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and health network level (including CHCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is

presented and reviewed by the Grievance and Resolutions (GARS) Committee, which reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for CalOptima Health, and the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty health care providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreach and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.

Providers not meeting timely access standards are remeasured and tracked, and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.

- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural and Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The most common languages spoken by CalOptima Health members across all programs are English, 54%; Spanish, 31%; Vietnamese, 9%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; Arabic, less than 1%; and other languages are less than 2%. CalOptima Health provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- OneCare member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.
- PACE participant materials are provided in three languages: English, Spanish and Vietnamese.

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with the identification of needs through a Population Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks

- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related training (e.g., providing gender-affirming care) for CalOptima Health employees and contracted provider staff (clinical and non-clinical).

Further details of the Cultural and Linguistics program, activities and measurements can be found in the 2025 Culturally and Linguistically Appropriate Services Program Description.

Delegated And Non-Delegated Activities

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Delegation Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Claims, Credentialing, Customer Service and Utilization Management.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted health networks and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated health networks must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity

- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2025 QIHETP WORK PLAN

B – 2025 POPULATION HEALTH MANAGEMENT STRATEGY AND WORK PLAN

C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2025 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS

D – 2025 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES PROGRAM DESCRIPTION

ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community-Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CLAS	Culturally and Linguistically Appropriate Service
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ECH	Equity and Community Health
	ED ECH	Executive Director, Equity and Community Health
	ED BHI	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs

	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long-Term Care
	LTSS	Long-Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin-resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity
	QIHEC	Quality Improvement Health Equity Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee

	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/Physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician/Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Determinants of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared-Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third-Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

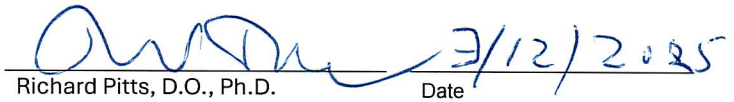
2025 QI Work Plan

I. PROGRAM OVERSIGHT

1 2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan
2 2024 QIHETP Description and Work Plan Evaluation
3 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description
4 2024 Integrated UM CM Program Evaluation
5 2025 Population Health Management (PHM) Strategy and PHM Work Plan
6 2024 PHM Strategy Evaluation
7 2025 Cultural and Linguistic Accessibility Services (CLAS) Program
8 2024 CLAS Program Evaluation
9 Population Health Management Committee (PHMC) Oversight
10 Credentialing Peer Review Committee (CPRC) Oversight
11 Grievance and Appeals Resolution Services (GARS) Committee
12 Member Experience (MEMX) Committee Oversight
13 Utilization Management Committee (UMC) Oversight
14 Whole Child Model - Clinical Advisory Committee (WCM CAC)
15 Care Management Program
16 Complex Case Management Program
17 Population Health Management (PHM) Strategy and Program
18 Disease Management Program
19 Health Education
20 CalAIM Community Supports and Enhance Care Management (ECM)
21 Street Medicine Program
22 Long-Term Support Services (LTSS)
23 Delegation Oversight
24 National Committee for Quality Assurance (NCQA) Accreditation
25 Quality Performance Improvement
26 Value Based Payment Program

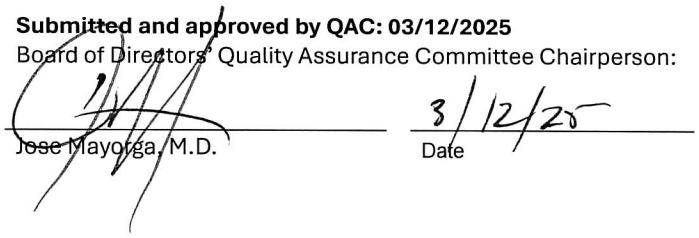
II. QUALITY OF CLINICAL CARE: Quality Management and Oversight

Submitted and approved by QIHEC: 1/14/2025
Quality Improvement Health Equity Committee Chairperson:



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

Submitted and approved by QAC: 03/12/2025
Board of Directors' Quality Assurance Committee Chairperson:



Jose Mayorga, M.D. Date

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28 Potential Quality Issues Review
29 Provider Credentialing and Recredentialing
30 Special Needs Plan (SNP) Model of Care (MOC)

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65 Experience with Language Services
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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	Continue Monitoring from 2024	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	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	X						
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 Q4 of 2025	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	X						

					and approved in Q1 2026.											
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	Executive Director of Clinical Operations	Director of Utilization Management	Utilization Management	X						
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	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	X						

5	Program Oversight	PHM	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	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						
6	Program Oversight	PHM	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	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						

7	Program Oversight	CLAS	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	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	X						
8	Program Oversight	CLAS	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	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	X						
9	Program Oversight	PHM	**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	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						

					Health's PHM strategic goals and priorities. 3. Facilitate quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.											
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 meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						

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 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.	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	X						
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	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager Quality Analytics / Manage of Quality Analytics	Quality Analytics	X						

					service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the “pain points” in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.											
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 quarterly. P&T and BMSC reports to the UMC, and minutes are	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	X						

					submitted to UMC quarterly.											
14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions 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 including the Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	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.	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	Program Specialist of Quality Improvement	Medical Management	X						

15	Program Oversight	PHM	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/CM2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMCQ1: 02/20/25Q2: 05/15/25Q3: 08/21/25Q4: 11/20/25	Director of Medical Management (Case Management)	Quality Improvement Nurse	Medical Management	X						
16	Program Oversight	PHM	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 the CCN and the delegates 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)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Nurse Specialist of Utilization Management	Case Management	X						

					4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)											
17	Program Oversight	PHM	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	Director of Equity and Community Health	Manager of Population Health Management/ Sr. Director Medical Management	Equity and Community Health	X						

18	Program Oversight	PHM	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 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.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						
19	Program Oversight	PHM	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	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						

					services and classes (e.g. 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).											
20	Program Oversight	PHM	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	Director of Medi-Cal and CalAIM	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	X							

21	Program Oversight	PHM	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 delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director, CalAIM Community Outreach	None	Medi-Cal and CalAIM	New						

					and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation											

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	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	X						
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	Director of Delegation Oversight	Manager of Delegation Oversight	Delegation Oversight	X						

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	Director Quality Improvement	Program Manager of Quality Improvement (NCQA)	Quality Improvement	X						
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: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X						

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 performance3. 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	Executive Director of Quality Improvement	Director of Quality Analytics	Quality Analytics	X						
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	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						

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	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						
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	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						
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	Director Medical Management	QI Nurse Specialist	Medical Management	X						

31	Quality of Clinical Care	PHM - LSC	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 complete chart chase efforts year-round	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Continue to Monitor W30 Not Met						

					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 Bridging Remediation for early intervention											

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 Colorectal Cancer Screening	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Quality Analyst of Quality Analytics / Manager of Quality Analytics	Quality Analytics	New							

					7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)											

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	Chief Medical Officer	Manager of Medical Management	Medical Management	X						

34	Quality of Clinical Care	CoC - PPC	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 6. Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X						

					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.											

35	Quality of Clinical Care	PHM	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	Director Equity and Community Health	Manager of Equity and Community Health/Manager of Behavioral Health Integration	Equity and Community Health	X					
36	Cultural and Linguistic Appropriate Services	PHMCLAS HE	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 resource navigation for	Report progress to QIHECQ1: 02/11/2025Q2: 05/13/2025Q3: 08/12/2025Q4: 11/20/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics/Manager of CalAIM/Director of Equity and Community Health	Equity and Community Health/ Cal AIM/Quality Analytics	X					

					pregnant and postpartum members.											

37	Quality of Clinical Care	PHM CoC-EED	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 physicians 7. Collaborate with OPH and	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director of Equity and Community Health	Manager of Quality Analytics	Equity and Community Health and Quality Analytics	X						

					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.											

38	Quality of Clinical Care	PHM CLAS HE	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	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	New						
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. Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality to pursue at-home DEXA testing via vendor. 4. Quality to provide timely notifications to	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Sr. Director Medical Management/Manager of Quality Analytics	Quality Improvement Nurse/Program Manager Quality Analytics	Medical Management (Case Management) /Quality Analytics	New						

					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 timely data and insight to the member's compliance deadline date to Health Network partners.											
40	Quality of Clinical Care	CoC - FMC	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	Director Medical Management	Quality Improvement Nurse	Case Management	New						

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 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	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor APM Not Met						

					to PCP on best practices.											
42	Quality of Clinical Care	PHM	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.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor AMM and DSF-E 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 members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.											

43	Quality of Clinical Care	CoC-SSD	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) 5) Member Health Reward Program. SAA Assess and report the following activities:	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor SSD Not Met						

					1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.											

44	Quality of Clinical Care	PHMCoC -FUM; FUA; FUI	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 member text messaging.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor FUA and FUM Not Met: New: FUI						

					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.											

