

2026 Medi-Cal Population Needs Assessment

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CalOptima Health, A Public Agency

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1. Population Needs Assessment Overview

1.1. Executive Summary

The 2026 Population Needs Assessment (PNA) provides a comprehensive analysis of the demographic, clinical and social factors shaping the health of CalOptima Health's Medi-Cal population. The National Committee for Quality Assurance (NCQA) and California Department of Health Care Services (DHCS) require a population assessment in their Population Health Management (PHM) requirements to ensure health plans systematically identify members' unique needs, risks and characteristics.

Drawing on 2025 data, this report examines membership trends, community conditions, disease prevalence, behavioral health needs and disparities across subpopulations. It also addresses emerging challenges, including policy changes, economic shifts and technological developments that affect how members access and engage with care. Together, these findings inform CalOptima Health's strategic direction and guide the development of targeted programs, partnerships and system-level interventions to advance health equity and improve outcomes for the communities we serve.

The broader policy environment is a significant driver of health access and utilization for CalOptima Health members. A shifting political climate, heightened immigration enforcement, and growing instability across social safety net programs are contributing to widespread uncertainty for families. Non-profit organizations and public agencies are simultaneously navigating post-COVID-19 funding constraints that continue to strain the community-based infrastructure on which members rely. Additionally, the rapid expansion of artificial intelligence and increasing reliance on digital health tools create new barriers for members with limited digital literacy, unreliable internet access or no email addresses – widening disparities rather than closing them. Simultaneously, growing expectations for data integration and exchange conflict with some members' privacy concerns, particularly when information related to immigration status, reproductive health or gender-affirming care could be subject to disclosure.

These contextual factors are resulting in noticeable clinical and social impacts across care settings. Providers report delays in preventive care, missed pediatric developmental screenings, lapses in immunizations, and growing concerns related to nutrition supports and economic insecurity. Members with chronic and complex conditions, as well as those navigating immigration-related stressors such as asylum requests or deportation threats, face compounding challenges that intersect with their clinical needs and disrupt care continuity. Access to gender-affirming care has also emerged as a significant concern, particularly for young people, due to recent policy changes.

In response, CalOptima Health is prioritizing strategies that reinforce access to care through expanded provider networks, investments in the healthcare workforce, and strengthened partnerships with safety net providers while maintaining ongoing awareness of the evolving policy landscape to respond swiftly to member needs.

1.2. Orange County Population and Community Assessments Landscape

Orange County has a robust ecosystem of community assessments that together illuminate the social, economic and environmental forces that drive health disparities and shape access to care. CalOptima Health's annual PNA sits at the intersection of this landscape, translating

countywide trends into a member-centered lens focused on the Medi-Cal population. Readers are encouraged to explore the assessments below as companion resources to this annual PNA:

Annual Report on the Conditions of Children in Orange County: Tracks child well-being indicators across Orange County, covering health, education, poverty and family stability.

Orange County Community Health Assessment (CHA): A local health jurisdiction (LHJ) assessment examining health status, needs and disparities across the county population. Under new DHCS guidance, LHJs will align to a standardized three-year cycle statewide, with the next CHA due December 2028.

Orange County Community Health Improvement Plan (CHIP): The action-oriented companion to the CHA, outlining priority strategies to address identified health needs. The CHIP is also moving to the statewide aligned cycle, due June 30, 2029.

Hospital Community Health Needs Assessments (CHNAs): Individual nonprofit hospitals conduct their own CHNAs periodically (typically every three years per IRS requirements). Orange County hospital CHNAs offer facility- and community-level health need data. Links to individual hospital CHNAs can be found on each health system's website.

Orange County Report on Older Adults: Focused assessment of the aging population in Orange County, covering health, social, economic and quality-of-life indicators relevant to seniors.

2026 Women & Girls of Orange County Report: The first comprehensive assessment of the conditions of women and girls in Orange County in more than three decades, establishing a countywide baseline to support data-driven policy and program development. Covers mental health, economic equity, financial security, education, leadership, housing, health care, and violence and domestic abuse.

OC Community Indicators Report 2024–2025 (OC Business Council): A broader socioeconomic and quality-of-life snapshot of Orange County, covering workforce, housing, education and health from a regional planning lens.

BHSA Behavioral Health Integrated Plan (2026–2029): Orange County's three-year integrated behavioral health spending and services plan, required under the Behavioral Health Services Act. Covers multiple behavioral health funding streams with a focus on reducing disparities and addressing unmet needs across the full care continuum.

CalOptima Health Member and Population Health Needs Assessment (MPHNA): Scheduled for release in August 2026, the MPHNA is a comprehensive mixed-methods study assessing the whole-person health needs, access-to-care gaps and community assets of CalOptima Health's member population in Orange County. This assessment incorporates primary data collection using member surveys in eight threshold languages, a provider survey, focus groups and key stakeholder interviews, combined with secondary data analysis of member demographics, social needs and use of services; county and hospital health assessments; and national, state and county public data sources. The MPHNA will detail a comprehensive report of findings with actionable recommendations to inform future planning, program development and community investments for CalOptima Health. In addition, it will feature an interactive Community Resource Map identifying existing resources and highlighting gaps and opportunities for community collaboration across Orange County.

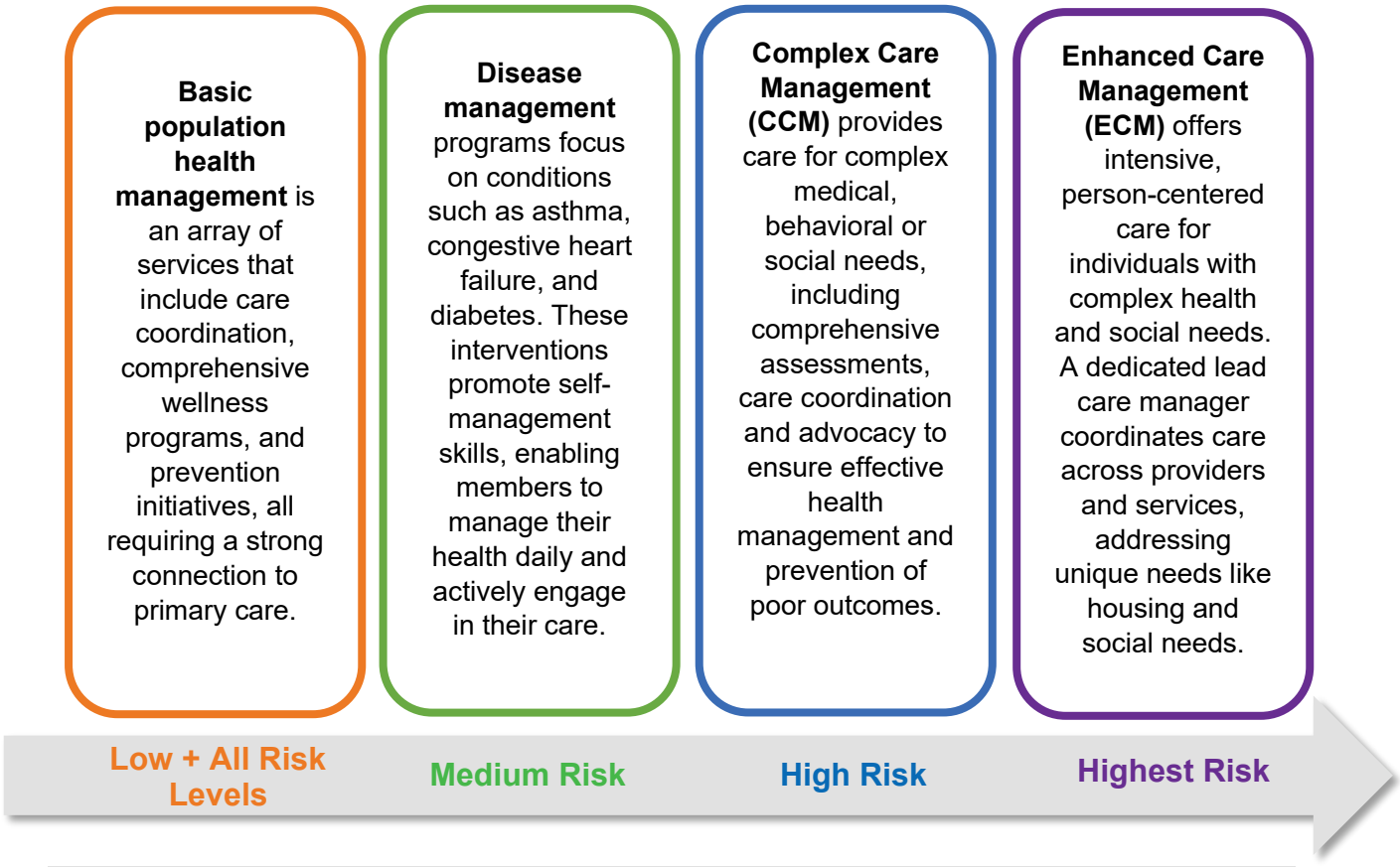
1.3. Population Segmentation and Care Coordination

CalOptima Health utilizes segmentation and risk stratification methodologies to better understand the risk profiles of its member population. By integrating demographic, clinical, social and utilization data, CalOptima Health groups members into meaningful segments that guide effective resource allocation, support tailored interventions, and ensure members receive the appropriate level of care to improve outcomes and reduce avoidable utilization.

Members are stratified into four risk levels to guide the intensity of care coordination and support they receive. Regardless of risk tier, all members have access to basic population health management services, including comprehensive wellness programs and prevention initiatives anchored in a strong connection to primary care.

- Low risk — Members who are generally healthy or have well-managed chronic conditions and do not require additional care coordination beyond routine preventive and primary care
- Medium risk — Members with early indicators of increasing medical, behavioral health or social complexity who may benefit from targeted outreach to prevent escalation in risk
- High risk — Members with multiple chronic conditions, significant utilization patterns, or notable risk factors that require structured care management
- Highest risk — Members with complex medical, behavioral and social needs who require intensive, proactive care coordination

Based on risk levels, members may receive, but are not limited to, the following services:



2. Methodology

To provide a comprehensive understanding of CalOptima Health's Medi-Cal membership needs, an extensive review of multiple data sources and reference materials was conducted. Data review of this assessment included CalOptima Health's administrative, clinical and encounter information, supplemented by external reports and community-level datasets. Key data sources included:

- Member demographic data
- Medical and behavioral claims and encounters
- Pharmacy claims
- Laboratory results
- Health appraisal results
- Health services programs within CalOptima Health
- Advanced data sources

Performance indicators were also included to support benchmarking, identify care gaps and guide quality improvement efforts. These indicators consisted of measures such as:

- Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year (MY) 2022–2024: A comprehensive set of standardized measures from NCQA used to evaluate and compare health plan performance.
- Medi-Cal Managed Care Accountability Set (MCAS) MY 2022–2024: Performance measures selected by DHCS for annual reporting by Medi-Cal managed care health plans.

To enhance and contextualize the population assessment, internal data was supplemented with publicly available data sources and community-level information. These data sources included:

- The Public Health Alliance of Southern California, California Healthy Places Index Map
- U.S. Census Bureau, American Community Survey (ACS) 2024 1-Year Estimate

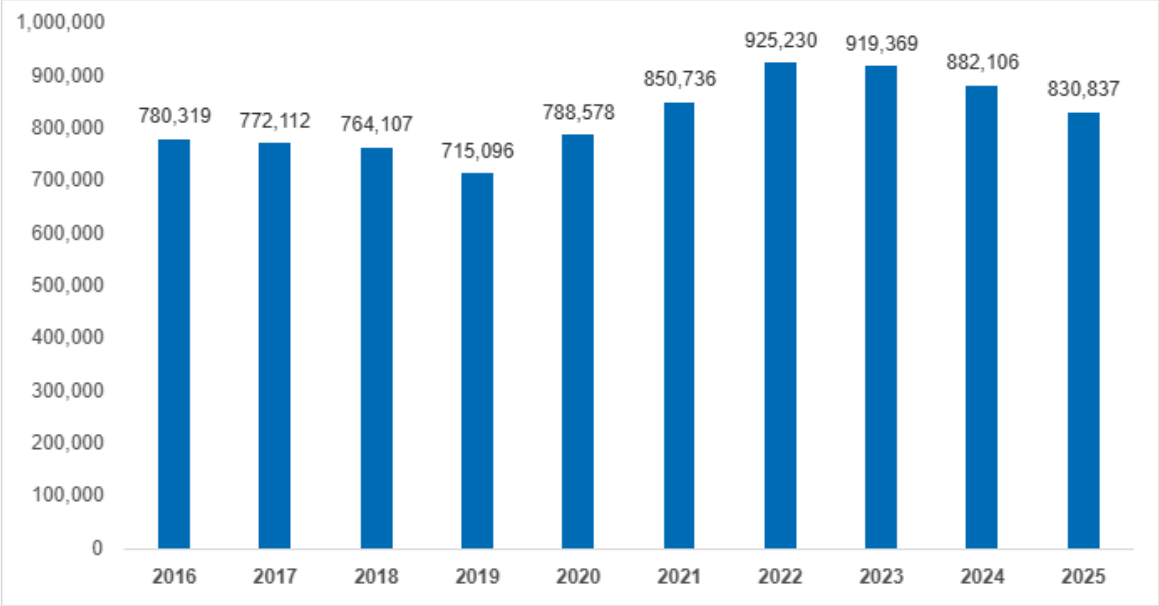
Findings from the assessment inform PHM activities and ensure that programs and resources are appropriately aligned with member needs. CalOptima Health reviews and updates these data at least annually to remain aligned with evolving population needs and emerging health and social risk trends.

3. Membership Profile

CalOptima Health monitors membership volume and trends over time to ensure adequate capacity, network access and resources to meet the evolving needs of its members. The chart below reflects a decade of enrollment trends, capturing the significant expansion of Medi-Cal eligibility during the COVID-19 pandemic and subsequent decline following the end of the federal continuous enrollment requirement.

3.1. Medi-Cal Membership

CalOptima Health Medi-Cal Membership Trends



Data Source: CalOptima Health (2016-2025). Membership Tableau Dashboard. Accessed February 2026.

Analysis:

CalOptima Health's Medi-Cal membership continued to decline in 2025, totaling 830,837. This reflects a decrease of 51,269 members from 2024 and a cumulative reduction of 94,393 members since the 2022 peak of 925,230. This represents the third consecutive year of enrollment decline, driven primarily by the return of the annual Medi-Cal redetermination process following the end of the COVID-19 public health emergency. As redetermination resumed, many members who had maintained coverage under the federal continuous enrollment requirement were found ineligible or lost coverage due to administrative barriers such as outdated contact information and incomplete renewal submissions. Steeper membership declines are anticipated in 2026, driven by additional federal policy changes affecting eligibility, including new work requirements and narrowed immigrant eligibility. Members with Unsatisfactory Immigration Status (UIS) are addressed in further detail in the Immigration Status section.

Conclusion:
As Medi-Cal enrollment declines through 2026 and beyond, many members risk losing coverage and access to essential services. While state and local efforts aim to mitigate these impacts, CalOptima Health must sustain robust, community-based outreach to support retention and prevent avoidable disenrollment. This shift from pandemic-era growth to sustained contraction requires CalOptima Health to manage the operational challenges of a shrinking membership while ensuring remaining members continue to receive high-quality, well-coordinated care. Strong outreach infrastructure and community partnerships will be critical to connecting eligible individuals with the coverage and support they need.