45	Quality of Clinical Care	CoC - APP	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	Manager, Director and Executive Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	New						
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	Manager, Director and Executive Director of Behavioral Health Integration	Project Manager of Behavioral Health Integration	Behavioral Health Integration	Changed						

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	Director of Medicare Stars and Quality Initiatives	Program Manager of Quality Analytics	Quality Analytics	New						
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	Director of Pharmacy Management	Manager of Pharmacy Management	Pharmacy Management	New						
49	Cultural and Linguistic Appropriate Services	CLAS HE	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	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Manager of Quality Analytics	Quality Analytics	X						

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 with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration/ Quality Analytics	X						
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	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	X						

					Persons with Diabetes											
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 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	X						

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 timely access standards 5) Develop and/or share tools to assist with improving access to services.	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Continue to Monitor Goals Not Met						

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: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	X						
55	Quality of Service: Access	PHM	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	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health/Program Manager Equity and Community Health	Equity and Community Health	X						

					within 120 days.											

56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star ImprovementMC: One Star Improvement	Assess and report on the following activities: 1) Conduct outreach to members in advance of 2025 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively.3) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments.4) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy.5) Propose mapping of member responses to CAHPS categories in support of the organization adopting a Voice of Member reporting system.6)	Report to MemX Q1: 01/28/2025Q2: 04/15/2025Q3: 07/15/2025Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager of Quality Analytics / Manage of Quality Analytics	Quality Analytics	Continue to Monitor Goals Not Met						

					Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.											

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.	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2: 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	X						

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: 10/21/2025	Director of Customer Services	Manager of Customer Service	Customer Service	X						
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. Collaborate with Quality /Data analytics to identify top 5-10 readmission DX – consider adding in top 5-10 member readmission data for targeted education and outreach for member/provider. 2. review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3. Provider education for E/M's post discharge	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	None	Case Management	New						

					appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments (UM/CM/TCS) for targeted outreach for member outreach for											
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: 03/11/2025 Q2: 06/10/2025 Q3: 09/09/2025 Q4: 12/09/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	Changed						

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.	Report to UMC Q1: 03/11/2025 Q2: 06/10/2025 Q3: 09/09/2025 Q4: 12/09/2025	Sr. Director of Utilization Management	Project Manager, Medical Management	Utilization Management	X						
62	Cultural and Linguistic Appropriate Services	CLAS	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	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X						

63	Cultural and Linguistic Appropriate Services	CLAS	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	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X						

64	Cultural and Linguistic Appropriate Services	CLAS	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 Health Networks.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	Program Manger Provider Data Operations	Provider Data Management Services	X						

65	Cultural and Linguistic Appropriate Services	CLAS	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	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Continue to Monitor Goals Not Met						
66	Cultural and Linguistic Appropriate Services	CLAS	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	Chief Health Equity Officer	Manager Human Resources and Provider Relations	HR and Provider Relations	New						

Domain abbreviations:
PHM = Population Health Management Strategy
CoC = Continuity of Care
HE = Health Equity
CLAS = Cultural and Linguistically Appropriate Services

2025
POPULATION HEALTH MANAGEMENT (PHM)
STRATEGY & WORK PLAN

Responsible Staff:

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INTRODUCTION

Organization Overview

CalOptima Health believes that our members deserve access to quality of care and service throughout the health care continuum. As a county organized health system, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies to achieve our mission and vision.

Our Mission

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

Our Vision

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

Strategy Purpose

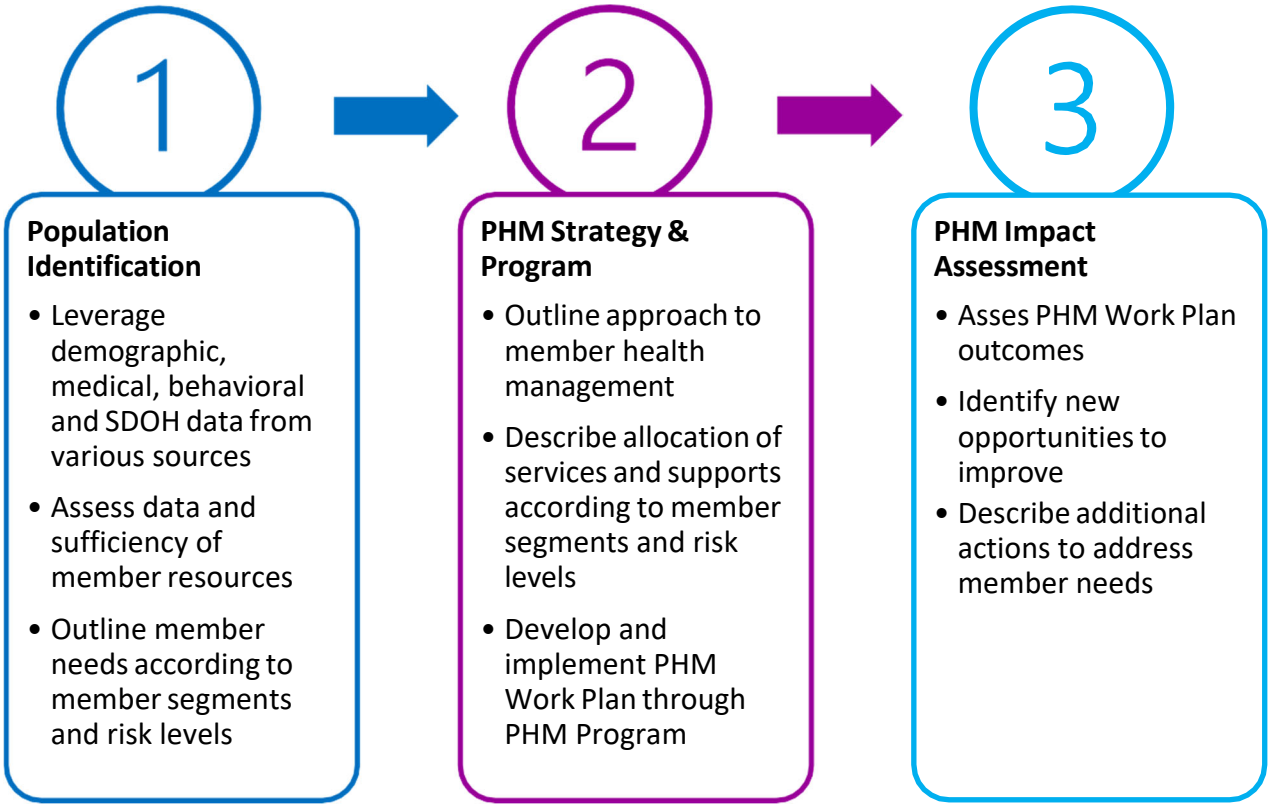
The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also incorporates an upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Increasing patient safety
4. Managing members with multiple chronic conditions
5. Providing advance care support

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data to understand our members' needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Work Plan. The following diagram illustrates these activities:



Population Identification

Population Needs Assessment

CalOptima Health's Population Needs Assessment (PNA) provides a comprehensive annual summary using a variety of data to describe member characteristics and health needs. Using the PNA to better understand trends in member health overall as well as specific focus populations supports better data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Work Plan, which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also help identify the need for process updates and resource allocation.