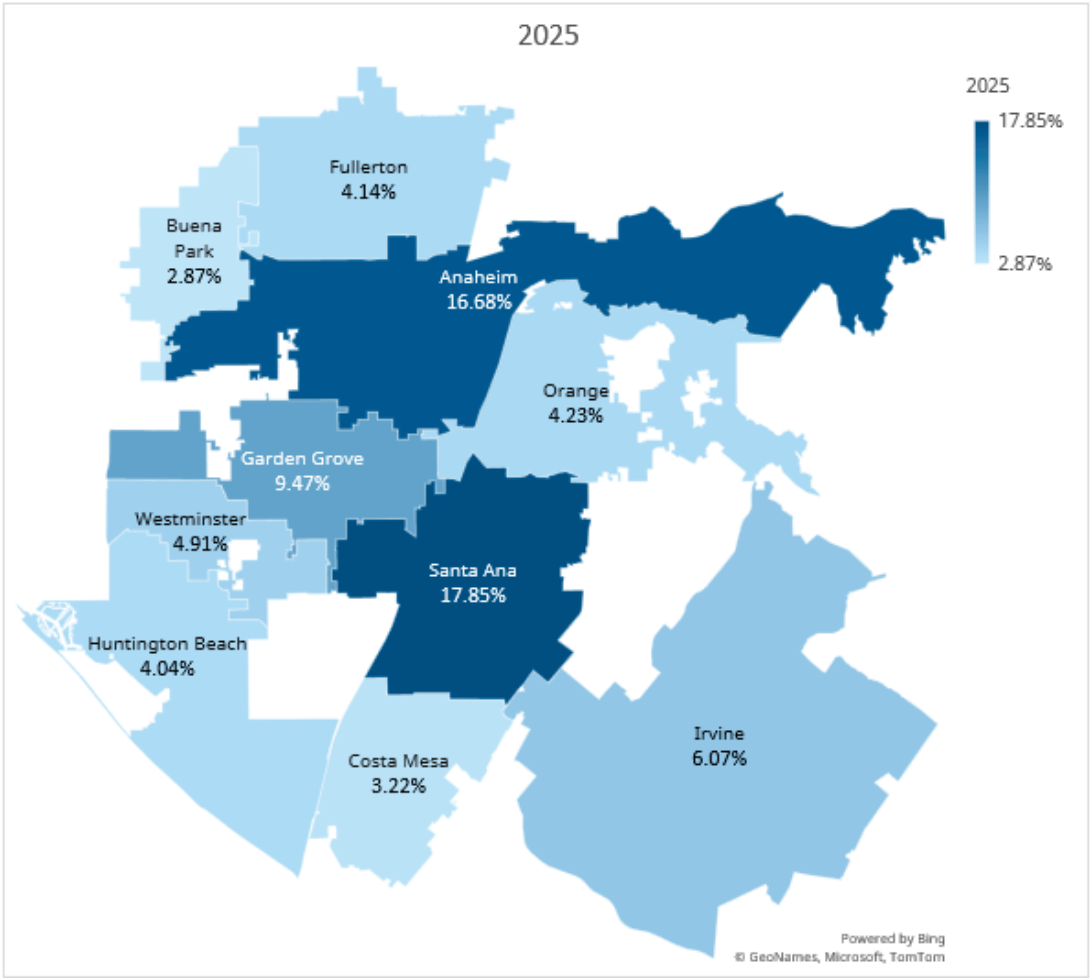
Activities/Resources to Address Gap:
To support member retention amid escalating policy changes, CalOptima Health is implementing a multifaceted strategy, including:

- Launching a Covered California program effective January 1, 2027, to provide continuity of care and expand access to affordable healthcare coverage for Orange County residents who may cycle in and out of Medi-Cal eligibility.
- Continued grant funding for community-based organizations to serve as trusted messengers supporting Medi-Cal enrollment, renewals and education.
- Rolling out Get Care Now and other communication campaigns to reinforce CalOptima Health's role as Orange County's health care safety net, emphasize coverage maintenance and educate members on options for accessing care through policy changes.

3.2. City and Living Conditions

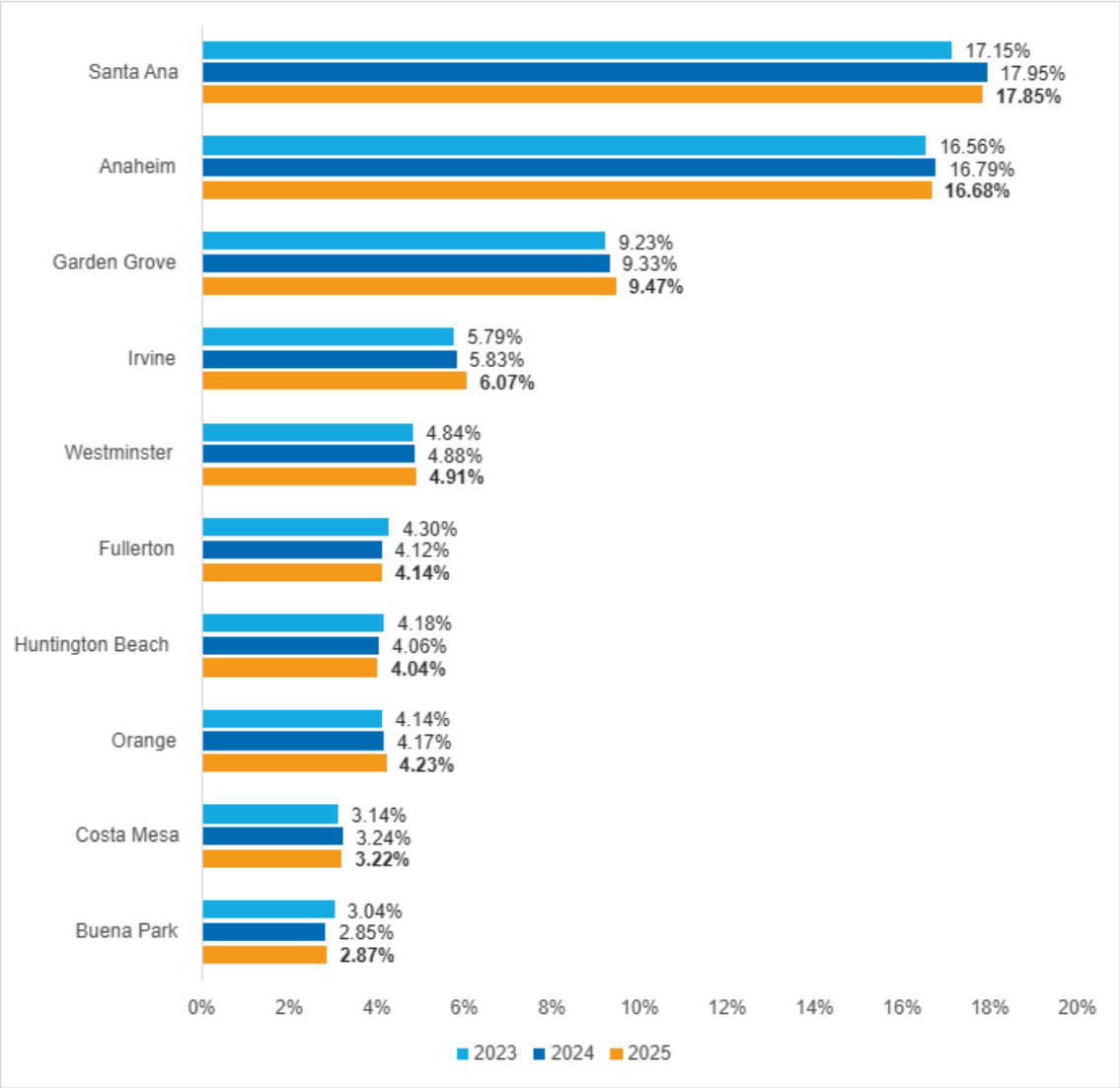
Where members live shapes how they experience health. CalOptima Health analyzes the geographic distribution of its membership alongside community-level indicators of social and economic conditions to better understand the environmental context in which members access care.

2025 Medi-Cal Membership by City



Data Source: CalOptima Health (2025). Membership Tableau Dashboard. Accessed February 2026.

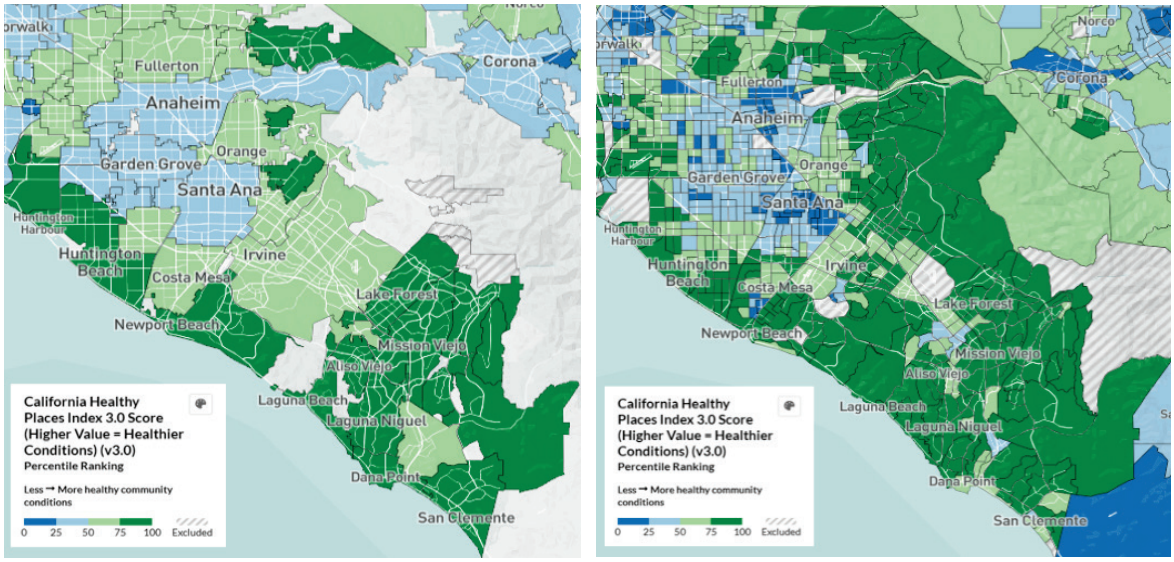
Medi-Cal Membership by City



Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed February 2026.

California Healthy Places Index[1]

By Cities **By Census Tracts**



Analysis:

In 2025, the majority of CalOptima Health's Medi-Cal members continued to reside in central Orange County. Santa Ana remained the city with the highest share of membership at 17.85%, followed closely by Anaheim at 16.68% and Garden Grove at 9.47%. Together, these three cities accounted for approximately 44% of total membership. This concentration in central Orange County has remained consistent over the three-year trending period from 2023 to 2025, with each of these three cities showing modest upward movement. Notably, Santa Ana's share increased from 17.15% in 2023 to 17.85% in 2025, and Garden Grove grew from 9.23% to 9.47% over the same period. Outside these central cities, Irvine (6.07%), Westminster (4.91%), Orange (4.23%), Fullerton (4.14%), Huntington Beach (4.04%), Costa Mesa (3.22%) and Buena Park (2.87%) round out the top 10 cities where members live.

To understand the living conditions shaping member health, CalOptima Health referenced the California Healthy Places Index (HPI) 3.0, which combines 25 community-level indicators (including access to health care, housing quality, education and economic opportunity) into a composite score reflecting the social conditions that predict life expectancy. The HPI map by city illustrates markedly lower scores in central Orange County relative to the county overall (80.4%), with Santa Ana scoring 29.0%, Anaheim 43.9% and Garden Grove 43.6%. At the census tract level, conditions are even more pronounced, with select neighborhoods scoring as low as 5.6% (Santa Ana near 17th Street and North Broadway), meaning they rank healthier than only 5.6% of communities statewide. These low-scoring tracts are concentrated precisely in the areas where CalOptima Health's membership is densest. According to

[1] The Public Health Alliance of Southern California. (2022). California Healthy Places Index., https://map.healthyplacesindex.org/?redirect=false

CalEnviroScreen, cities in central Orange County also carry a disproportionate environmental pollution burden, compounding the social and economic disadvantages already reflected in the HPI[2].

Conclusion:
Membership distribution in 2025 confirms a persistent pattern: CalOptima Health's highest-need members are concentrated in communities with the lowest HPI scores, the highest poverty rates and the greatest environmental burden. The modest but steady increases in membership share in Santa Ana, Anaheim and Garden Grove reinforce the need for sustained, community-based approaches to outreach and service delivery. Health conditions do not exist in isolation from the places people live. Housing instability, environmental exposures, limited economic opportunity and reduced access to preventive care intersect to shape health outcomes for members in these communities. Addressing disparities in health outcomes requires meeting members where they are and designing interventions that account for the full context of their lives.

Activities/Resources to Address Gap:
In response to the geographic concentration of members in high-need communities, CalOptima Health has made significant direct investments in the cities where members live through its Street Medicine program, countywide housing investments and community-based partnerships.

CalOptima Health's Street Medicine Program deploys mobile medical teams directly into the communities where unhoused members live, delivering primary care, peer support, care management and housing navigation. The program operates across Garden Grove, Costa Mesa, Anaheim and Santa Ana, and has collectively served more than 850 members across all sites (as of August 2025).

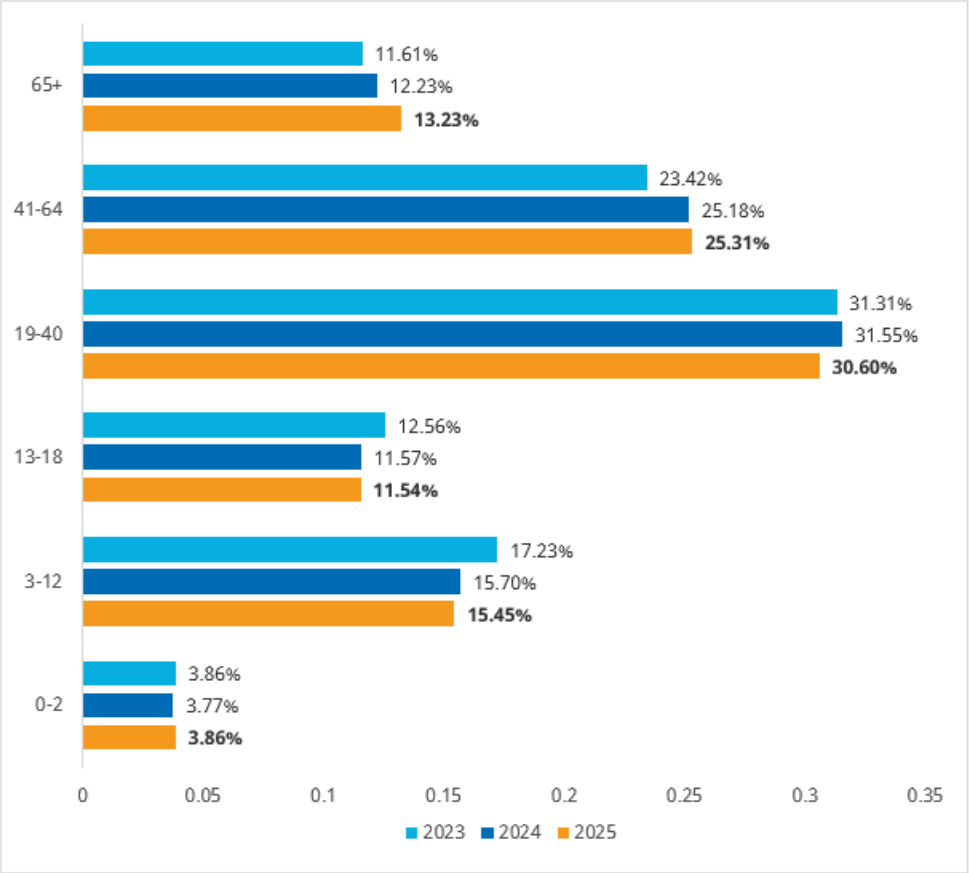
Through CalOptima Health's Housing and Homelessness Incentive Program (HHIP), CalOptima Health has directed grant funding toward transitional and permanent supportive housing and expanded community-based services, and systems change initiatives across Orange County. Grant investments have supported a range of community partners working with vulnerable populations, including justice-involved youth and families facing housing insecurity. CalOptima Health has also partnered with several housing authorities, including those in Anaheim, Garden Grove and Santa Ana, to streamline Medi-Cal enrollment for individuals receiving or applying for rental assistance, and connect them with CalAIM services that address housing insecurity and other needs.

3.3. Age

CalOptima Health serves members across all stages of life, and understanding the age distribution of its membership is critical to ensuring that programs, services and resources are appropriately tailored to meet the needs of each group.

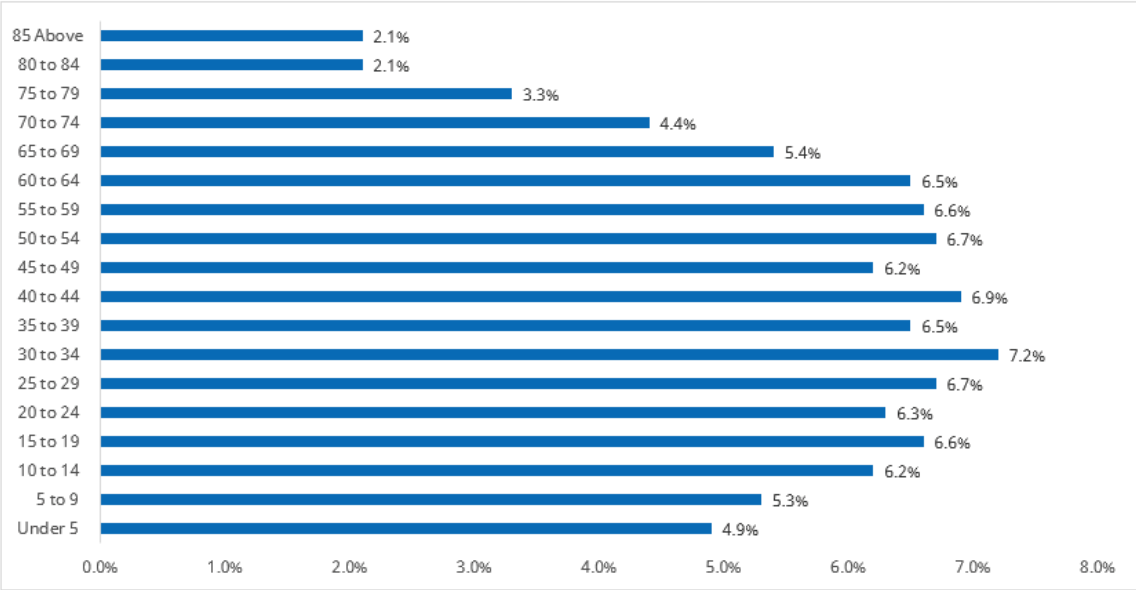
[2] https://oehha.ca.gov/calenviroscreen

CalOptima Health Medi-Cal Membership by Age



Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed February 2026.

Orange County Population by Age



Data Source: U.S. Census Bureau (2024). American Community Survey 1-Year Estimates. Accessed February 2025.

Analysis:
Member data from 2025 reflects a continued demographic shift within CalOptima Health's Medi-Cal population. Adults ages 19–64 remain the largest segment at approximately 55.91%, comprised of members ages 19–40 (30.60%) and 41–64 (25.31%). This represents a slight decline from 56.73% in 2024, largely attributable to redetermination-related attrition and the enrollment freeze for new undocumented adults, which disproportionately affects working-age adults. Children ages 0–18 represent approximately 30.85% of membership, a continued gradual decline from 31.04% in 2024 and 33.65% in 2023. Older adults aged 65 and up account for 13.23%, an increase from 12.23% in 2024 and 11.61% in 2023. The steady upward trend in 65+ enrollment reflects broader demographic aging patterns and continued growth in this cohort's Medi-Cal eligibility.

When compared with the Orange County population overall using U.S. Census Bureau American Community Survey (ACS) data, CalOptima Health's membership skews younger but continues to trend toward greater alignment with countywide aging patterns. The ACS data shows that Orange County's population is broadly distributed across age groups, with the largest single cohort in the 30–34 range (7.2%), and older adults ages 65 and above collectively comprising a substantial share of the county population.

Conclusion:
The continued growth of enrollment among older adults underscores the increasing complexity of care needs within CalOptima Health's membership. Older adults are more likely to have multiple chronic conditions, require more frequent and coordinated care, and generate higher overall health care costs. At the same time, the gradual decline in the child population warrants monitoring, as children represent a key population for preventive care investment that yields long-term health outcomes. These trends reinforce the need for a care continuum that is responsive across the lifespan — from pediatric prevention and development to chronic condition management and senior-focused care coordination.

Activities/Resources to Address Gap:
To meet the evolving needs of the adult and senior Medi-Cal members, CalOptima Health's PHM Program delivers whole-person, equitable and high-quality services across the care continuum, including basic population health management, chronic condition management, CCM and ECM. These programs are designed to support members across risk levels, with higher-intensity services available for those with the most complex medical and social needs.

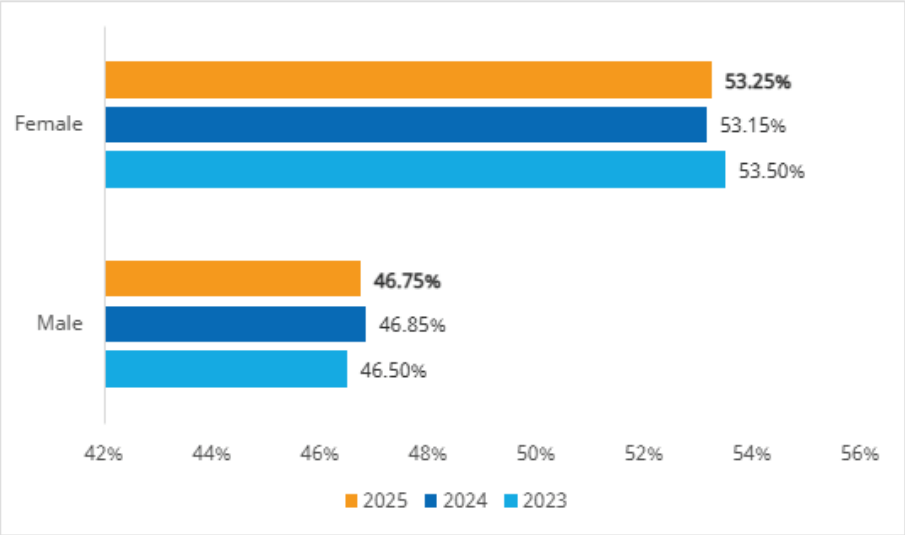
To support the growing senior population specifically, CalOptima Health offers OneCare, a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) that combines Medi-Cal and Medicare benefits for seniors and people with disabilities, as well as the Program of All-Inclusive Care for the Elderly (PACE), which provides comprehensive health and social services enabling frail elders to remain living at home.

For children and adolescents, CalOptima Health continues to offer a range of programs addressing pediatric chronic conditions, behavioral health and developmental needs, including the Whole-Child Model for members with complex conditions and the services initiated through the Student Behavioral Health Incentive Program (SBHIP) in partnership with all 28 Orange County public school districts and the Orange County Department of Education.

3.4. Gender

CalOptima Health monitors the gender composition of its membership to ensure that programs and services are equitably designed and responsive to the distinct health needs of all members, including those related to reproductive health, gender-affirming care and conditions that disproportionately affect specific gender groups.

CalOptima Health Medi-Cal Membership by Sex at Birth



Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed February 2026.

Analysis:
CalOptima Health's female membership (53.25%) continues to exceed male membership (46.75%) in 2025, a modest increase from 53.15% in 2024. This distribution has remained consistent over the three-year trending period from 2023 to 2025, with female membership hovering between 53% and 54%. By comparison, the Orange County population overall reflects a narrower gap, with 50.44% female based on ACS 2019–2023 5-Year Estimates.

Conclusion:
The higher proportion of female members in CalOptima Health's Medi-Cal population is consistent with national Medicaid trends, where women are more likely to qualify through pregnancy-related eligibility and to meet income thresholds due to wage disparities.

Activities/Resources to Address Gap:
Given that female members represent the majority of CalOptima Health's Medi-Cal membership, several programs are specifically designed to address the health needs of women across their lifespans.

Maternal Health Program: CalOptima Health's Maternal Health Program supports members through pregnancy and the postpartum period, offering telephonic outreach, nutrition, health education, and connection to support services and community resources. The program

coordinates with providers through pregnancy notification and delivers trimester and postpartum follow-up to help ensure healthy outcomes for both mothers and newborns.

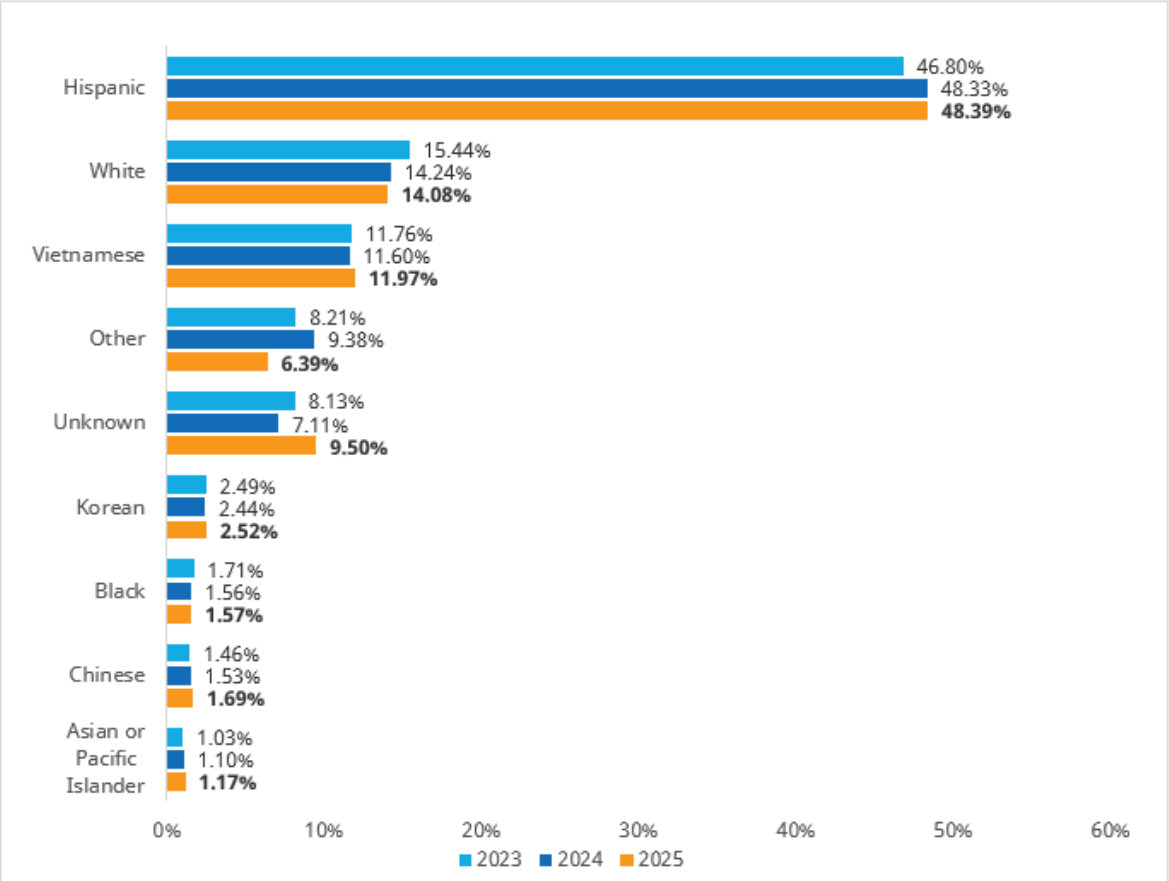
Comprehensive Community Cancer Screening Program: CalOptima Health's Comprehensive Community Cancer Screening Program aims to reduce late-stage diagnoses of breast, cervical, colorectal and lung cancers, with a particular emphasis on Hispanic women. Although Hispanic women experience a 20%–30% lower incidence of breast cancer compared to non-Hispanic White women, they face higher mortality rates due to lower screening participation and more frequent late-stage detection. To close this gap, the program brings mobile mammography services directly into the communities where members live, such as Northgate Gonzalez Market in Anaheim, providing no-cost screenings in familiar, accessible settings.

Member Health Rewards Program: CalOptima Health provides member rewards to encourage female members to complete key preventive screenings, including mammograms and cervical cancer screenings, providing an incentive to access early detection and engage with preventive care.

3.5. Race/Ethnicity

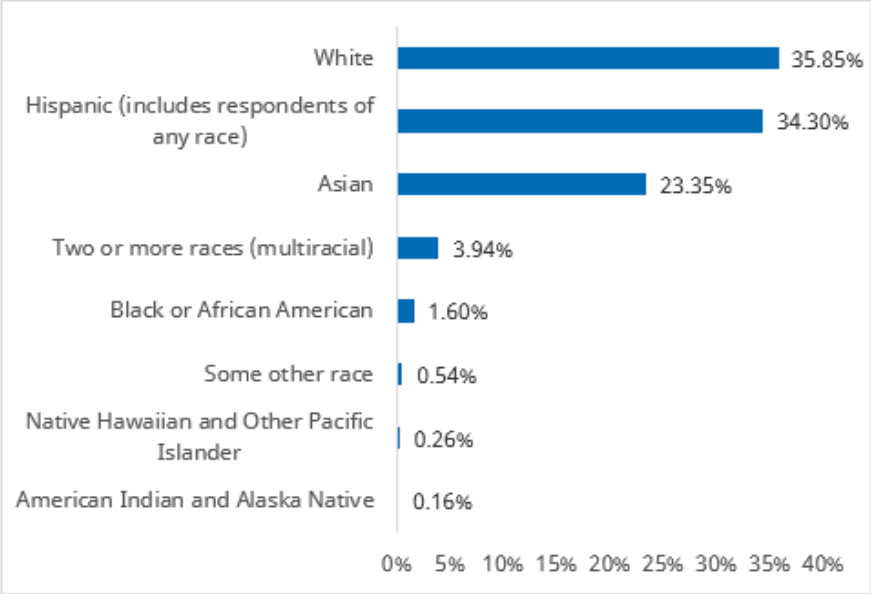
Understanding the racial and ethnic composition of its membership is fundamental to CalOptima Health's commitment to health equity, enabling the plan to identify disparities, tailor culturally responsive interventions, and direct resources to the communities that carry the greatest burden of unmet health needs.

CalOptima Health Medi-Cal Membership by Race/Ethnicity



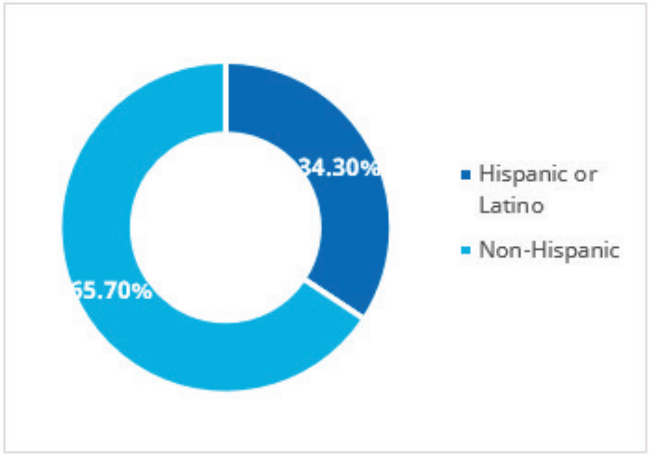
Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed February 2026.

Orange County Population by Race



Data Source: U.S. Census Bureau (2024). American Community Survey 1-year estimates. Accessed February 2026.

Orange County Population by Ethnicity



Data Source: U.S. Census Bureau (2024). Hispanic or Latino Origin by Race American Community Survey 1-year estimates. Accessed February 2026.

Analysis:

The majority of CalOptima Health members self-identify as Hispanic (48.39%), followed by White (14.08%) and Vietnamese (11.97%). By comparison, Orange County data from the U.S. Census ACS (2024) shows the largest racial group is White (35.85%), followed by Asians (23.35%). A notable portion of CalOptima Health's members continue to report Other or Unknown race/ethnicity, limiting direct comparisons with county-level data. Both CalOptima Health and Orange County significantly vary in the stratification of their race and ethnicity data, which limits the opportunity to compare data directly. The composition of CalOptima

Health's membership has remained broadly consistent over the three-year trending period, with Hispanic members continuing to represent nearly half of total enrollment.

Conclusion:

While the majority of members self-identify as Hispanic, a significant portion is categorized as Other or Unknown race/ethnicity, indicating an ongoing gap in racial and ethnic identification. Smaller populations within the membership, including Korean, Black, Chinese, and Asian or Pacific Islander members, highlight that CalOptima Health serves a diverse but disproportionately underrepresented mix of non-Hispanic and non-Vietnamese communities. This indicates an opportunity to address gaps in culturally appropriate outreach, engagement and data completeness for certain racial and ethnic groups within the overall membership.