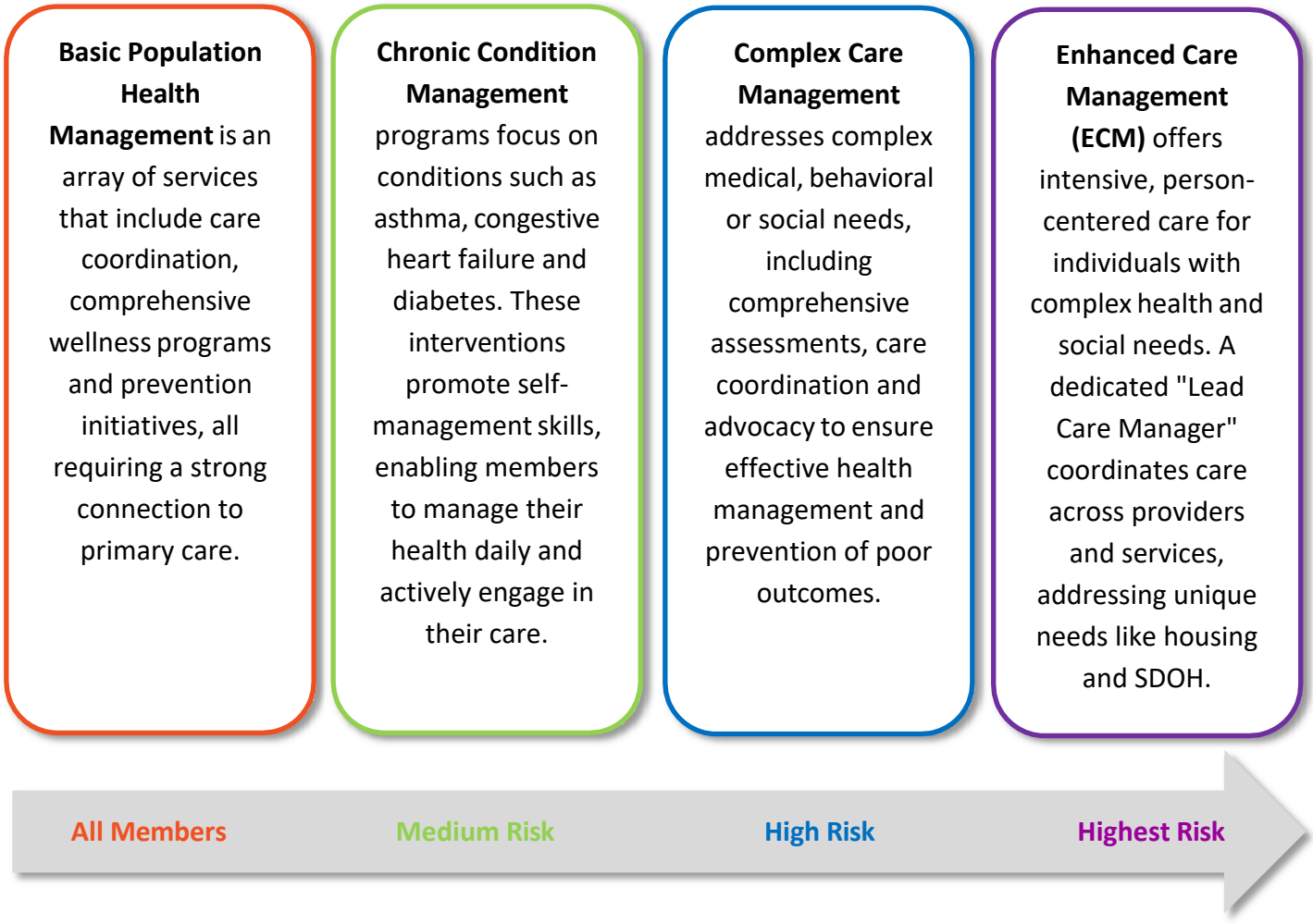
Population Segmentation and Care Coordination

CalOptima Health segments and stratifies its entire member population based on potential risk factors, such as health outcomes, utilization and claims data. This process aims to target focused interventions for members who are most likely to benefit. The segmentation and risk stratification methodology informs resource allocation and the development of tailored interventions, including program access and eligibility for specific services.

CalOptima Health divides its member population into meaningful segments using information collected from population assessments and other sources. These segments are defined by shared needs, characteristics, identities, conditions or behaviors, and include the following:

- Low risk
- Medium risk
- High risk
- Highest risk

Based on these risk levels, members may receive a variety of services and interventions, including but not limited to:



PHM Strategy and Program

PHM Work Plan

CalOptima Health uses insights from the PNA, population segmentation and care coordination to guide its PHM Strategy and Work Plan. These findings help address care gaps, inform interventions, and identify areas for process improvements and resource allocation. In alignment with our commitment to health equity, this strategy also takes an upstream approach to address SDOH and reduce the health disparities that affect our members.

The following outlines CalOptima Health's 2025 PHM Work Plan:

Keeping Members Healthy

- Children's Preventive Services
- Maternal Health Program
- Healthy Heart Program

Managing Emerging Risk

- Chronic Condition Care and Self-Management Program

Increasing Patient Safety

- CalAIM Community Supports
- Street Medicine Program
- Behavioral Health Services

Managing Multiple Chronic Conditions

- Complex Care Management Program

Providing Advance Care Support

- Enhanced Care Management

PHM Program

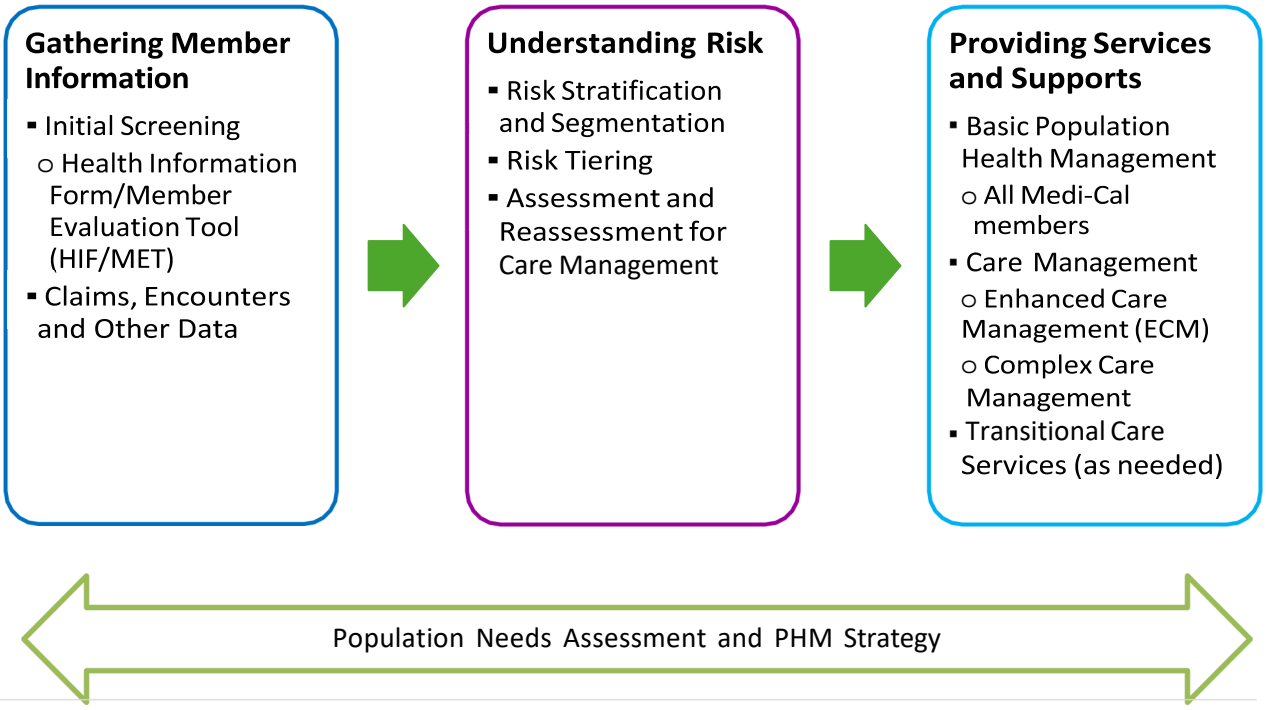
The PHM Strategy guides CalOptima Health's PHM Program. Our PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program:

- ***Population Needs Assessment and PHM Strategy*** to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access, and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identify opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members' needs across a continuum of care.



PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Equity and Community Health
- Long-Term Support Services (LTSS)
- Multipurpose Senior Services Program (MSSP)
- Program of All-inclusive Care for the Elderly (PACE)
- Pharmacy
- Utilization Management

Through its care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identify member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized care plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform interdisciplinary care team of member care needs, related activities and health goal progress.

Informing Members About PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via an initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to Medi-Cal and OneCare members who meet the PHM program criteria. When a member is referred to a PHM program, the member is directed to the appropriate staff for assistance with enrollment into the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they can opt out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is committed to reducing health disparities and serving members with the excellence, dignity and care they deserve. This commitment extends into the heart of the communities our members call home. By focusing on SDOH, uncovering implicit biases and dismantling systemic barriers, we will improve the experience and health outcomes for every member — because it is the right thing to do.

Our vision for health equity remains bold and ambitious, centered on all our operational and strategic priorities. To keep us focused on impact, our health equity framework includes five focus areas:

- **Reducing Health Disparities:** Mitigate racial, ethnic, gender and socioeconomic disparities in health outcomes.
- **Leadership and Advocacy for Equity:** Drive health equity initiatives through advocacy, partnership and continuous quality improvement.
- **Member-Centered Care:** Provide equitable, culturally responsive and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.
- **Community Engagement and Partnership:** Empower and collaborate with community stakeholders to co-create equitable health solutions that include prevention.
- **Empowering Change Through Data-Driven Strategies:** Leverage data to discover gaps, strengths and assets to co-design strategies that improve health outcomes with the community.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health (SDOH)

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions

- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard highlights CalOptima Health's current efforts to better identify and address the health disparities caused by SDOH in our member population. CalOptima Health plans to continue enhancing our understanding of SDOH's impact on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, recalibrate existing programs, redistribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Work Plan. Indirect member activities apply to multiple areas of focus and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and others to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act [PDSA] and Performance Improvement Projects [PIP]) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., health networks, providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

DELIVERY SYSTEM SUPPORTS

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or shared decision-making aids, holding continuing education sessions, and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers monthly to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and monthly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision-making among providers and their members. These are approved by CalOptima Health's Quality Improvement committees, posted to CalOptima Health's provider website and promoted through our provider newsletter. Shared decision-making aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality care while strengthening the safety net system across the county. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County. The goal is to shift from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored to the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcomes-focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high-priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

While CalOptima Health has long offered Cultural Competency training for staff and providers, in 2025 it will offer an expanded learning experience to ensure health equity is integrated across the care continuum. The training will encompass a comprehensive approach to sensitivity, diversity, inclusion, cultural competency, and health equity within the context of health care. Key areas of focus will include SDOH, gender-affirming care, mitigating bias, and gender identity and pronouns. The curriculum will also explicitly delve into understanding and addressing structural and institutional racism, provide information on relevant health inequities, and discuss important cultural considerations within the CalOptima Health member population.