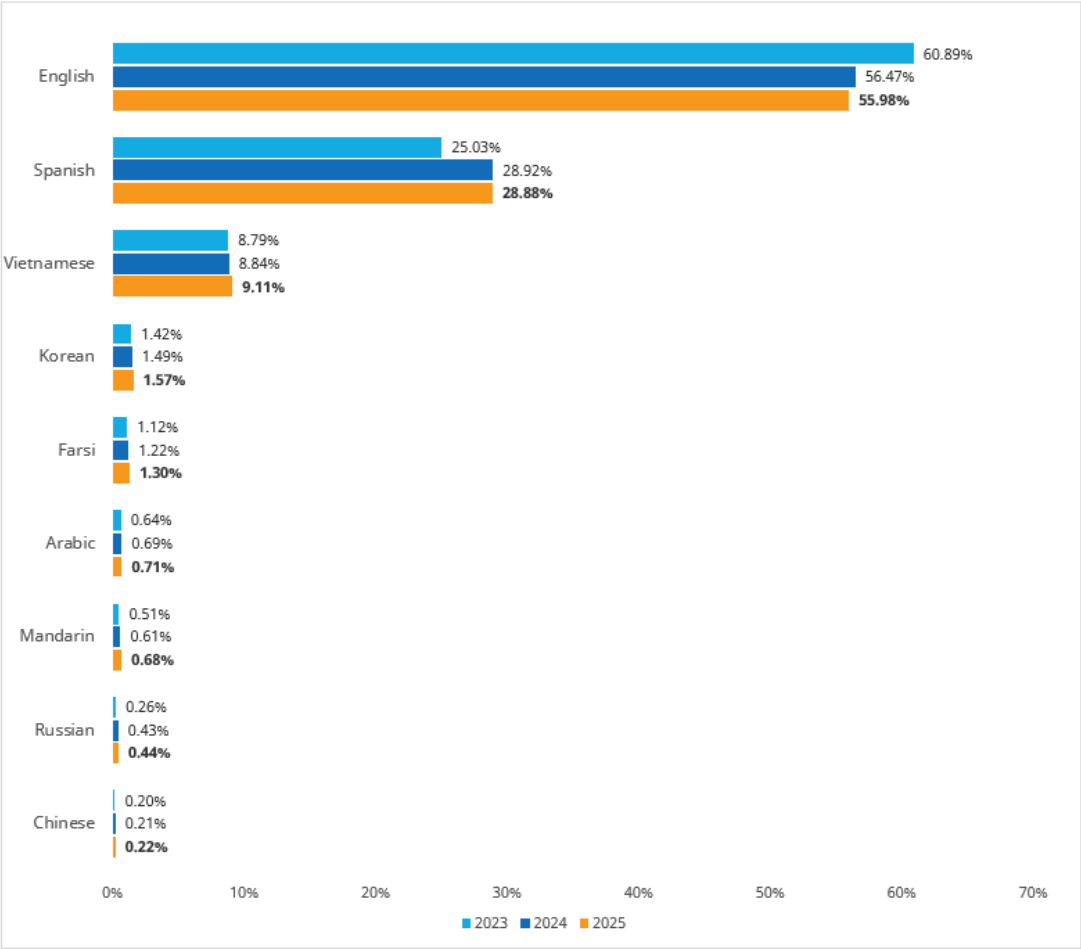
Activities/Resources to Address Gap:

To best serve the needs of its racially and ethnically diverse populations, CalOptima Health requires annual provider training on cultural competency, health equity, and gender-affirming care. In 2025, CalOptima Health also launched a series of in-person gatherings called Culture and Health Conversations. These events bring together community leaders and health care professionals to explore how culture and lived experiences shape health outcomes. Community-based organizations serving Cambodian, Vietnamese, and Hispanic/Latino communities partnered with CalOptima Health to engage nearly 300 participants in these sessions. Additional sessions are planned for 2026 with an expanded focus on gathering insights for codesigning prevention campaigns.

3.6. Primary Language

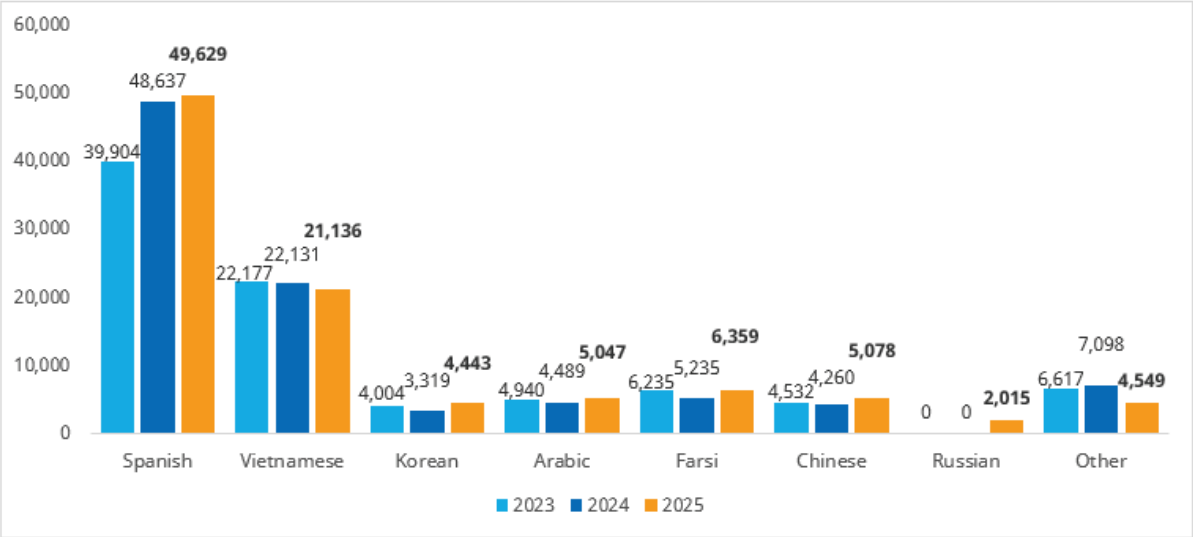
CalOptima Health tracks the primary languages spoken by its members to ensure that language is not a barrier to accessing care and to guide ongoing investment in culturally and linguistically appropriate services across the membership, including translation and interpretation.

CalOptima Health Medi-Cal Membership by Primary Language



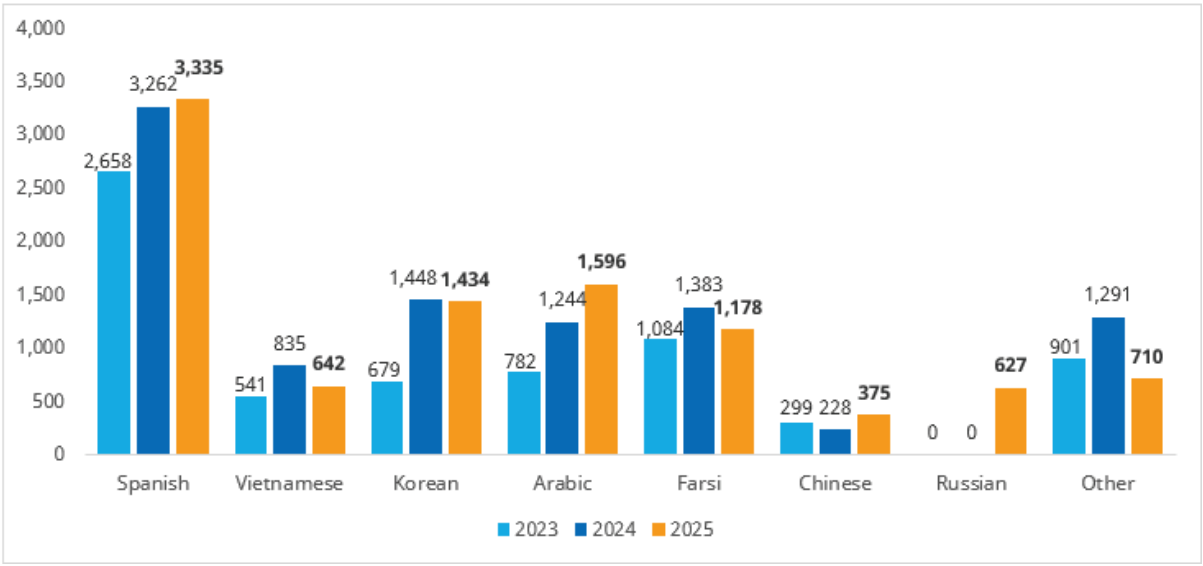
Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed April 2026.

CalOptima Health Telephonic Interpretation Services by Language



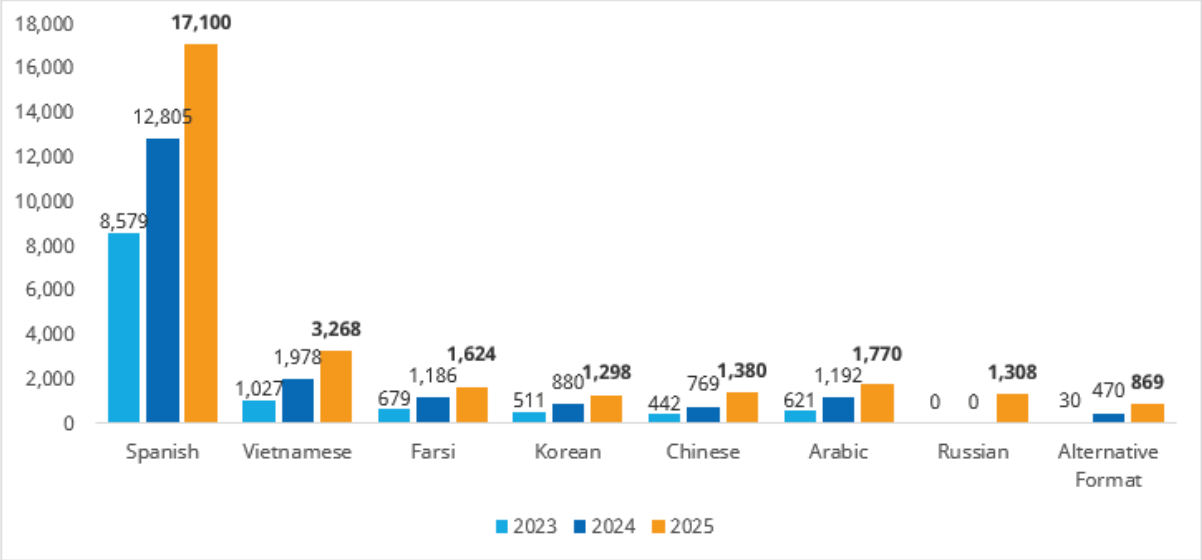
Data Source: CalOptima Health (2025). 2025 Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation.

CalOptima Health Face-to-Face Interpretation Services by Language



Data Source: CalOptima Health (2025). 2025 Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation.

CalOptima Health Document Translation Services by Language



Data Source: CalOptima Health (2025). 2025 Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation.

Analysis:

CalOptima Health members represent a linguistically diverse population. In 2025, English remained the most commonly spoken primary language (56.02%), followed by Spanish (28.88%) and Vietnamese (9.12%). Utilization of language assistance services like telephonic interpretation, face-to-face interpretation and document translation increased across all six threshold languages other than English (Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese) compared with prior years. Spanish and Vietnamese were the most frequently used languages for telephonic interpretation, consistent with member demographics. Face-to-face interpretation and document translation were also most often requested in Spanish, Vietnamese and Korean. In 2025, Russian was introduced as a new CalOptima Health threshold language to meet DHCS requirements, and a full-time Russian translator was hired to support in-house Russian translation.

Conclusion:

The addition of Russian as a threshold language reflects CalOptima Health's ongoing commitment to identifying and responding to the evolving language needs of its membership in compliance with DHCS requirements. The data reinforces the importance of improving the accuracy and consistency of member language data and continuing to expand access to culturally and linguistically appropriate services (CLAS) to ensure that all members can effectively engage with their health care. Continued investment in language assistance services is essential to reducing disparities in care access and outcomes for members with limited English proficiency.

Activities/Resources to Address Gap:

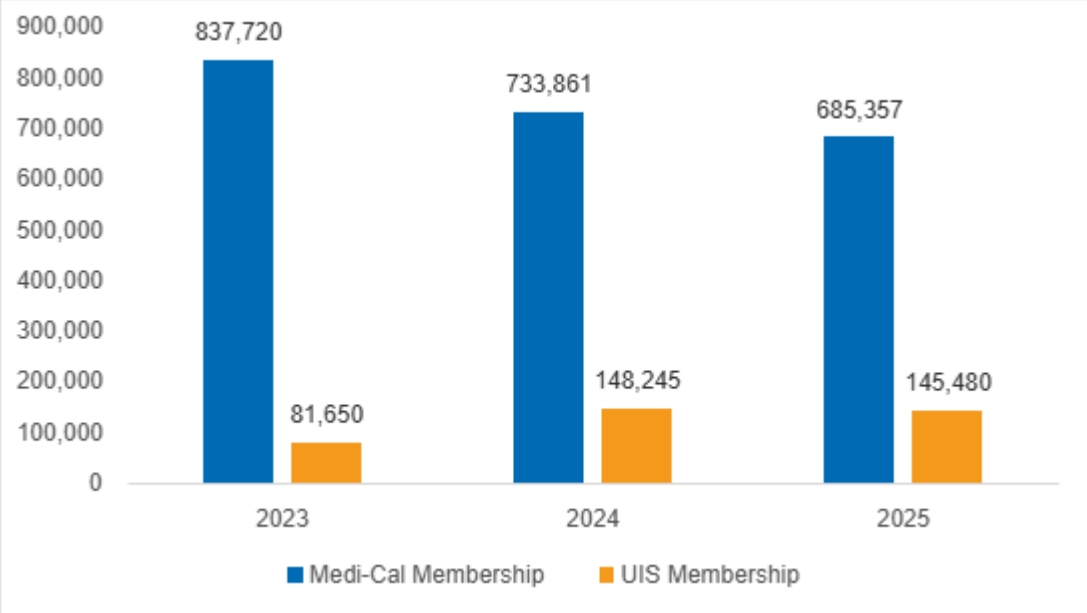
CalOptima Health provides member materials in eight threshold languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic and Russian. Language services include 24-hour telephonic and face-to-face interpretation at key points of contact. CalOptima Health includes multilingual notifications with all mailed member communications, written in more than 15

languages, reflecting all threshold languages in compliance with DHCS guidelines. A full-time Russian translator was hired in 2025 to support in-house translation capacity for the growing Russian-speaking member population. Additionally, CalOptima Health launched member and staff satisfaction surveys for language services to help improve the quality of services provided. Document translation services are available across all member-facing communications, including notices, care plans, and educational materials. CalOptima Health monitors the availability of primary care providers (PCPs) by language to identify and address access gaps for members with limited English proficiency, and bilingual staff are tested quarterly to evaluate language skills and translation competency across all the threshold languages.

3.7. Immigration Status

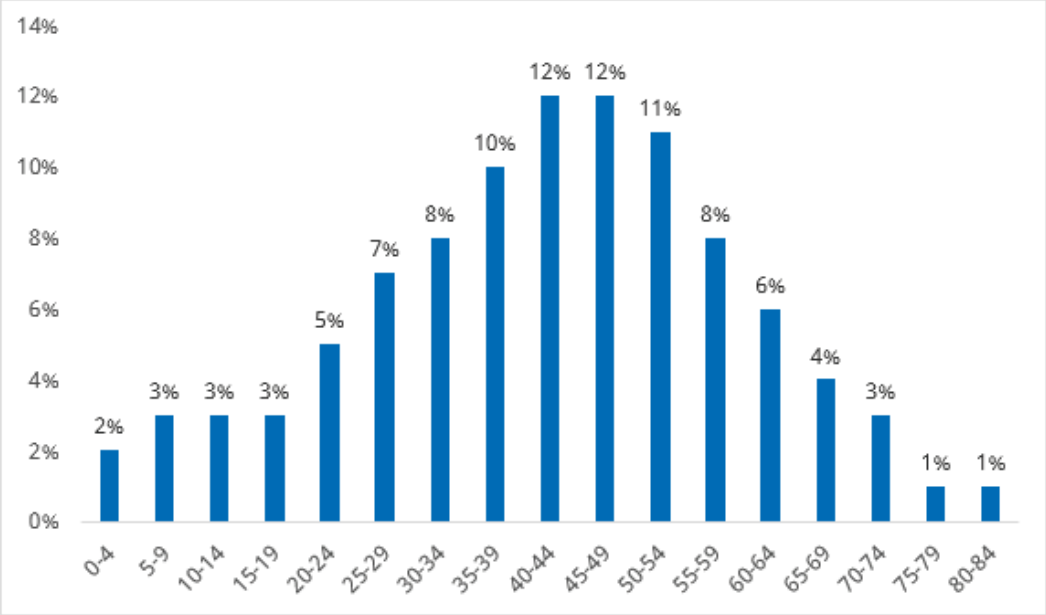
CalOptima Health Medi-Cal Members: Unsatisfactory Immigration Status

Members with UIS represent a significant and vulnerable segment of CalOptima Health's Medi-Cal membership whose access to coverage is directly shaped by federal and state policy. CalOptima Health closely monitors enrollment trends for this population to anticipate coverage impacts and ensure continuity of care for affected members.



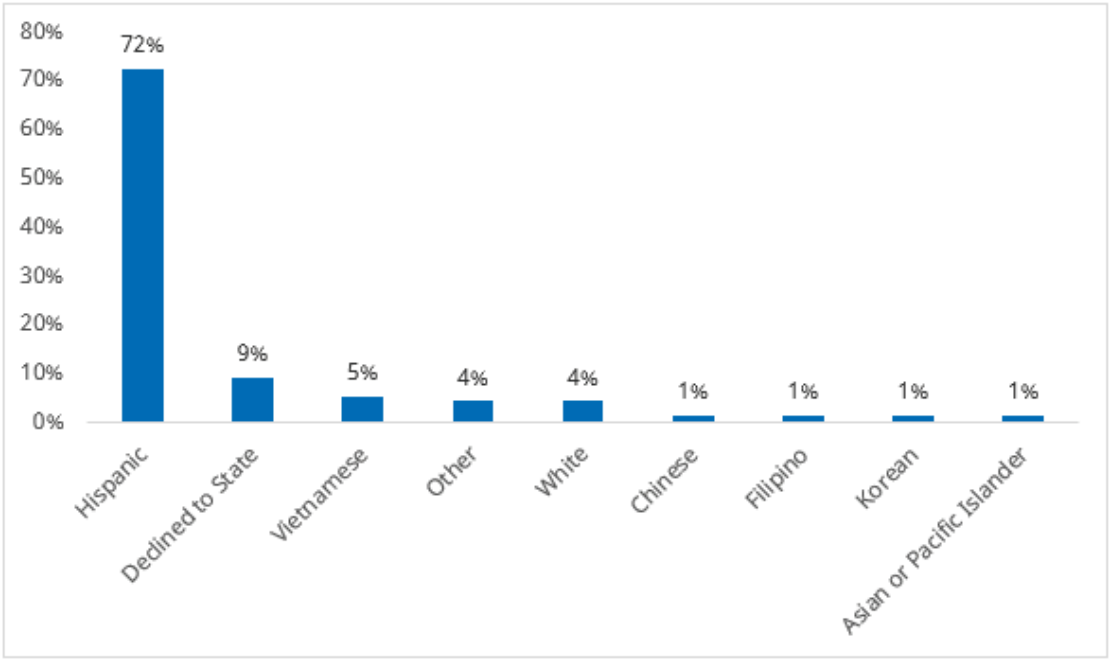
Data Source: CalOptima Health (2023–2025). Membership Tableau Dashboard. Accessed February 2026.

Unsatisfactory Immigration Status by Age



Data Source: CalOptima Health (2025). Membership Tableau Dashboard. Accessed April 2026.

Unsatisfactory Immigration Status by Ethnicity



Data Source: CalOptima Health (2025). Membership Tableau Dashboard. Accessed April 2026.

Analysis:
In 2025, 145,480 members had UIS, a decrease of 2,765 from 2024. This follows a sharp rise from 2016 to 2024, when California incrementally expanded Medi-Cal eligibility to low-income residents regardless of immigration status. Steeper membership declines are anticipated to continue in 2026 following the enrollment freeze for nonpregnant UIS members ages 19 and older, effective January 1, 2026.

The UIS population is predominantly working-age adults, with the largest concentrations in the 40–44 and 45–49 age groups (12% each), followed by members ages 50-54 (11%). Together, members ages 35–54 represent nearly half of the UIS population. Children and adolescents under 20 years old collectively represent approximately 11%, while older adults ages 65 and above account for approximately 6%.

Ethnically, the UIS population is overwhelmingly Hispanic at 72%, higher than the 69% Hispanic share of the overall Medi-Cal membership, followed by members who declined to state their ethnicity (9%), Vietnamese (5%), Other (4%) and White (4%). This ethnic and linguistic concentration underscores the importance of Spanish and Vietnamese outreach as the primary vehicles for reaching and retaining this population.

Conclusion:
The enrollment freeze, effective January 1, 2026, for nonpregnant UIS members ages 19 and older represents a significant and immediate risk of coverage loss for this population. The concentration of UIS members in the 35–54 age range signals a population with a growing chronic disease burden over time, making continuity of coverage and access to preventive and disease management services particularly important. While state and local action aims to reduce these risks through policy advocacy and enhanced outreach, CalOptima Health will work to maintain strong, community-based engagement to support member retention, prevent avoidable disenrollment and ensure that members who lose Medi-Cal eligibility have access to other sources of care.

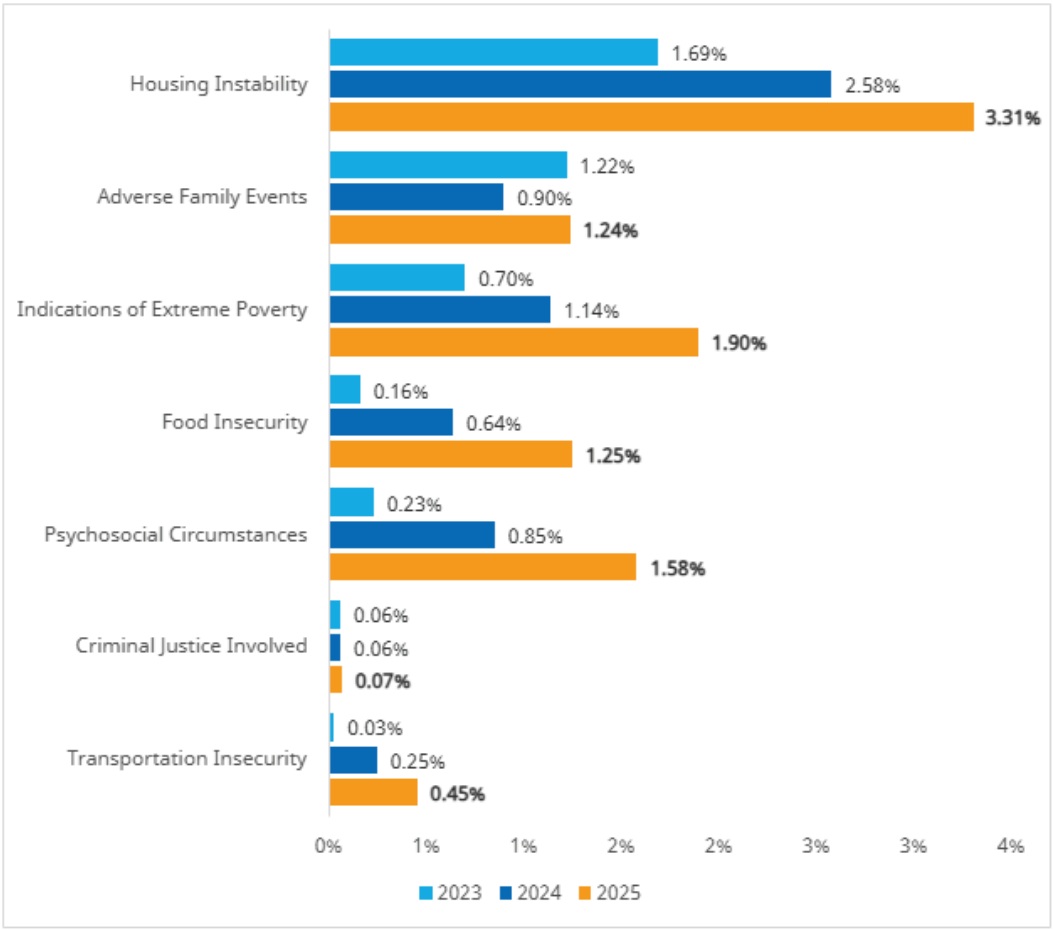
Activities/Resources to Address Gap:
To support member retention amid escalating policy changes, CalOptima Health is implementing a multifaceted strategy, including:

- Launching a Covered California program effective January 1, 2027, to provide continuity of care and expand access to affordable healthcare coverage for Orange County residents who may cycle in and out of Medi-Cal eligibility.
- Continued grant funding for community-based organizations to serve as trusted messengers supporting Medi-Cal enrollment, renewals and education.
- Rolling out Get Care Now and other communication campaigns to reinforce CalOptima Health's role as Orange County's health care safety net, emphasize coverage maintenance and educate members on options for accessing care in the midst of policy changes.
- Convening a bimonthly workgroup to foster cross-sector collaboration, elevate community voices, coordinate resources and codesign strategies that impact optimal health outcomes for members, including coverage and retention.

3.8. Social Determinants of Health

The conditions in which people live, work and age have a profound influence on their health outcomes. CalOptima Health screens for and monitors social determinants of health (SDOH) across its membership to identify unmet social needs and connect members to resources that address the nonmedical factors driving health disparities.

CalOptima Health Medi-Cal Membership by SDOH



Data Source: CalOptima Health (2023-2025). Membership Tableau Dashboard. Population Health Management Tableau Dashboard. Accessed March 2026.

Analysis:

CalOptima Health recognizes the importance of SDOH screenings and resources to better address non-medical factors that significantly impact members' health outcomes. Based on 2024–2025 claims data and SDOH ICD-10 (Z-code) documentation, the most commonly reported SDOH categories among screened members were adverse family events (including divorce, parental incarceration, domestic violence, and substance abuse), extreme poverty and housing instability, consistent with the three-year trending period.

Conclusion:

CalOptima Health's reported SDOH rates are based on service utilization and claims that include SDOH ICD-10 (Z-code) documentation. As a result, the actual prevalence of social needs is likely underrepresented due to limited service utilization, inconsistent screening

practices and incomplete documentation by providers. While provider use of SDOH Z-codes has increased year over year, the data continues to reflect only a fraction of total membership, indicating significant room for improvement in screening and reporting. These findings are consistent with community priorities identified through the 2024–2026 Orange County CHIP, which identified mental health, economic disparities, and housing and homelessness as three of six key focus areas.

Activities/Resources to Address Gap:

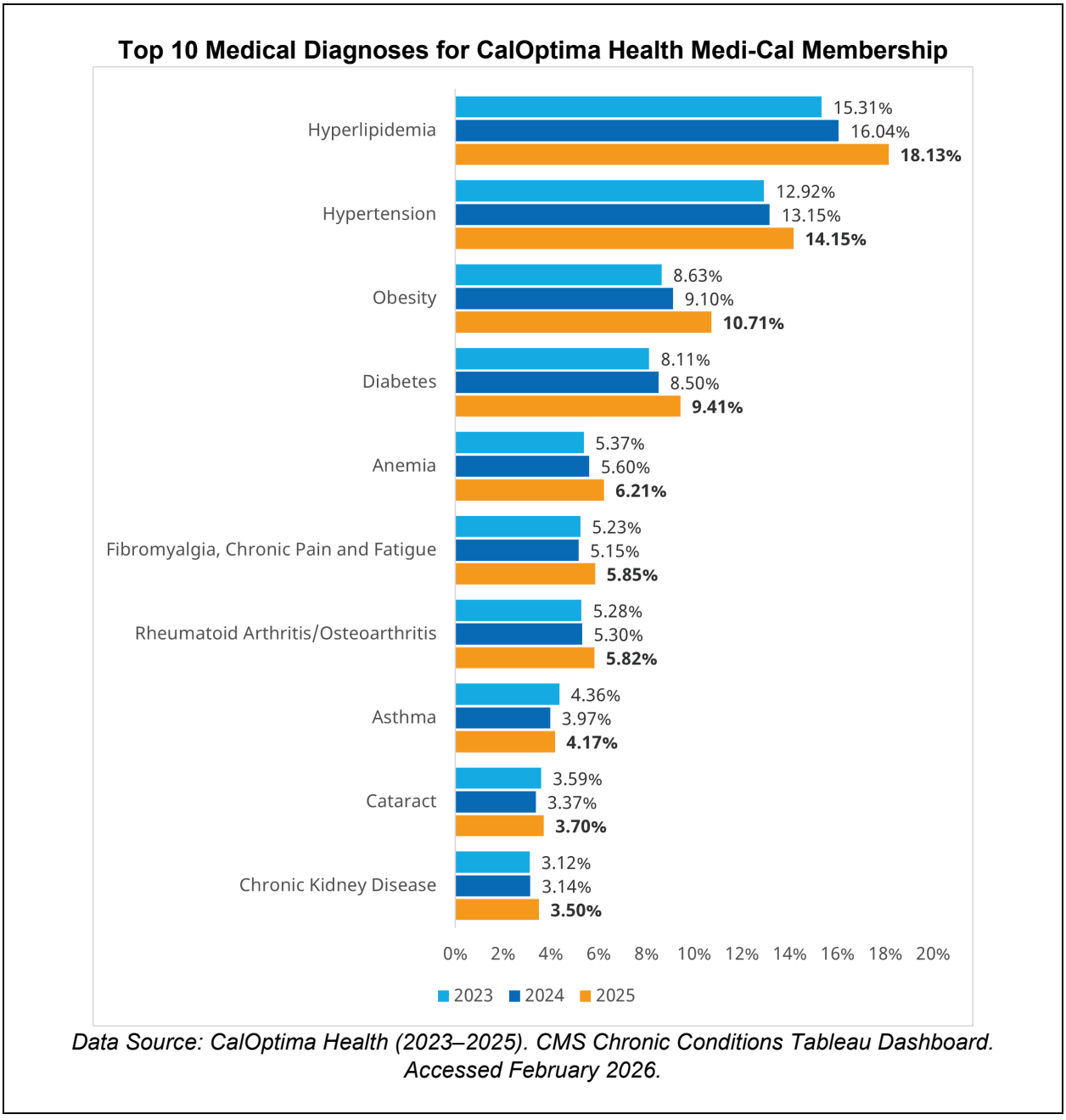
CalOptima Health addresses SDOH through multiple strategies. CalAIM ECM and Community Supports connect high-need members to housing navigation, medically tailored meals, sobering centers, and other social services. The Street Medicine Program extends direct care and social needs support to unhoused members in Anaheim, Santa Ana, Garden Grove and Costa Mesa, with 2026 goals to sustain or exceed 80% of participating unhoused members connected to an active PCP and 90% engaged with CalAIM ECM and Housing Navigation. CalOptima Health is strengthening SDOH screening and documentation processes for newly enrolled Medi-Cal members through the Initial Health Appointment (IHA), with a goal to increase IHA completion rates for all new members from 34.4% to 40%. The CalOptima Health Member Portal supports self-administered SDOH assessments to allow members to identify and report unmet social needs. CalOptima Health works with providers to increase SDOH Z-code documentation and encourages the use of standardized, evidence-based SDOH assessments. CalOptima Health actively participates in CHIP implementation workgroups focused on housing/homelessness, behavioral health and economic disparities and will use the forthcoming MPHNA and Community Resource Map to identify opportunities for community investment.

4. Membership Health Status and Disease Prevalence

Understanding the clinical profile of CalOptima Health's membership is essential to designing effective disease management programs, targeting quality improvement efforts and ensuring members with the greatest health needs receive timely, coordinated care. This section presents the most prevalent medical and behavioral health diagnoses across the Medi-Cal membership, with breakdowns by key demographic subgroups to illuminate where disparities exist and where targeted interventions are most needed.

4.1. Medical Diagnoses

4.1.1. Top Medical Diagnoses for Medi-Cal Membership



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:
In 2025, the most common medical diagnoses among CalOptima Health's Medi-Cal members were hyperlipidemia (18.13%), hypertension (14.15%), obesity (10.71%), diabetes (9.41%) and anemia (6.21%). Additional top diagnoses included rheumatoid arthritis/osteoarthritis (5.82%), fibromyalgia/chronic pain and fatigue (5.85%), asthma (4.17%), cataracts (3.71%), and chronic kidney disease (3.5%). Trending data from 2022 to 2025 shows continued increases in the top chronic conditions, consistent with patterns observed in prior years. These diagnoses reflect the chronic disease burden common to an aging population comprised of lower-income and historically underserved communities served through Medi-Cal.

Conclusion:
The continued rise in chronic disease prevalence among CalOptima Health members highlights the critical need for expanded prevention education and comprehensive disease management services. Supporting members in managing these conditions early and effectively is essential to improving health outcomes and reducing long-term health care costs. Many of these conditions are preventable or manageable through consistent primary care engagement, preventive screenings, chronic disease education and care management.

Activities/Resources to Address Gap:
CalOptima Health offers a range of health and wellness services aimed at chronic disease prevention and management. Members have access to health education resources and health coaching on topics such as weight management, prediabetes, hyperlipidemia and hypertension. In 2025, CalOptima Health updated its Disease Management (DM) program by developing a standardized playbook inclusive of member identification and stratification, evidence-based interventions, and health network and provider collaboration strategies. CalOptima Health's DM Program offers tailored diabetes and asthma self-management programs led by registered dietitians, master's-level health educators and care coordinators. CalOptima Health also uses multimodal outreach, such as text, Interactive Voice Response (IVR), interactive digital tools like HealthHub, and mailed education materials, to empower members with clinically appropriate information.

4.1.2. Top Medical Diagnoses by Ethnicity and Gender

The tables below demonstrate the prevalence of each of the top five medical conditions by ethnicity and gender.