Pay for Value (P4V)

CalOptima Health's Pay for Value (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 and CalOptima Health Community Network (CHCN) primary care providers are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance.
2. Provide comparative performance information about CalOptima Health to members, providers and the public.
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Sets (MCAS) required to achieve minimum performance levels (MPLs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. The Equity and Community Health (ECH) team assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, ECH oversees the strategic management efforts, including the identification of the health and wellness needs of CalOptima Health members and aligning organizational and community efforts to meet these needs, in accordance with DHCS and National Committee for Quality Assurance (NCQA) requirements. The following describes ECH team roles and responsibilities.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the Quality Improvement Health Equity Committee (QIHEC) satisfies all requirements of the PHM Program, as specified in state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health. The CHEO oversees Equity and Community Health (ECH) and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design and engagement strategies, and participating in testing and evaluation initiatives.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including PHM. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures related to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Medical Director, Equity and Community Health (MD ECH) is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines and shared decision-making aids, and consulting on individual member cases within PHM programs.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima Health's BHI department, along with implementation of new state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Clinical Operations (ED CO) is responsible for overseeing all clinical operations functions, including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas.

Executive Director, Equity and Community Health (ED ECH) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO and Executive Directors from Behavioral Health, Quality, and Clinical Operations departments, supports efforts to promote adherence to established quality improvement strategies and integrates behavioral health across the delivery system and populations served. The Director of ECH reports to the ED ECH.

Executive Director, Medi-Cal/CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and member care.

Executive Director, Network Operations (ED NO) is responsible for the overall success of network operations to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system. The ED NO is responsible for provider relations and support, including provider education and problem resolution. The ED NO and their staff must have the ability to collaborate with all internal departments to support and assist delegated provider entities and directly contracted providers in their day-to-day interactions and transactions with the plan.

Executive Director, Operations (ED O) is responsible for overseeing and guiding the following operational departments: Claims Administration, Customer Service, and Grievance & Appeals Resolution Services. The ED O works closely with top-level leadership to establish policies and implement procedures for the management of departments to accomplish the goals and objectives of CalOptima Health within budget and within applicable legal requirements. In addition, the ED O will oversee the day-to-day operations of the departments, which includes facilitating communication with members, providers and regulators.

Executive Director, Quality (ED Q) is responsible for facilitating the companywide QI Program deployment; driving performance results in HEDIS, DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED Q serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and ED CO, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED Q are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Strategic Development (ED SD) is responsible for the oversight and implementation of CalOptima Health's strategic development programs. Under the general guidance of the Chief Administrative Officer (CAO), the ED SD works closely with top-level leadership to plan,

develop and implement strategies and carry out organizational goals and priorities to effectively promote and implement CalOptima Health's mission and vision with internal and external contacts, including employees, the public, members, government officials and the media.

Sr. Director, Equity and Community Health (Sr. ECH Director) is responsible for leading the development and implementation of community outreach and member engagement strategies designed to address identified health inequities. The Sr. ECH Director is responsible for assisting the CHEO in developing, implementing, analyzing, and refining the CalOptima Health goals and objectives related to health equity. The Sr. ECH Director partners with the CHEO, ED ECH and other leaders to strengthen the organization's commitment and strategy to advance health equity and reduce health disparities, as well as to remain a diverse, equitable, and inclusive organization.

Director, Equity and Community Health (ECH Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive PHM plan and health equity framework aligned with the organization's strategic goals. ECH Director provides oversight and supervision of staff to monitor the implementation of organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima Health's overall mission and strategic goals. The ECH Director ensures that the department meets ongoing regulatory compliance and accreditation standards. ECH Director plays a key leadership role, interacting with all levels of CalOptima Health staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes, and member and provider satisfaction.

The following staff support the implementation of PHM strategies within ECH:

- *ECH Managers:* Develop PHM goals and priorities, improve operational efficiency, and ensure regulatory compliance.
- *ECH Supervisors:* Oversee staff productivity, compliance and special projects, addressing complex member or provider requests.
- *ECH Program Managers:* Lead cross-organization initiatives and regulatory compliance, develop and evaluate new interventions, and stay informed on health care policy impacts.
- *ECH Health Educators and Coaches:* Deliver member-focused health education, coaching, group classes and self-management support for chronic conditions, sharing progress with care teams.
- *ECH Registered Dietitians:* Provide nutrition counseling, develop education materials and collaborate on member care planning.
- *ECH Personal Care Coordinators:* Conduct assessments and coordinate member care, ensuring seamless transitions.
- *ECH Program Coordinators and Specialists:* Provide analytical and administrative support for programs, track milestones and assist with the development and evaluation of initiatives.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

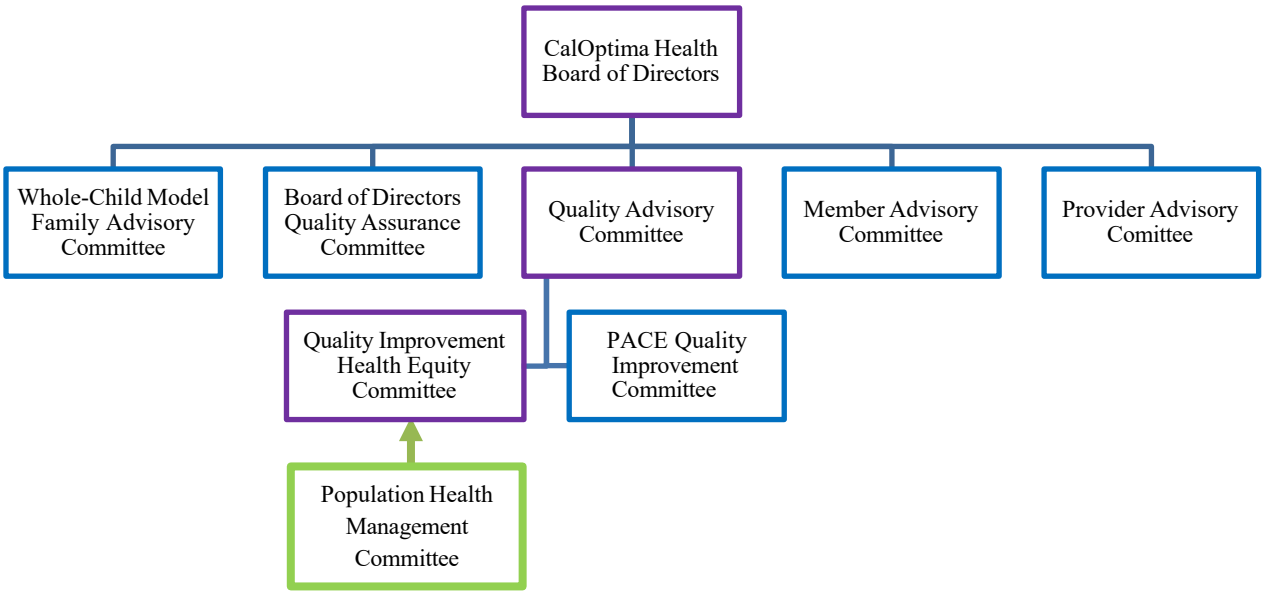
PHM Oversight Responsibilities

Dedicated staff from ECH, in collaboration with other multidisciplinary work teams throughout the organization and with guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by the Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Work Plan proposals. The PHM Strategy and Work Plan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Work Plans to the Board of Directors' Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Oversight Structure



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to ensure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