CalOptima Health Medi-Cal Population: Top 5 Medical Diagnoses by Ethnicity

	#1 Condition	#2 Condition	#3 Condition	#4 Condition	#5 Condition
Asian or Pacific Islander	Hyperlipidemia 30.52% (2,940)	Hypertension 25.25% (2,433)	Diabetes 15.97% (1,539)	Rheumatoid Arthritis/ Osteoarthritis 10.54% (1,016)	Anemia 9.72% (937)
Black	Hypertension 13.54% (1,770)	Obesity 11.81% (1,544)	Hyperlipidemia 11.01% (1,440)	Anemia 7.66% (1,001)	Diabetes 7.13% (933)
Chinese	Hyperlipidemia 18.16% (2,543)	Hypertension 13.36% (1,871)	Diabetes 7.53% (1,054)	Rheumatoid Arthritis/ Osteoarthritis 4.68% (656)	Cataract 4.56% (639)
Hispanic	Obesity 13.93% (55,990)	Hyperlipidemia 13.15% (52,888)	Hypertension 10.00% (40,196)	Diabetes 8.59% (34,535)	Anemia 5.77% (23,180)
Korean	Hyperlipidemia 25.19% (5,278)	Hypertension 18.19% (3,812)	Diabetes 11.09% (2,408)	Rheumatoid Arthritis/ Osteoarthritis 8.23% (1,788)	Cataract 7.03% (1,527)
Vietnamese	Hyperlipidemia 37.95% (37,734)	Hypertension 27.75% (27,591)	Diabetes 14.98% (14,900)	Rheumatoid Arthritis/ Osteoarthritis 11.71% (11,641)	Glaucoma 10.78% (10,721)
White	Hyperlipidemia 17.17% (20,082)	Hypertension 15.42% (18,030)	Obesity 10.48% (12,250)	Fibromyalgia, Chronic Pain and Fatigue 9.34% (10,921)	Rheumatoid Arthritis/ Osteoarthritis 8.23% (9,624)

Highest Prevalence → Lower Prevalence

Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

CalOptima Health Medi-Cal Population: Top 5 Medical Diagnoses by Gender

	#1 Condition	#2 Condition	#3 Condition	#4 Condition	#5 Condition
Female	Hyperlipidemia 20.07% (88,801)	Hypertension 14.86% (65,761)	Obesity 12.53% (55,455)	Diabetes 10.03% (44,357)	Anemia 7.61% (33,660)
Male	Hyperlipidemia 15.91% (61,811)	Hypertension 13.34% (51,809)	Diabetes 8.72% (33,859)	Obesity 8.63% (33,519)	Anemia 4.63% (17,975)

Highest Prevalence → Lower Prevalence

Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

The tables above display the top five medical diagnoses segmented by ethnicity and gender. In 2025, hyperlipidemia and hypertension were the leading diagnoses across all groups analyzed, consistent with prior year trends. Diabetes ranked among the top three diagnoses for Asian/Pacific Islander, Korean and Vietnamese members, while obesity ranked third for Chinese, White and Black members. Other conditions appearing in the top five by ethnicity included anemia, asthma, cataracts, fibromyalgia/chronic pain and fatigue, glaucoma, and rheumatoid arthritis/osteoarthritis. When analyzed by gender, the top medical diagnoses were

broadly consistent between male and female members, with no significant differences in ranking.

Conclusion:

Because the top medical conditions are generally consistent across racial, ethnic and gender groups, CalOptima Health can deliver standardized health education and support services with appropriate cultural and linguistic modifications to meet the unique needs of each population. The overlap in conditions across groups also reinforces the importance of universal outreach strategies paired with targeted, culturally responsive interventions for populations with elevated disease prevalence.

Activities/Resources to Address Gap:

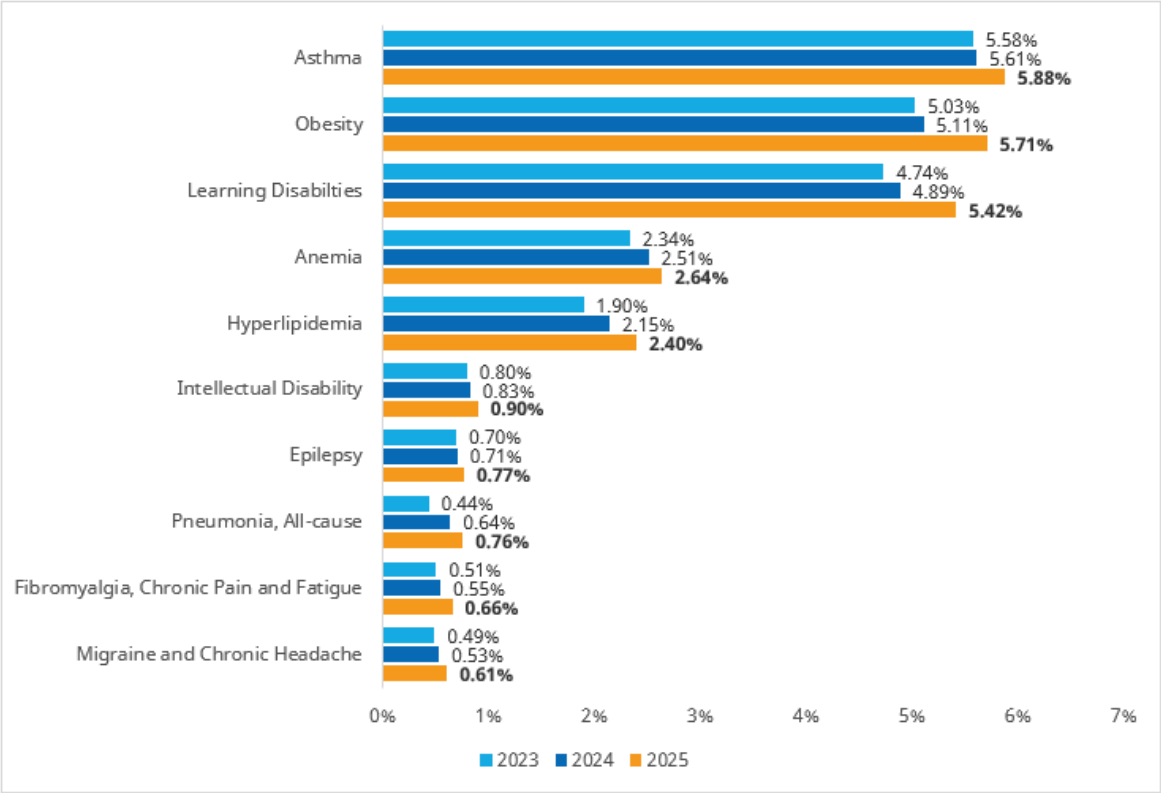
CalOptima Health ensures that health and wellness services are available in members' preferred languages and are responsive to cultural norms and practices. Staff and providers receive annual training on topics such as health equity, serving diverse populations, stigma reduction and language access. Members can access health coaching, group classes, and educational resources covering chronic condition management and prevention, including weight management, prediabetes, hyperlipidemia and hypertension.

CalOptima Health and its health networks work to reach members who may be overdue for preventive or chronic care services. The combination of telephonic outreach and digital tools is proving to be one of the most effective and scalable approaches. Call-based engagement, particularly when conducted by trained care coordinators or population health teams, creates a direct, human connection that builds trust and reduces friction for members who may struggle with complex health care processes. This multimodal outreach model improves not only access but continuity. Members gain a clearer understanding of next steps in their care, experience fewer logistical obstacles and develop a sustained connection to their care team.

SDOH screening, documentation and referral processes, when integrated directly into care pathways, help teams systematically identify nonmedical barriers that may prevent members from following treatment plans, attending appointments or maintaining disease control. These integrated models ensure that the assessment of social needs is not treated as an optional add-on, but as a standard component of high-quality care.

4.1.3. Top Medical Diagnoses by Children and Adolescents (Ages 2–19)

Top Medical Diagnoses by Children and Adolescents (Ages 2–19)



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

Among children and adolescents ages 2–19, the most common medical diagnoses differ from those of the overall CalOptima Health Medi-Cal population. Asthma remained the leading condition (5.88%), consistent with the prior year trend. Other top diagnoses in 2025 included obesity (5.71%), learning disabilities (5.42%), anemia (2.64%) and hyperlipidemia (2.40%). The top diagnoses in this age group have shown a gradual upward trend over the three-year period, indicating a continued rise in chronic and developmental conditions among CalOptima Health's youth population.

Conclusion:

The gradual increase in chronic conditions among children and adolescents underscores the need for continued and expanded disease prevention and management strategies tailored to younger populations. Focusing on both the child and family unit is essential to improving outcomes, particularly in addressing preventable or manageable conditions such as asthma and obesity. Primary care engagement during the pediatric years offers a high-value opportunity to improve lifelong health outcomes.

Activities/Resources to Address Gap:

To support children with asthma, CalOptima Health provides self-care guides, condition-specific educational materials and action plans for families and caregivers. A recurring member mailing campaign delivers printed asthma education to member households, and a

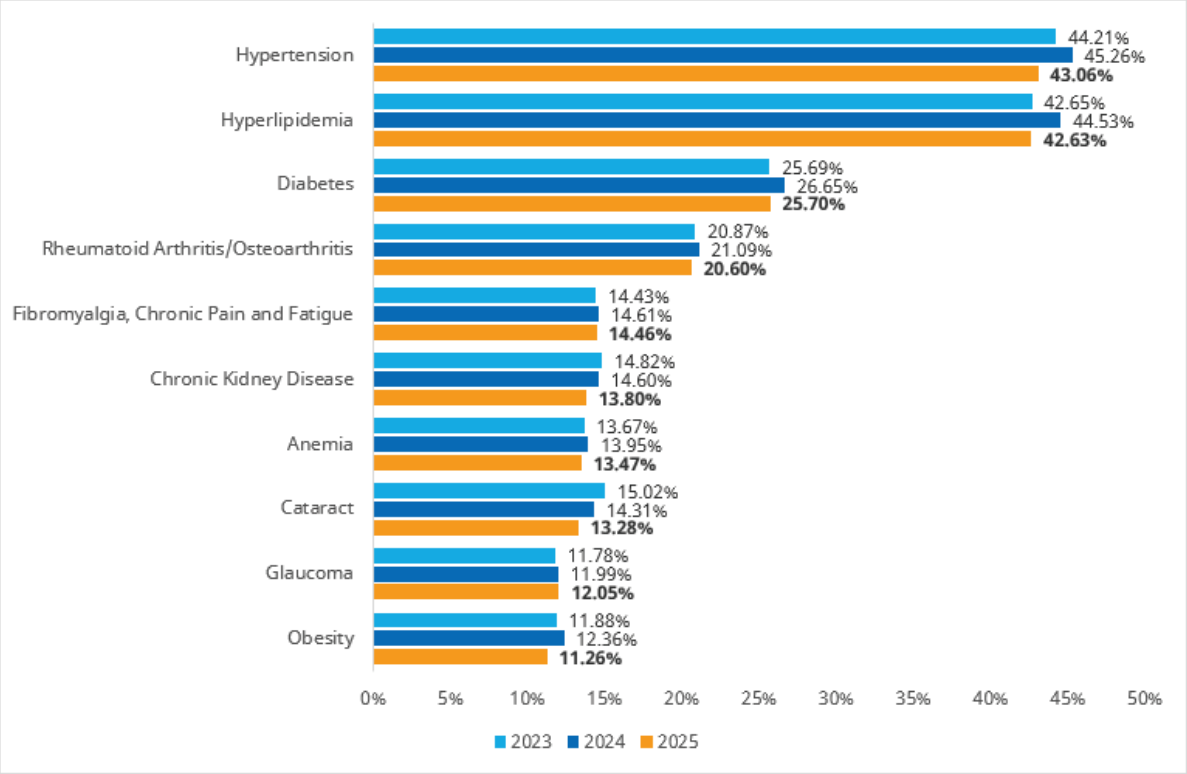
two-way text messaging campaign connects interested members with a health coach for expedited engagement. CalOptima Health also offers CalAIM Asthma Home Remediation service for eligible members, mitigating environmental triggers through home assessments and remediation supplies. To address childhood obesity, CalOptima Health collaborates with the Orange County HCA and community partners through the Orange County CHIP, implementing strategies such as family-based programs, school- and community-based gardening, and peer-based networks that promote healthy behaviors. The 2026 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan includes a Performance Improvement Project (PIP) to improve Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA), and Child and Adolescent Well-Care Visits (WCV) with a focus on reducing disparities among Black, White and Native Hawaiian/Other Pacific Islander populations through culturally tailored, multimodal outreach campaigns.

4.1.4. Top Medical Diagnoses for People with Disabilities

CalOptima Health is committed to providing all members, including older adults and people with disabilities, access to compassionate, high-quality, person-centered care. While older adults and people with disabilities are often considered together under the term seniors and persons with disabilities (SPD), this group is highly diverse, encompassing individuals across a broad range of ages, functional abilities and care needs. For purposes of this analysis, members with disabilities are identified based on SPD aid code designations, consistent with DHCS reporting methodology.

The following chart presents the top medical diagnoses among CalOptima Health's SPD members across a three-year trending period.

Top Medical Diagnoses for People with Disabilities



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

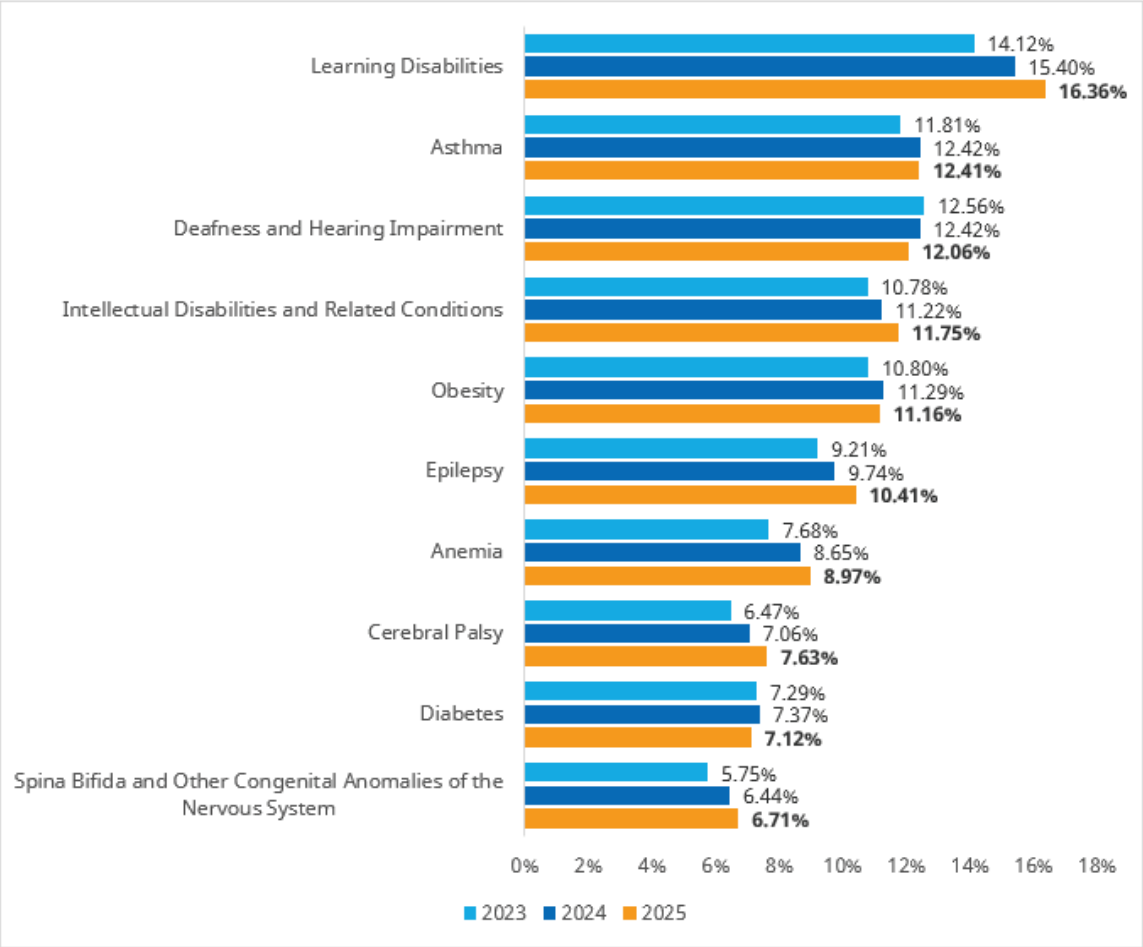
In 2025, the top two medical diagnoses among CalOptima Health Medi-Cal members with disabilities were hypertension (43.06%) and hyperlipidemia (42.63%), consistent with prior year trends. These conditions occurred at significantly higher rates than others, followed by diabetes and rheumatoid arthritis/osteoarthritis. All four showed slight increases in prevalence compared with prior years, indicating a growing need for ongoing chronic condition management within this population. Notably, the average age for the Medi-Cal population with disabilities is 66.59 years, compared to 28.74 years for the Medi-Cal population without an identified disability, which helps explain the higher burden of chronic disease in this group.

Additional top diagnoses include fibromyalgia/chronic pain and fatigue, chronic kidney disease, cataracts, anemia, obesity and glaucoma.
Conclusion: The continued rise in chronic conditions among members with disabilities highlights the need for more targeted and comprehensive care initiatives. Tailored interventions that address both clinical needs and accessibility barriers are essential to improving health outcomes for this population. People with disabilities are more likely to experience functional limitations, communication barriers and transportation challenges that compound the difficulty of managing chronic conditions.
Activities/Resources to Address Gap: To better support members with disabilities, CalOptima Health has expanded telehealth services, which offer greater flexibility for members who may face transportation or mobility challenges. CalOptima Health members have expansive access to language assistance services, including teletypewriter (TTY) for members with hearing or speech impairments. CalOptima Health actively engages with disability service providers and monitors the accessibility compliance of contracted health networks and provider offices, evaluating timely access, physical accessibility and effective communication methods. Disability awareness training is required for all staff and contracted providers, with annual refreshers. Additionally, multiple programs are available to help eligible members with disabilities, including PACE, CCM, ECM, Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and In-Home Supportive Services (IHSS).

4.1.5. Top Medical Diagnoses for Whole Child Model Members (Ages 0-21)

The Whole-Child Model (WCM) serves CalOptima Health members up to age 21 with complex medical needs who qualify for California Children's Services (CCS), integrating both Medi-Cal and CCS benefits under a single coordinated care model to ensure these members receive comprehensive, seamless support across all their health needs.

Top Medical Diagnoses for Whole Child Model Members (Ages 0–21)



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

The top medical diagnoses affecting more than 10% of WCM members in 2025 included learning disabilities (16.36%), asthma (12.41%), deafness and hearing impairment (12.06%), obesity (11.16%), and intellectual disabilities and related conditions (11.75%). The top diagnoses affecting smaller proportions of WCM members include epilepsy, anemia, diabetes, cerebral palsy, spina bifida and other congenital anomalies of the nervous system. The three-year trend period shows increases across the majority of the top diagnoses, reinforcing the growing complexity of care needs within this population.

Conclusion:
The increase in the top medical diagnoses for WCM members supports the continued need for thorough health care coordination and management that addresses both the member's CCS-eligible condition and their whole-child health needs. The complexity of this population underscores the value of dedicated case management and seamless coordination across CalOptima Health, health networks and community-based service providers.

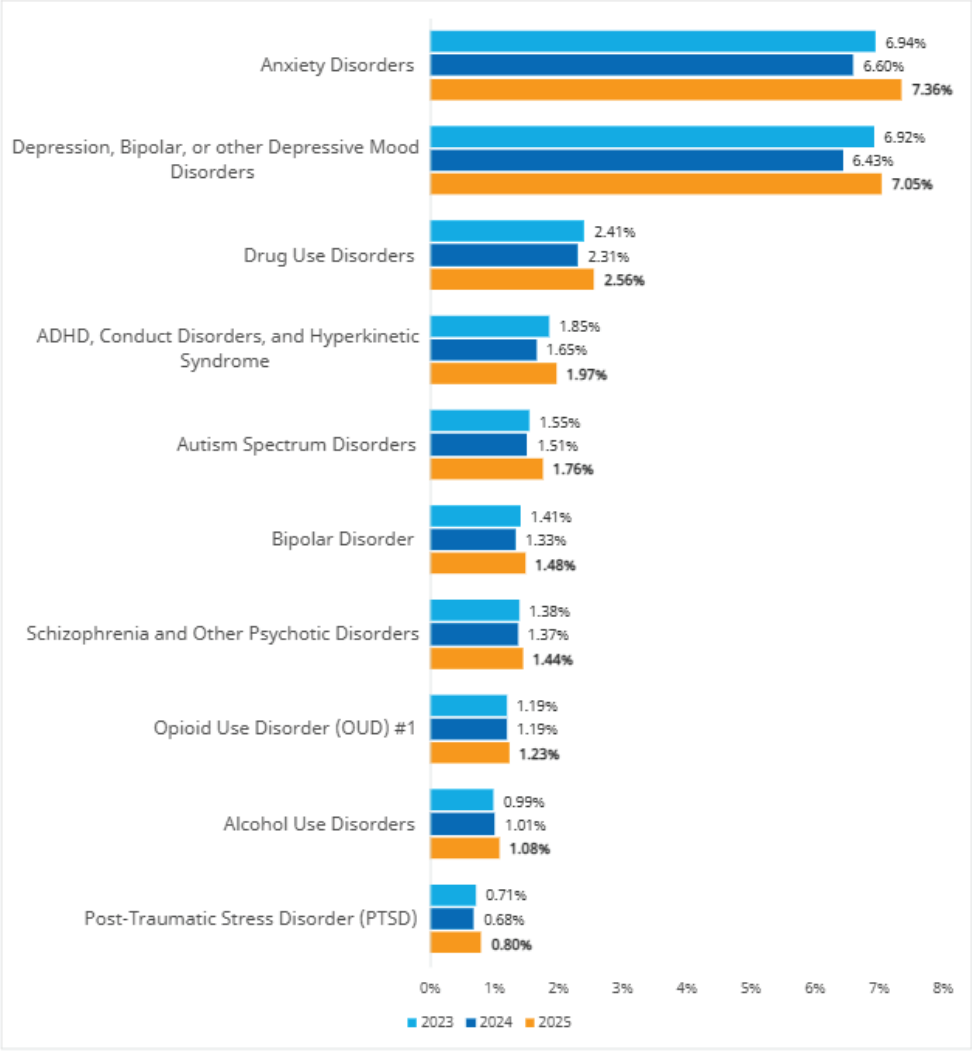
Activities/Resources to Address Gap:
Since 2019, CalOptima Health has managed the Medi-Cal and CCS benefits for WCM members with complex needs up to 21 years of age. Each WCM member has a care team consisting of a personal care coordinator, medical case manager and medical director who ensure the member receives care coordination, has access to services and has all their health needs met. Pediatric Facility Clinical Rounds were implemented in 2025 to focus on long lengths of stay and coordination of CCS eligibility, with a dedicated Pediatric Workgroup reviewing cases for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria. The WCM Family Advisory Committee (WCM FAC) provides member and family input into program design and delivery.

4.2. Behavioral Health Diagnoses

Behavioral health conditions are prevalent across CalOptima Health's membership and intersect significantly with chronic disease, social needs and overall health outcomes. Nearly one in five (16.8%) Medi-Cal members have had a behavioral health diagnosis in the past 18 months[3]. Understanding the distribution of behavioral health diagnoses across the membership, including age, gender, ethnicity and population subgroup, informs CalOptima Health's ongoing investment in accessible, integrated and culturally responsive behavioral health services.

4.2.1. Top Behavioral Health Diagnoses for CalOptima Health Medi-Cal Membership

Top 10 Behavioral Health Diagnoses for Medi-Cal Membership (All Ages)



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

[3] CalOptima Health Member Risk Dashboard, Access April 2026

Analysis:
The data above highlights the most prevalent behavioral health conditions among CalOptima Health members as of December 2025. The top behavioral health diagnoses include anxiety disorders (7.36%), depression, bipolar or other depressive mood disorders (7.36%), followed by drug use disorders (2.56%), ADHD/conduct disorders/hyperkinetic syndrome (1.97%), and bipolar disorder (1.48%). Additional commonly reported conditions include autism spectrum disorders (1.76%), schizophrenia and other psychotic disorders (1.44%), opioid use disorder (1.23%), alcohol use disorder (1.08%), and post-traumatic stress disorder (PTSD) (0.8%). The co-occurrence of behavioral health and chronic conditions is also widespread among Medi-Cal members. For example, among members 18 years and older with depression, bipolar or other depressive mood disorders, the rate of hypertension is 40.05%, more than double the rate of hypertension among the overall adult population (19.92%). Trending data reflects the patterns established in prior years, with anxiety and depressive disorders continuing to represent the highest-prevalence behavioral health conditions across the membership.

Conclusion:
The prevalence of behavioral health conditions across CalOptima Health's membership reinforces the critical importance of integrating behavioral health into primary care and care management. CalOptima Health remains committed to providing comprehensive behavioral health services that are accessible, timely, and responsive to the evolving needs of members. Untreated behavioral health conditions lead to higher overall medical costs and increased emergency department (ED) visits. They also contribute to poor management of chronic diseases and a reduced quality of life across all member populations.

Activities/Resources to Address Gap:
CalOptima Health partners with a robust network of licensed behavioral health providers. Services include outpatient psychotherapy (individual, family, and group), psychological testing, psychiatric consultations, medication management, and dyadic services. CalOptima Health members can also access care via telehealth; many individual and group providers offer virtual outpatient behavioral health appointments. CalOptima Health's Behavioral Health Integration (BHI) department promotes the integration of behavioral health services throughout the care continuum and works closely with the Orange County Behavioral Health Plan (BHP) to coordinate specialty mental health and substance use services for members.

4.2.2. Top Behavioral Health Diagnoses by Ethnicity and Gender

The tables below demonstrate the prevalence of each of the top five behavioral health conditions by ethnicity and gender.

Top 5 Behavioral Health Diagnoses by Ethnicity

	#1 Condition	#2 Condition	#3 Condition	#4 Condition	#5 Condition
Asian or Pacific Islander	Depression, Bipolar, or Other Depressive Mood Disorders 9.07% (874)	Anxiety Disorders 7.60% (732)	Schizophrenia and Other Psychotic Disorders 3.69% (356)	Bipolar Disorders 1.99% (192)	Drug Use Disorder 1.93% (186)
Black	Depression, Bipolar, or Other Depressive Mood Disorders 9.85% (1,288)	Anxiety Disorders 9.85% (1,288)	Drug Use Disorder 4.66% (609)	Schizophrenia and Other Psychotic Disorders 3.16% (413)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 3.11% (407)
Chinese	Anxiety Disorders 3.85% (540)	Depression, Bipolar, or Other Depressive Mood Disorders 3.68% (515)	Drug Use Disorder 1.39% (195)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 1.16% (163)	Schizophrenia and Other Psychotic Disorders 0.63% (89)
Hispanic	Anxiety Disorders 6.05% (24,322)	Depression, Bipolar, or Other Depressive Mood Disorder 5.30% (21,316)	Drug Use Disorder 1.86% (7,492)	Autism Spectrum Disorders 1.80% (7,253)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 1.47% (5,925)
Korean	Depression, Bipolar, or Other Depressive Mood Disorders 7.35% (1,540)	Anxiety Disorders 5.24% (1,098)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 1.39% (291)	Drug Use Disorder 1.38% (290)	Schizophrenia and Other Psychotic Disorders 1.21% (253)
Vietnamese	Depression, Bipolar, or Other Depressive Mood Disorders 5.34% (5,311)	Anxiety Disorders 4.23% (4,206)	Drug Use Disorder 2.20% (2,192)	Schizophrenia and Other Psychotic Disorders 1.27% (1,265)	Autism Spectrum Disorders 1.24% (1,234)
White	Anxiety Disorders 14.74% (17,240)	Depression, Bipolar, or Other Depressive Mood Disorder 14.10% (16,488)	Drug Use Disorder 5.94% (6,944)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 4.41% (5,154)	Bipolar Disorder 4.06% (4,746)

Highest Prevalence → Lower Prevalence

Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Top 5 Behavioral Health Diagnoses by Gender

	#1 Condition	#2 Condition	#3 Condition	#4 Condition	#5 Condition
Female	Anxiety Disorders 9.01% (39,842)	Depression, Bipolar, or Other Depressive Mood Disorders 8.74% (37,667)	Drug Use Disorder 2.06% (9,096)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 1.64% (7,244)	Bipolar Disorders 1.62% (7,167)
Male	Anxiety Disorders 5.50% (21,350)	Depression, Bipolar, or Other Depressive Mood Disorders	Drug Use Disorder 3.13% (12,178)	Austism Spectrum Disorders 2.79% (10,836)	ADHD, Conduct Disorders, and Hyperkinetic Syndrome 2.35% (9,132)

Highest Prevalence → Lower Prevalence

Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

The tables above show the top five behavioral health diagnoses by ethnicity and gender. In 2025, anxiety disorders and depression, bipolar, or other depressive mood disorders were the top two behavioral health diagnoses across all CalOptima Health ethnicities, consistent with overall membership trends. Other conditions rounding out the top five by ethnicity include attention-deficit/hyperactivity disorder (ADHD)/conduct disorders/hyperkinetic syndrome, autism spectrum disorders, bipolar disorders, drug use disorder, opioid use disorder, and

schizophrenia and other psychotic disorders. When examined by gender, the top three diagnoses were consistent across male and female members, with drug use disorder and schizophrenia appearing in the top five for both groups.

Conclusion:

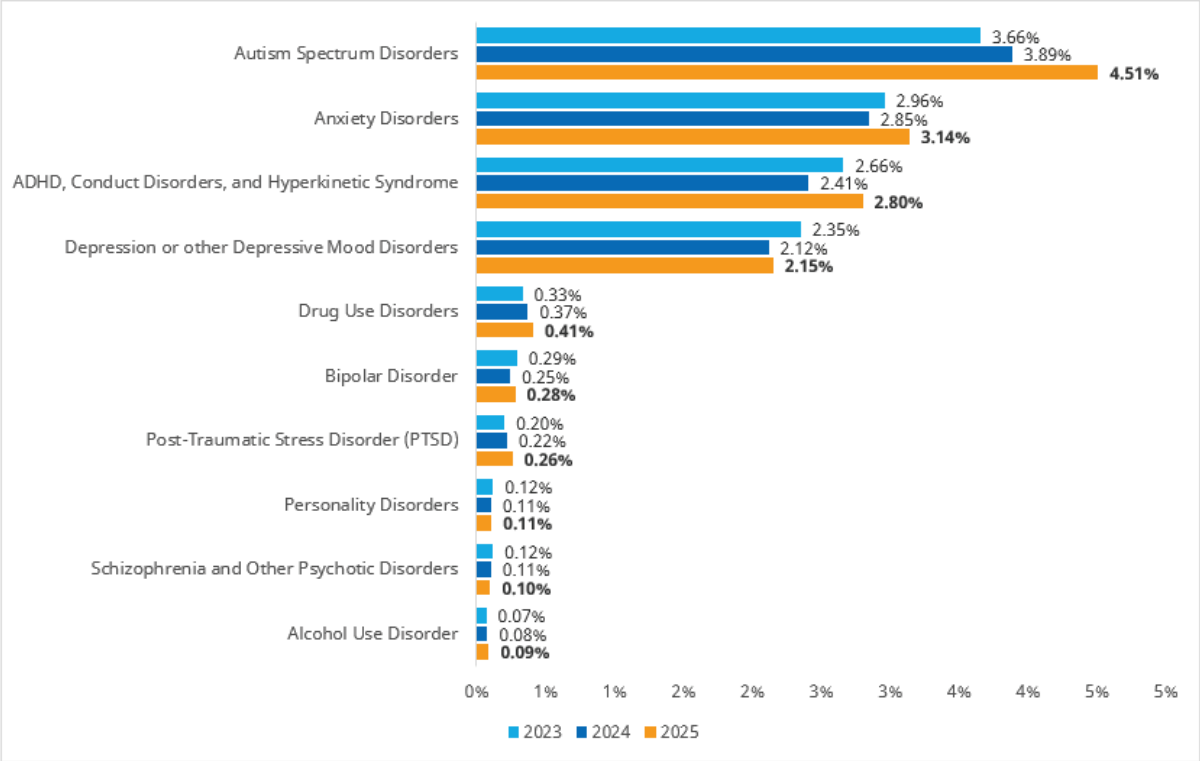
The overlap of behavioral health conditions by ethnicity and gender validates the importance of providing culturally appropriate education on accessing behavioral health resources and services. As CalOptima Health members have varying behavioral health diagnoses and cultural backgrounds, there is a continued need for providers who can deliver behavioral health services responsive to the diverse needs of the population.

Activities/Resources to Address Gap:

CalOptima Health provides member-centric support through dedicated behavioral health staff who assist with screening and assessment and with linking members to available benefit services and resources. In addition, we provide educational materials to members and providers on topics such as treatment options, applied behavior analysis (ABA) and understanding depression, available in all threshold languages. Grants provided through the CalOptima Health Provider Workforce Development Initiative support the recruitment, training and retention of culturally and linguistically responsive behavioral health professionals, including student interns, licensed clinicians and peer support specialists. Virtual access to outpatient behavioral health care is available through our behavioral health providers, including our virtual vendor, TeleMed2U.

4.2.3. Top Behavioral Health Diagnoses by Children and Adolescents (Ages 2–19)

Top Behavioral Health Diagnoses among Children and Adolescents (Ages 2–19)



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

As of December 2025, the top behavioral health conditions among CalOptima Health members ages 2–19 were autism spectrum disorders (4.51%), anxiety disorders (3.14%), and ADHD, conduct disorders and hyperkinetic syndrome (2.81%). Other conditions in the top 10 include depression or other depressive mood disorders (2.15%), drug use disorders (0.41%), bipolar disorder (0.28%), PTSD (0.26%), personality disorders (0.11%), schizophrenia and other psychotic disorders (0.10%), and alcohol use disorder (0.09%). Autism spectrum disorders continued to show the most significant increase over the prior year period, reflecting national trends in autism diagnosis rates.