2025 Population Health Management Work Plan

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
1	Program Oversight	Population Health Management (PHM) Strategy & Work Plan	The PHM Program ensures that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care. The 2025 PHM Strategy & Work Plan aims to: • Keep Members Healthy • Reduce Emerging Risks • Increase Patient Safety • Help Members Management Multiple Chronic Conditions ▪Provide Advance Care Support	By April 30, 2025, present the 2025 PHM Strategy and Work Plan and obtain CalOptima Health Board of Director approval.	Present to: • QIHEC: 01/14/2025 • PHMC: 02/20/2025 • QAC: 03/12/2025 • BOD: 4/3/2025 (Annual BOD adoption by end of April 2025) Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	All CalOptima Health members.	PHM Strategy will be adopted on an annual basis.* **Population Health Management Committee (PHMC), Quality Improvement Health Equity Committee (QIHEC), Quality Assurance Committee (QAC), and CalOptima Health Board of Director (BOD) approval must be obtained annually).*	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	PHMC	X					
2	Program Oversight	Population Health Management (PHM) Strategy Evaluation	CalOptima Health's annual Population Health Management (PHM) Impact Report measures the effectiveness of the agency's PHM Strategy and Work Plan to address member care needs.	By April 30, 2025, evaluate the effectiveness of 2024 PHM Strategy and Work Plan.	Present to: • QIHEC: 02/11/25 • PHMC: 02/20/25 • QAC: 03/12/25 • BOD: 04/03/25	Please refer to strategy for population subsets for focused interventions .	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	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	PHMC	X					
3	Program Oversight	Population Health Management (PHM) Strategy &	The PHM Strategy guides CalOptima Health's PHM Program which	By January 1, 2025, implement initiatives for the 2025 PHM program.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25	All CalOptima Health members.	Conduct and report the following activities: 1. Population	Director of Equity and Community Health, Senior Director of Medical	Equity and Community Health/ Medical Manageme	PHMC	X					

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		Program	spans across several settings, providers and levels of care to meet our members' needs.		• Q4: 11/20/25		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.	Management & Manager of Equity and Community Health	nt							
4	Program Oversight	Population Health Management Committee (PHMC)	PHMC provides oversight of population health management activities to improve population health outcomes and advance health equity.	On a quarterly basis (at a minimum of three times between January 1 – December 31, 2025), PHMC will report PHMC key updates, activities, and recommendations to the Quality Improvement Health Equity Committee (QIHEC).	Report progress to QIHEC : • Q1: 03/11/25 • Q2: 06/10/25 • Q3: 09/9/25 • Q4: 12/9/25	All CalOptima Health members.	1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversees that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	QIHEC	X					
5	Program Oversight	Disease Management Program	The Disease Management program identifies, assesses, and mitigates serious health risks among our members. Through these	By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	• Members with medium risk level are identified from monthly stratification to receive health coaching. • Low-risk members	1. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	PHMC	X					

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			efforts, CalOptima Health aims to reduce the risk of chronic conditions complications and improve long-term well-being among members	satisfaction with program.		receive a package through the mail with information about the condition and on how to access health education services.	outreach, member self-referral, etc.) 2. 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).									
6	Program Oversight	Health Education	The Health Education program promotes early detection, fosters healthy habits, and supports preventive care. With a focus of prevention, CalOptima Health aims to reduce the risk of chronic conditions and improve long-term well-being among members.	By January 1, 2025, implement interventions for the 2025 Health Education program focused on promoting early detection, building fostering healthy habits, and empowering members to be proactive with preventive care.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with no to low risk.	1. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 2. 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).	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	PHMC	X					
7	Quality of Service	Increase primary care utilization - Initial Health Appointment (IHA)	CalOptima Health ensures provision of an IHA. An IHA at a minimum must include: • History of the member's physical and mental health; • Identification of risks;	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	All new CalOptima Health members.	1. Enhance methods of informing members of the importance of IHA and preventive screenings. 2. Collaborate with delegation oversight to improve IHA	Senior Manager of Equity and Community Health & Program Manager of Equity and Community Health	Equity and Community Health	PHMC	X					

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			• Assessment of need for preventive screens or services and health education; • Physical examination; and • Diagnosis and plan for treatment of any diseases* **Unless the member's primary care provider (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.*				compliance by Health Network. 3. Provider and HN education to support new member screening for SDOH screening within 120 days.									
8	Cultural and Linguistic Appropriate Services	Birth Equity: Maternity Care for Black Members	CalOptima Health's Birth Equity initiative aims to improve birth outcomes by ensuring that all members have optimal birth conditions and addressing racial and asocial inequalities in birth outcomes.	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.	Report progress to QIHEC : • Q1: 02/11/25 • Q2: 05/13/25 • Q3: 08/12/25 • Q4: 11/11/25	Pregnant members who are Black and Native American.	*Objectives 1 -2:* 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 resource navigation for pregnant and postpartum members.	Manager of Quality Analytics & Program Manager of Quality Analytics	Quality Analytics	QIHEC	X					

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9	Keeping Members Healthy	Blood Lead Testing in Children	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.	Increase the rate for blood lead testing in children (LSC) from 63.75% to 63.84% by December 31, 2025.	Report progress to QIHEC : • Q1: 02/11/25 • Q2: 05/13/25 • Q3: 08/12/25 • Q4: 11/11/25	Members that are 12 and 24 months and due for a blood lead test. Blood Lead Testing at 12 Months of Age: • Numerator: Medi-Cal members who completed a one lead capillary or venous blood test within 6 months (before or after) their first birthday. • Denominator: Medi-Cal members who turn 12 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the first birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month. Blood Lead Testing at 24 Months of Age: - Numerator: Medi-Cal members who	1. Co-develop an educational communications toolkit on blood lead testing with Kaiser Permanente and Health Care Agency. 2. Develop an informational and educational brief to recommend at least one policy or systems change to increase blood testing for children. 3. Provide trainings to local community-based organizations and local health care providers promoting blood lead testing in Orange County	Manager of Quality Analytics & Program Manager of Quality Analytics	Quality Analytics	QIHEC	X					

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						complete one lead capillary or venous blood test within 6 months (before or after) their second birthday. - Denominator: Medi-Cal members who turn 24 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the 2nd birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.											
10	Keeping Members Healthy	Maternal Health	The Maternal Health program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.	1. Increase the Prenatal Depression Screening (PND-E) rate from 14.52% to 16.03% by December 31, 2025. 2. Increase the Prenatal Depression Screening (PND-E) follow-up rate on positive screening from 52.80% to 53.33% by December 31, 2025.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members who are expecting or recently delivered. PND-E (Prenatal) Numerators: 1. Depression Screening - Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening	*Objectives 1 -4:* 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 depression screenings at community events with a target population of maternal and	Director of Equity and Community Health & Senior Manager of Equity and Community Health	Equity and Community Health & Quality Analytics	PHMC	X					

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				3. Increase the Postpartum Depression Screening (PDS-E) rate from 17.33% to 29.84% by December 31, 2025. 4. Increase the Postpartum Depression Screening (PDS-E) follow-up rate on positive screening from 56.84% to 61.70% by December 31, 2025.		instrument, performed during pregnancy (on or between pregnancy start date and the delivery date) 2. Follow-Up on Positive Screen - Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). PND-E Numerators: 1. Depression Screening - The initial population, minus exclusions. 2. Follow-Up on Positive Screen - All deliveries from numerator 1 with a positive finding for depression during pregnancy. PDS-E (Postpartum) Numerators: 1. Depression Screening - Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized instrument,	infant members.										

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						performed during the 7–84 days following the delivery date. 2. Follow-Up on Positive Screen - Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). PDS-E Denominators : 1. Depression Screening - The initial population, minus exclusions. 2. Follow-Up on Positive Screen - All deliveries from numerator 1 with a positive finding for depression during the 7–84 days following the date of delivery.										
11	Keeping Members Healthy	Heart Health (Hypertension)	As the second most common chronic condition among CalOptima Health members, hypertension efforts will focus on member screenings at community/clinic events, promoting healthy lifestyle	1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by December 31, 2025. 2. Increase CBP rate among Black and African American Medicare members from	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	• Members with lower rates of HEDIS CBP Measure, including (but not limited to) Black and African American, Korean and Vietnamese members. • Members meeting the established criteria by	*Objectives 1 -4* : Expand Hypertension Program to offer both virtual and in-person hypertension education	Manager of Equity and Community Health & Supervisor of Equity and Community Health	Equity and Community Health	QIHEC	New					

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			change and self-management.	47.24% to 77% by December 31, 2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by December 31, 2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by December 31, 2025.		DHCS to receive a blood pressure monitor based on their health conditions and has not received one.										
12	Emerging Risk	Chronic Condition Care and Self-Management Program	Chronic Condition Care and Self-Management program promotes self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.	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.*	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with diabetes that are at risk of HbA1c poor control. • Numerator: Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) who participated in the Chronic Conditions Care and Self-Management Program and lowered their HbA1c to less than 8% during the measurement year. • Denominator : Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) with a result of HbA1c 8.0%	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.	Manager of Quality Analytics, Quality Improvement Specialist & Manager of Equity and Community Health	Quality Analytics & Equity and Community Health	PHMC	X					

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						to HbA1c 9.0% who were previously in good control (HbA1c less than 8.0%) in previous 12 months.										
13	Emerging Risk	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	The FUA program assesses the percentage of emergency department (ED) visits for members aged 13 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.	1. Increase the FUA (7-days) rates from 11.23% to 18.76% by December 31, 2025. 2. Increase the FUA (30-days) rates from 21.12% to 36.18% by December 31, 2025.	Report progress to QIHEC : • Q1: 02/11/25 • Q2: 05/13/25 • Q3: 08/12/25 • Q4: 11/11/25	Members 13 years and older as of the ED visit for substance use. • Numerators: ▫ 7-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. ▫ 30-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. • Denominator: Medi-Cal members ages 13 and	*Objectives 1 -2:* 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. Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5. Bi-Weekly Member Text Messaging (approx. 500 members) 6. Member Newsletter (Spring)	Director of Behavioral Health Integration & Senior Manager of Behavioral Health Integration	Behavioral Health Integration	QIHEC	X					

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						older who had emergency department (ED) visits with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up during the measurement period.										
14	Patient Safety	CalAIM Community Supports	California Advancing and Innovating Medi-Cal (CalAIM) is a 5-year initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.	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.	Report progress to PHMC : ▪ Q1: 02/20/25 ▪ Q2: 05/15/25 ▪ Q3: 08/21/25 ▪ Q4: 11/20/25	Eligible CalOptima Health Members that are referred to CalAIM Community Supports. ▪ Numerator: Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between January 1st - December 31st, 2025 and received at least one CCS. ▪ Denominator: Eligible CalOptima Health members referred to CCS* between January 1st - December 31st, 2025. To qualify for CalAIM Community	1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits.	Director of Medi-Cal & CalAIM	CalAIM	PHMC	X					

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						the member must be eligible for CalOptima Health and referred or self-referred to CCS. Eligibility criteria for each CSS varies and listed on the referral form.										
15	Patient Safety	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.	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.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members that are experiencing homelessness Numerator: Eligible CalOptima Health members who are experiencing homelessness *, opted into the Street Medicine program, and: - assigned to a Medical Home; - received CalAIM ECM or at least one Community Support; OR - referred to a shelter or other housing option. Denominator: Members eligible for CalOptima Health who are experiencing homelessness * during the measurement period. *Members that are eligible for CalOptima Health	*Objective 1:* 1. Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. 2. Utilize Releases of Information when member has active PCP to increase collaboration and communication. 3. Support member with PCP change, as needed. 4. Care scheduling and delivery. *Objective 2:* 1. Make attempts to engage with members weekly. 2. Provide ECM and/or Housing Navigation appointments face to face at least every other week. 3. Care scheduling and delivery. 4. Document all encounters. *Objective 3:* 1, Outreach to and engage unsheltered	Director of Medi-Cal & CalAIM	CalAIM	PHMC	X					

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						services self-report experiencing homelessness to Street Medicine Team canvassing in designated geographic locations within Orange County during the measurement period.	individuals 2. Provide ECM and/or Housing Navigation 3. Enter members in to the Coordinated Entry System 4. Connect individuals to local shelters 5. Work with members on completing housing documentation									
16	Managing Multiple Chronic Conditions	Complex Case Management Program	Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.	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 31, 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.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups (including, but not limited to): Spinal injuries, transplants, cancer (with additional complex condition, serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and	*Objective 1:* 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/ situations. *Objective 2:* 1. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes or and improve the member experience in CM programs. 2. Ongoing training and support for new and existing staff *Objective 3:* 1. Continue to gather member feedback to improve outcomes.	Director of Case Management & Quality Improvement Nurse Specialist	Case Management	PHMC	X					

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
						complex social situation that affects the medical management of the members' care and requires extensive use of resources. ▪ Numerator: Members enrolled for 60 days or longer, complete satisfaction survey, and who's results show satisfaction* with the program. * The survey tool utilizes a rating scale of options for six questions. For five of the six questions, satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful, Very Beneficial, Beneficial. For the sixth question a response of "yes" defines satisfaction. ▪ Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully	2. Training and education on member centric care plans.									

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
						completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year. The denominator excludes blanks or “not applicable” responses. Methodology for Members who found CCM services helpful in achieving their goals. • Numerator: Members enrolled for 60 days or longer, completed question 13 (How helpful was the case management process in helping you to meet your care plan goals?) in the satisfaction survey, and whose results show satisfaction* with the program. * The survey tool utilizes a rating scale of options for the questions related to developing and helping with care plan goals. Satisfaction is										

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
						defined by selecting one of the following responses, Very Helpful, Helpful. ▪ Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually or upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.										
17	Advanced Care Management	Enhanced Care Management (ECM) Services	A whole-person interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services. ECMS includes coordinating care across the physical and behavioral health delivery systems.	Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Report progress to PHMC : ▪ Q1: 02/20/25 ▪ Q2: 05/15/25 ▪ Q3: 08/21/25 ▪ Q4: 11/20/25	Eligible CalOptima Health Members that are referred to CalAIM ECM. ▪ Numerator: Eligible CalOptima Health members who qualify for CalAIM ECM between January 1st - December 31st, 2025 and received at least one ECM service. ▪ Denominator: Eligible CalOptima Health members	Track ECM outreach, authorizations and services.	Director of Medi-Cal & CalAIM	CalAIM	PHMC	New					

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
						referred to ECM between January 1st - December 31st, 2025. To qualify for CalAIM Community the member must be eligible for CalOptima Health and referred or self-referred to ECM. Eligibility criteria for each ECM varies and listed on the referral form.										

CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

MY2025 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 incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY2025 Medi-Cal P4V

1. Include measures held to an MPL in the MY2025 MCAS measure set.

MY 2025 Medi-Cal Pay for Value Program Measurement Set	
Measure Category	**Measure**
HEDIS	Follow-up After ED Visit for Mental Illness- 30 days
	Follow-Up After ED Visit for Substance Abuse- 30 days
	Child and Adolescent Well-Care Visits
	Childhood Immunization Status- Combination 10
	Development Screening in the First Three Years of Life
	Immunizations for Adolescents- Combination 2
	Lead Screening in Children
	Topical Fluoride in Children
	Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits
	Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits
	Asthma Medication Ratio
	Controlling High Blood Pressure*
	Glycemic Status Assessment for Patients with Diabetes (>9%) lower is better*
	Chlamydia Screening in Women
	Prenatal and Postpartum Care: Postpartum Care
	Prenatal and Postpartum Care: Timeliness of Prenatal Care
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Depression Remission or Response for Adolescents and Adults
	Depression Screening and Follow-Up for * Adolescents and Adults
	Pharmacotherapy for Opioid Use Disorder
	Postpartum Depression Screening and Follow Up
	Prenatal Depression Screening and Follow Up
	Prenatal Immunization Status
CAHPS	CAHPS- Rating of Health Plan: Adult and Child

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	CAHPS- Rating of Health Care: Adult and Child
	CAHPS- Rating of Personal Doctor: Adult and Child
	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
	CAHPS- Getting Needed Care: Adult and Child
	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- 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.

2. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
3. 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
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{\text{(MY2022 Rate-S0th Percentile)}}{\text{((MY2022 Rate-MY2021 Rate)/9)}}\right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{\text{(MY2022 Rate-MY2021 Rate)}}{\text{((9Sth Percentile-MY2021 Rate)/10)}}\right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
   - Measure weighting
     - HEDIS measures weighted 1.0
     - CAHPS measures weighted 1.5
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance 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 Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures and measure weights:

MY 2025 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D HEDIS	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
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
Part D Member Experience	Rating of Drug Plan
	Getting Needed Prescription Drugs

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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
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{\text{(MY2022 Rate-S0th Percentile)}}{\text{((MY2022 Rate-MY2021 Rate)/9)}}\right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{\text{(MY2022 Rate-MY2021 Rate)}}{\text{((9Sth Percentile-MY2021 Rate)/10)}}\right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicare percentiles used as benchmarks.
   - Measure weighting
     - HEDIS process measures weighted 1.0
     - CAHPS measures weighted 2.0
     - Outcome measures weighted 3.0
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

3. Program funding of $20 PMPM

2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description

Table of Contents

CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal** – California's Medicaid Program for low-income children, adults, seniors and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO D-SNP**) – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

Membership Demographics

Membership Data (as of 10/31/2024)

Total CalOptima Health Membership 910,063	Program	Members
	Medi-Cal	892,392
	OneCare (HMO D-SNP)	17,173
	Program of All-Inclusive Care for the Elderly (PACE)	498
	*Based on unaudited financial report and include prior period adjustment	

Member Demographics (as of 10/31/2024)

Member Age

0 to 5	**8%**
6 to 18	**23%**
19 to 44	**35%**
45 to 64	**20%**
65+	**14%**

Language Preference

English	**54%**
Spanish	**31%**
Vietnamese	**10%**
Other	**2%**
Korean	**1%**
Farsi	**1%**
Chinese	**<1%**
Arabic	**<1%**

Medi-Cal Aid Category

Temporary Assistance for Needy Families	**37%**
Expansion	**38%**
Optional Targeted Low-Income Children	**8%**
Seniors	**11%**
People with Disabilities	**5%**
Long-Term Care	**<1%**
Other	**<1%**

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. CalOptima Health is committed to providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of planning and operation.

Objectives for culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions are not unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually, which includes the CLAS Program.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluations, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI),

health equity and CLAS contractual and regulatory standards and the Department of Health Care Services (DHCS) Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or authorized family members (two seats)
- Member advocate
- County of Orange Social Services Agency (SSA)
- OneCare member or authorized family members (four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by SSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health

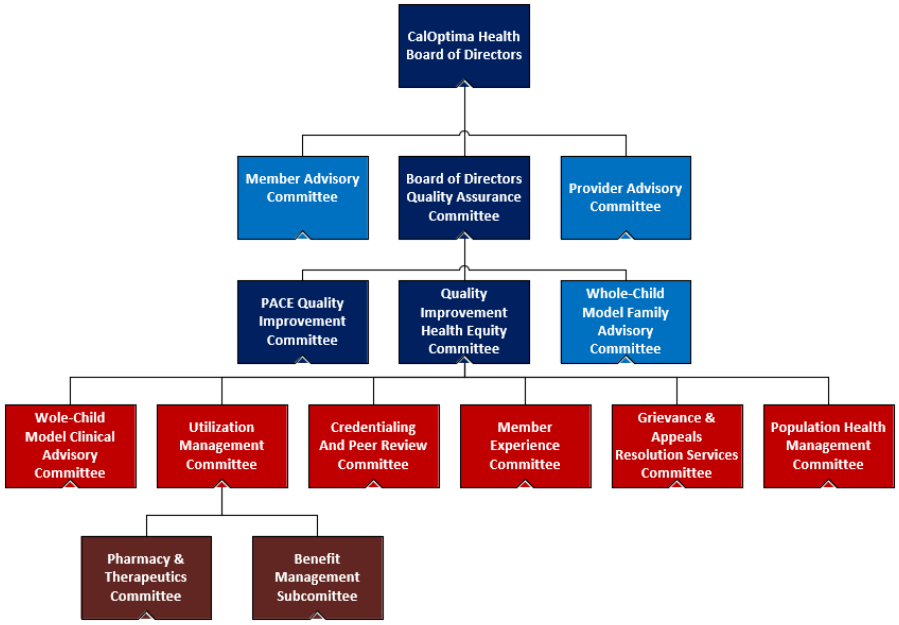
members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of Orange County Health Care Agency, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Orange County Health Care Agency (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

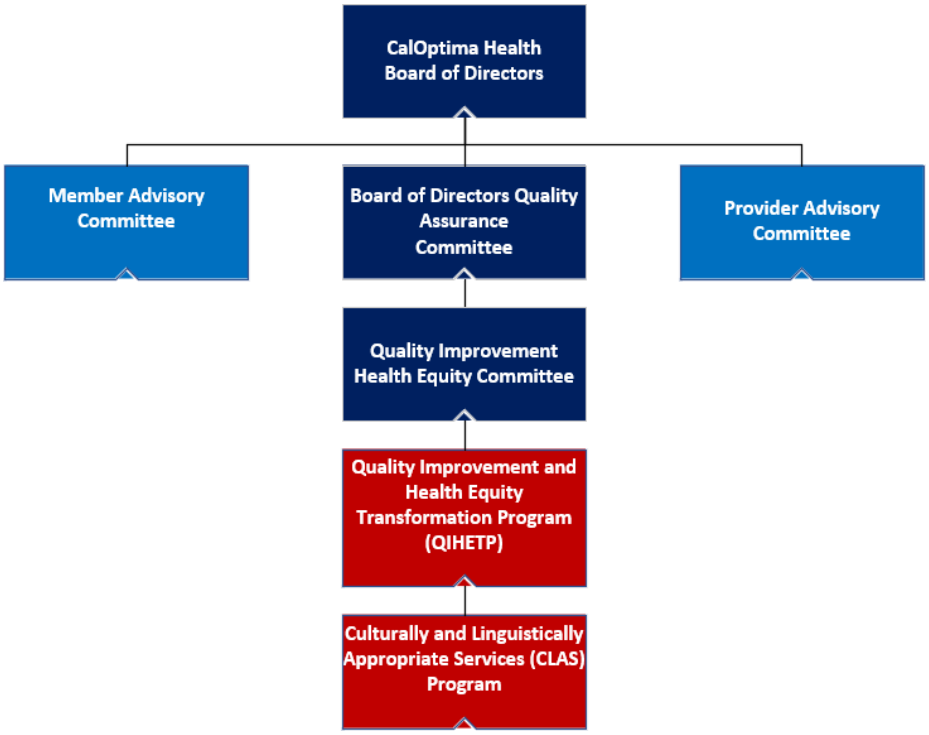
Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the CLAS Program and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and they collaboratively develop and oversee the QIHETP and QIHETP Workplan activities.

The purpose of the QIHEC is to ensure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated health networks and their contracted provider and practitioner partners.



CLAS Reporting Structure



The CLAS Program is a part of the overall QIHETP, and CLAS activities are embedded in the QIHETP Work Plan. CLAS activities are reported to QIHEC for analysis, evaluation and adjustment as needed.

Community and Member Engagement

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health engages members through the MAC and seeks input and advice related to cultural and linguistic and health equity goals. The MAC has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

MAC represents the diversity of its membership. The following table depicts the current MAC breakdown by ethnic diversity. MAC includes individuals representing the ethnicity and language groups that represent at least 5% of the population.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	46%	Spanish	31%	5	4 OneCare Members 1 Behavioral/ Mental Health Representative
White	17%	English	55%	8	1 Adult Beneficiaries 1 Children 1 Foster Children 2 Medi-Cal Beneficiaries or Authorized Family Members 1 Persons with Special Needs 1 Recipient of CalWORKS 1 Seniors
Vietnamese	13%	Vietnamese	9%	1	1 Persons with Disabilities
Korean	3%	Korean	1%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups, meetings and/or surveys, such as implementing a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientations.

Goals

The following are the 2025 goals for the CLAS Program:

1. 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).
2. By March 31st, 2025, CalOptima Health will launch a language services experience survey for members and staff and aim to collect feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.
3. By Dec. 31st, 2025, CalOptima Health will increase the collection race/ethnicity/language (REL) by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. 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.
5. 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.

CLAS Workplan

The CLAS Workplan is a subset of and is embedded within the QIHETP Workplan and outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable staff for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity

- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the CLAS Program and applicable policies and procedures. The 2025 CLAS Work Plan includes all cultural and linguistic focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve the collection, storing, retrieval and sharing of race/ethnicity, language, and SOGI data. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans are also publicly available on the CalOptima Health website.

For more details on the 2025 CLAS Work Plan, see Appendix A: 2025 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health conducts ongoing assessments of CLAS-related activities and integrates CLAS-related measures into measurement and continuous quality improvement activities. The QIHEC continuously monitors progress against CLAS goals. At least quarterly, dedicated staff from the Cultural & Linguistic Services (C&L) department, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at QIHEC meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Directors' Quality Assurance Committee (QAC).

CLAS Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's CLAS Program are reviewed and evaluated annually by the QIHEC and QAC, as part of the overall CLAS Program Evaluation and approved by the Board of Directors, as reflected in the CLAS Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the CLAS Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing CLAS activities that address the cultural and linguistic needs of our members, including the achievement or progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of translation and interpreter services.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and

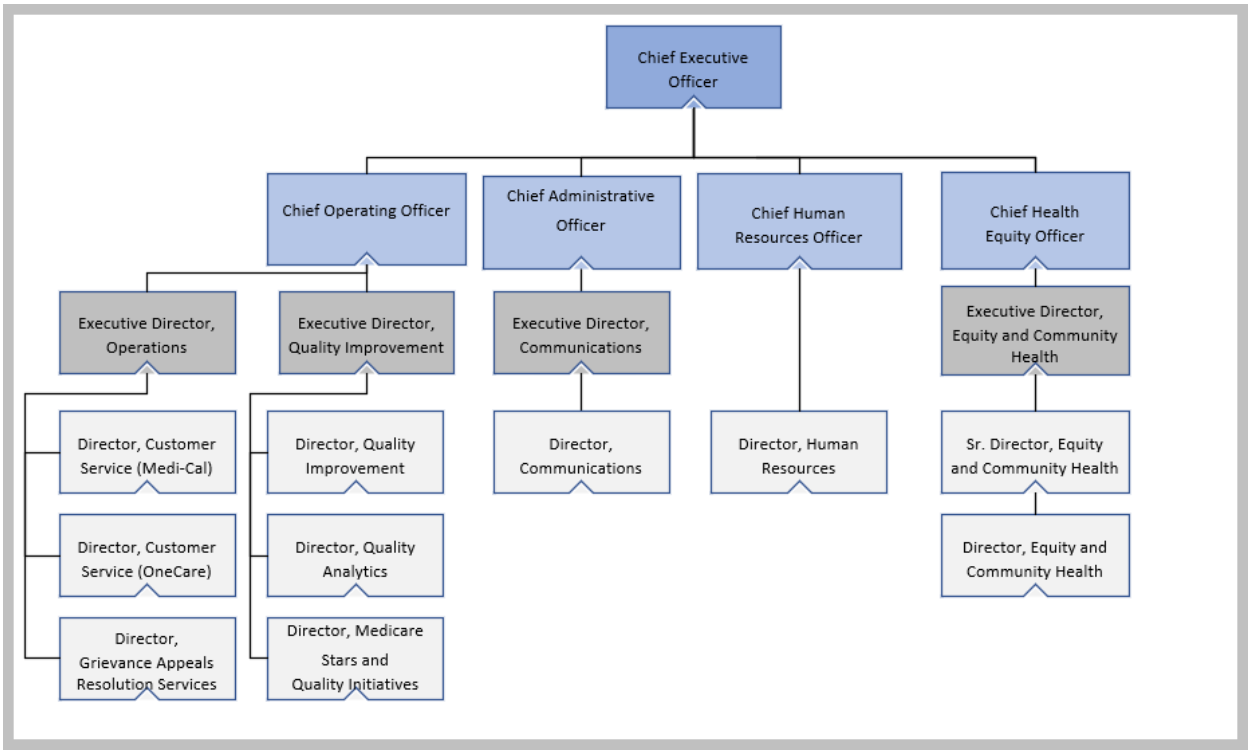
barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the CLAS Evaluation is also publicly available on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, Manager of Cultural & Linguistics, and nine Program Specialists who are responsible for the translation of documents and coordinating cultural and linguistic services with contracted vendors. The C&L department is supported by CalOptima Health departments including but not limited to:

- Communications
- Contracting
- Customer Service
- Equity and Community Health
- Human Resources
- Network Operations
- Provider Relations
- Quality Analytics

Cultural & Linguistic Services Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, and the Executive Directors who have oversight of these areas.

Chief Administrative Officer (CAO) has overall responsibility and accountability for the activities of the Clerk of the Board, Communications & Marketing, Government Affairs, Strategic Development, and Enterprise Project Management. The CAO creates a shared sense of purpose to achieve an aligned mission and vision executed through CalOptima Health's strategic plan and Chief Executive Officer (CEO) initiatives. The CAO is expected to lead by example and influence others by exhibiting the highest professional and ethical behaviors.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the Human Resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO,

the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining National Committee for Quality Assurance (NCQA) accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts; responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve the member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, address disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service (Medi-Cal) is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including Medi-Cal Call Center, Behavioral Health Call Center, Member Liaison, Customer Service Data Analysts,

member-facing sections of the CalOptima Health website and the CalOptima Health Member Portal.

Director, Customer Service (OneCare) is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including OneCare Call Center, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, member-facing sections of the CalOptima Health website and the CalOptima Health Member Portal.

Director, Grievance and Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including to ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading the collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. This director conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure the effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the organization-wide QIHETP.

Director, Medicare Stars and Quality Initiatives is responsible for leading the implementation of quality initiatives to improve quality outcomes for Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. This director provides data analytical direction to support quality measurement activities for the organization-wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. The position provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. This director interacts with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also

conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiates provider contracts.

Director, Provider Operations is responsible for all operational aspects of the Provider Network Operations department. The director will oversee the onboarding of all new provider partners, provider data management and analysis, and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meets regulatory requirements and NCQA standards; leverages the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of health care services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources is responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs and processes. The Director will also be responsible for Human Resources record retention practices, policy maintenance, project management and Fair Labor Standards Act (FLSA) compliance

Sr. Director, Equity and Community Health (ECH) The Sr. Director of Health Equity is responsible for leading the development and implementation of community outreach and member engagement strategies designed to address identified health inequities. This position is responsible for directly assisting the Chief Health Equity Officer (CHEO) in developing, implementing, analyzing, and refining the CalOptima Health goals and objectives related to health equity (HE). This position will partner with the CHEO, Executive Director of Equity and Community Health and other leaders to strengthen the organization's commitment and strategy to advance health equity and reduce health disparities of our member population, as well as to remain a diverse, equitable, and inclusive organization.

Director, Equity and Community Health (ECH) is responsible for program development and implementation for comprehensive population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ECH also supports

the Model of Care implementation for members, and reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.

Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services

Language Services

CalOptima Health's CLAS Program ensures all members have access to health care-related interpreter services in any language and translated member materials in CalOptima Health's threshold languages. CalOptima Health offers language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information in English, Spanish, Vietnamese, Arabic, Farsi, Korean and Chinese.
- Oral translation for other languages upon request or as needed, by a qualified translator at no cost.
- Routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay or modification of benefits, and the right to file a grievance or appeal at no cost.
- Free access to materials in alternative formats such as Braille, large print, data, and audio files.
- Free 24-hours access to telephonic interpreter services for members with limited English proficiency at no cost.
- Free remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

- "Language Interpreting Services" poster in the reception area where members can point to their preferred language
- Member Handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New Member Orientations
- Customer Service Call Center
- Health education workshops

- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations and public agencies

CalOptima Health also provides easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. CalOptima Health provides informational materials to members written at no higher than a sixth (6th) grade reading level and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

CalOptima Health ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Cultural & Linguistic Services Language Competency Testing

Cultural & Linguistic Services staff are tested quarterly to evaluate their language skills, logical thinking and translation competency for U.S. health care materials in each of the six CalOptima Health threshold languages: Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese.

The test consists of translating a sample document and replying to several questions. Based on their translation and answers, a trained evaluator will assess their translation competence. A trained evaluator will evaluate the translator's fluency in source and target language, their ability to transfer the source meaning into the target language, their familiarity with source and target culture, and their research skills.

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness with:

- **Race:** Any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape.

- **Ethnicity:** A group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- **Culture:** The ideas, customs, skills, arts, etc. of a people or group that are transferred, communicated or passed along to current or succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation and gender identity.

During the onboarding of new employees, on an annual basis, and as needed, CalOptima Health ensures staff, providers, health networks, and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Training courses include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new employee “Boot Camp” C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

For contracted health networks (including their subdelegates) and all staff who are in direct contact with (oral and/or written) members in the delivery of care or member services with individuals who identify as transgender, gender diverse or intersex (TGI), CalOptima Health ensures evidenced-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as TGI, every two years or more often if needed.

Promotion of Diversity, Equity and Inclusion

CalOptima Health is committed to reducing bias and improving diversity, equity and inclusion and supports initiatives to advance health equity for Medi-Cal members.

CalOptima Health is committed to workforce diversity and cultural responsiveness and supports initiatives to recruit, retain and train a diverse health care workforce that reflects the cultural and linguistic diversity of the communities serviced. This includes the following:

- Inclusive job descriptions and hiring practices.
- Training on the following topics for leaders:
    - Diversity, Inclusion and Unconscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Regular pay equity analysis
- Benefits and perks that support the diverse needs of employees (i.e., flexible work arrangements)

CalOptima Health is also committed to creating better relationships and connectivity with diverse members across populations disadvantaged by the system and supports initiatives to

create an inclusive environment within CalOptima Health and with network providers, and other community-based contractors and staff with lived experience. CalOptima Health ensures CalOptima Health staff, contracted health networks (including subdelegates), and network providers receive DEI training that includes the following up-to-date and evidence-based DEI trainings topics:

- Sensitivity
- Diversity
- Cultural Competency
- Cultural Humility
- Health Equity

Data Collect and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Complete, accurate data on race, ethnicity, disability, language, sexual orientation and gender identity and/or expression information for Medi-Cal members will be used to illuminate and evaluate the impact of CLAS on health equity and outcomes that will inform service delivery and address health inequities. Focus is placed on collecting, storing and retrieving member health care data in order to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identity and sexual orientation.
- Health outcomes
- Language preferences

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance, health care data and member experience data are stratified by race, ethnicity, language and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan where the progress of planned activities is tracked toward achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

CalOptima Health conducts regular assessments of community health assets and needs and uses the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. CalOptima Health annually conducts a Population Needs Assessment (PNA) to review and prioritize the needs of our member population and relevant subpopulations through data-driven planning and decision-making. The PNA considers the unique health needs of children and adults throughout Orange County who are enrolled in Medi-Cal including:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old

- Members with disabilities
- Member clinical and utilization trends, including analysis by racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations, including members who are pregnant or experiencing homelessness

The PNA's key findings are used to inform the annual CLAS Program, which aims to identify health disparities and address gaps in member cultural and linguistic needs. Key findings also help identify the need for process updates and resource allocation.