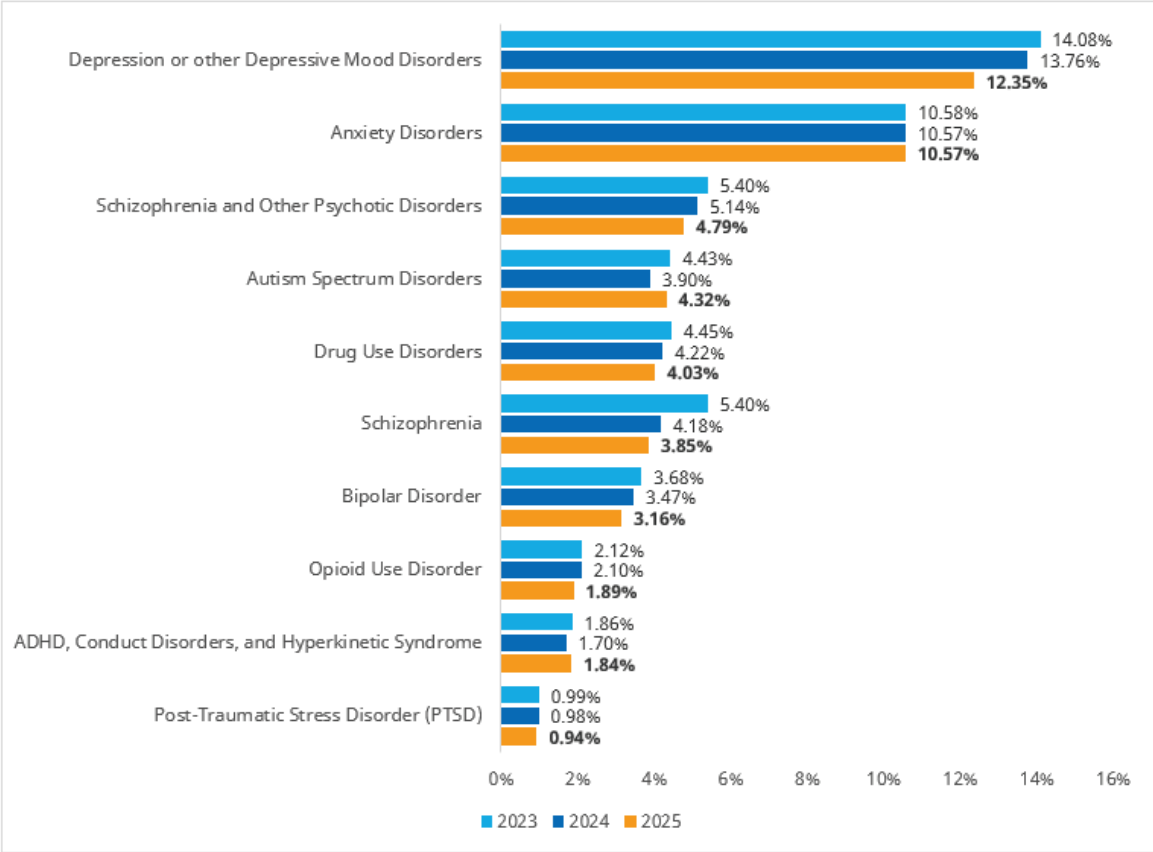
Conclusion:

With autism spectrum disorders growing as the most common behavioral health diagnosis among children and adolescents, there is a growing need to support families navigating the challenges associated with autism. In addition to clinical care, families benefit from community-based services such as case management, parent training and social skills programs, as well as support from local school districts through individualized education plans. Coordinated efforts between health care providers, schools, Regional Centers and community organizations are essential to ensure children and families receive comprehensive support.

Activities/Resources to Address Gap:
SBHIP concluded in 2024, resulting in increased behavioral health access for children and youth in school settings across Orange County. As part of SBHIP, CalOptima Health partnered with Children's Hospital of Orange County (CHOC), Hazel Health, Western Youth Services, the Orange County Department of Education and all 28 public school districts. CHOC developed the curriculum for an Autism Comprehensive Care Program serving CalOptima Health youth ages 12–17, designed to support emotional and behavioral regulation and social skills development. CalOptima Health covers behavioral health treatment (BHT), including ABA, for members under 21. CalOptima Health also has a Pay for Value program for ABA providers that drives the overall quality of care for members receiving ABA services.

4.2.4. Top Behavioral Health Diagnoses for People with Disabilities

Top Behavioral Health Diagnoses for People with Disabilities



Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:

In 2025, the most common behavioral health diagnoses among CalOptima Health members with disabilities were depression or other depressive mood disorders (12.35%) and anxiety disorders (10.57%). These conditions occurred at significantly higher rates than other diagnoses, including schizophrenia and other psychotic disorders (4.79%), drug use disorders and schizophrenia. Additional diagnoses include autism spectrum disorders, bipolar disorder, opioid use disorder, ADHD/conduct disorders/hyperkinetic syndrome and PTSD. These conditions have higher prevalence in the population of people with disabilities compared to the overall Medi-Cal population and are consistent with prior year trends, with slight variation across the top conditions.

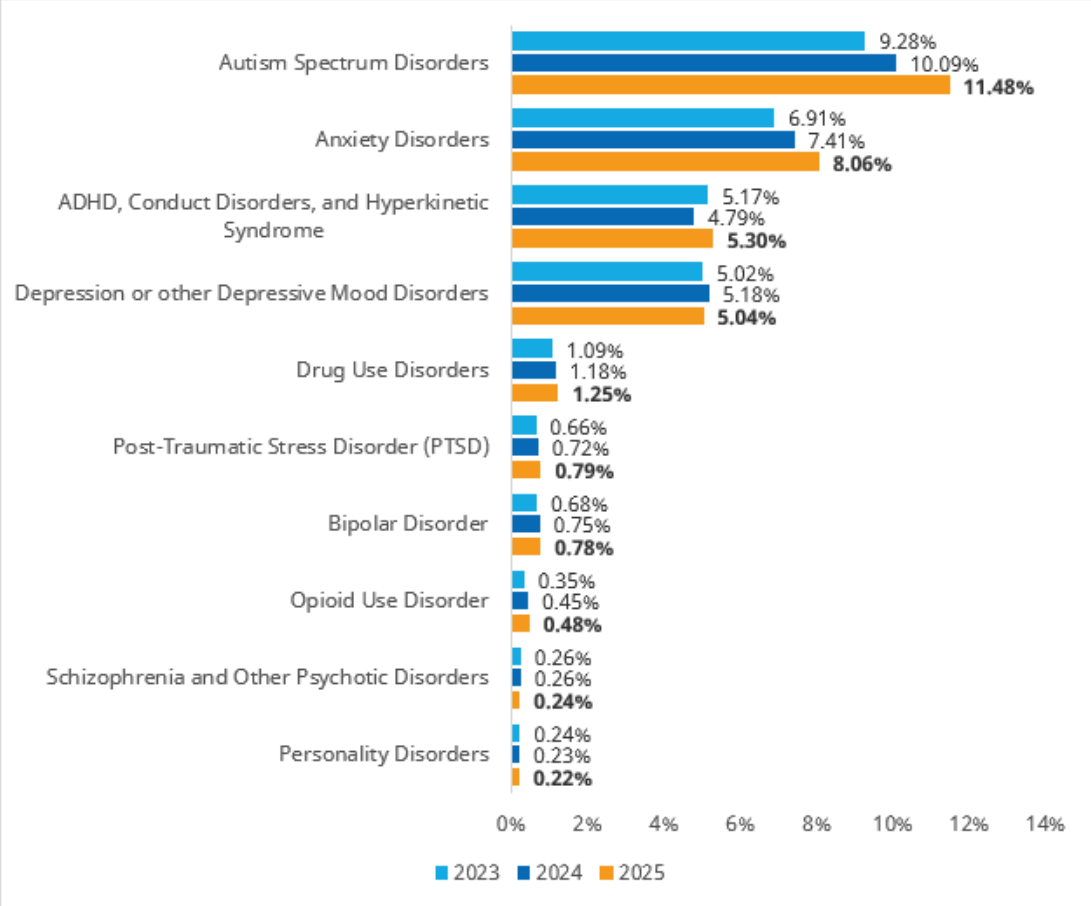
Conclusion:

Members with disabilities remain at higher risk for conditions such as depression and anxiety due to a range of social, physical and systemic challenges. This underscores the ongoing need for proactive outreach, prevention and monitoring. CalOptima Health must continue to prioritize early identification and access to culturally and linguistically appropriate behavioral health care to support the well-being of members with disabilities. Integrated care approaches that address behavioral and physical health needs simultaneously are critical for this population.

Activities/Resources to Address Gap:
Health risk assessments are used to develop personalized care plans that address the medical, functional, psychosocial and social support needs of SPD members. CCM coordinates care and connects SPD members with behavioral health diagnoses to essential services and facilitates referrals to external behavioral health and social support resources. CalOptima Health's OneCare (HMO D-SNP), a Medicare Medi-Cal plan, offers enhanced benefits for low-income SPD members enrolled in both Medicare and Medi-Cal, including in-home health services, companion care and wellness initiatives. TeleMed2U provides virtual behavioral health access for members who may face mobility or transportation barriers.

4.2.5. Top Behavioral Health Diagnoses for Whole Child Model Members (Ages 0–21)

Top Behavioral Health Diagnoses for Whole Child Model Members (Ages 0–21)



Data Source: CalOptima Health (2023-2025). CMS Chronic Conditions Tableau Dashboard. Accessed February 2026.

Analysis:
In 2025, the top behavioral health diagnoses for WCM members were autism spectrum disorders (11.48%), anxiety disorders (8.06%), depression or other depressive mood disorders (5.04%), ADHD/conduct disorders/hyperkinetic syndrome (5.3%), and drug use

disorders (1.25%). The majority of the top 10 diagnoses showed slight increases compared with the prior year, with autism spectrum disorders and anxiety disorders reflecting the largest increases. These patterns mirror those observed in the broader CalOptima Health child and adolescent population.

Conclusion:

The top behavioral health diagnoses for WCM members in 2025 are consistent with those of the broader child and adolescent population, reinforcing the ongoing need for robust behavioral health services to support WCM members. Although increases across the top diagnoses are modest, the data confirms the need for continued investment in care coordination, behavioral health access and family support services for this medically complex population.

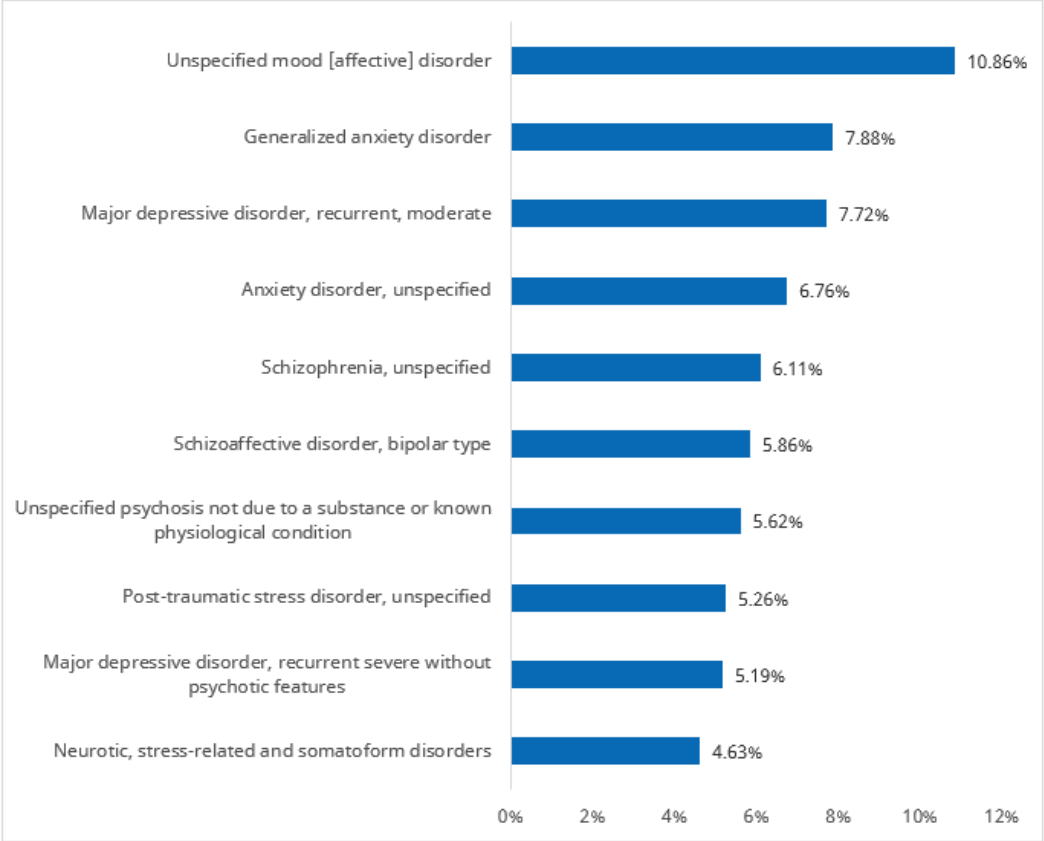
Activities/Resources to Address Gap:

CalOptima Health has a designated licensed clinician who reviews Individual Care Plans (ICPs) and participates in WCM Community Care Network (CCN) Interdisciplinary Care Teams (ICTs). WCM members have access to the full range of behavioral health services available to all CalOptima Health children and adolescents, including ABA. TeleMed2U provides virtual outpatient psychiatry for members age 5 and older and psychotherapy for members ages 13 and older. Through SBHIP, Hazel Health provides counseling services for students ages 4–19 at 20 of the 28 public school districts in Orange County. The Dyadic Services Program Academy, in partnership with First 5 Orange County, supports early childhood development by addressing caregiver and family risk factors in pediatric clinical settings.

4.2.6. Top Behavioral Health Diagnoses for Members with Serious Mental Illness

For the purposes of this analysis, serious mental illness (SMI) means a mental disorder that is severe in degree and persistent in duration and that may cause behavioral disorder or impair functioning so as to interfere substantially with activities of daily living[4].

Top Behavioral Health Diagnoses for Members with Serious Mental Illness



Data Source: CalOptima Health (2025). DHCS All-Payer Claims Database Common Data Layout (APCD-CDL) Medical SMI Population Tableau Dashboard. Accessed March 2026.

Analysis:

In 2025, CalOptima Health analyzed diagnoses among members designated as having SMI to better understand the clinical profile and care needs of this population. The most frequently recorded diagnosis was unspecified mood (affective) disorder (10.86%), followed by generalized anxiety disorder (7.88%), and major depressive disorder, recurrent, moderate (7.72%). Anxiety disorder, unspecified (6.76%), schizophrenia unspecified (6.11%), and schizoaffective disorder, bipolar type (5.86%) were also among the most common. Additional diagnoses included unspecified psychosis not due to a substance or known physiological condition (5.62%), PTSD (5.26%), major depressive disorder recurrent severe without psychotic features (5.19%), and neurotic, stress-related, and somatoform disorders (4.63%).

Mood and anxiety disorders represent the largest share of principal diagnoses within this population, while psychotic spectrum conditions like schizophrenia, schizoaffective disorder,

[4] California Welfare and Institutions Code Section 5600.3

and unspecified psychosis collectively account for a significant portion of the clinical profile. The prominence of trauma-related diagnoses such as PTSD further reflects the complex, layered needs of this subpopulation, many of whom have histories of adverse experiences that intersect with their psychiatric conditions. Members with SMI are also at elevated risk for co-occurring substance use disorders, housing instability and chronic medical conditions, all of which compound complexity and create barriers to consistent engagement with care.

Conclusion:

The diagnostic distribution among CalOptima Health's SMI population reflects a clinically diverse group whose needs span mood disorders, anxiety, psychotic spectrum conditions, and trauma, requiring a flexible, coordinated approach to care management and service navigation. Because specialty mental health services for this population are delivered through the Orange County BHP rather than through CalOptima Health, effective outcomes depend on seamless coordination and warm handoffs across a carved-out delivery system. Gaps in follow-up care after ED visits for mental illness (FUM) underscore the ongoing challenges of maintaining continuity for members who frequently cycle through crisis settings without consistent connection to outpatient care. Addressing these gaps requires sustained cross-system collaboration, real-time data sharing and proactive member engagement strategies that bridge the specialty behavioral health system with CalOptima Health's care management infrastructure.

Activities/Resources to Address Gap:

In California, behavioral health services for Medi-Cal members are organized through a carved-out delivery system. Specialty Mental Health Services for members with SMI and Drug Medi-Cal Organized Delivery System services for members with moderate-to-severe substance use disorders are provided through the Orange County BHP, not through CalOptima Health. CalOptima Health retains responsibility for Non-Specialty Mental Health Services (NSMHS), including outpatient therapy, psychiatric consultation, and medication management for members with lower acuity behavioral health needs. Coordination between CalOptima Health and HCA is governed by a formal memorandum of understanding to ensure continuity of care and warm handoffs for members transitioning between systems. CalOptima Health and HCA are participating in the Institute for Healthcare Improvement (IHI) & DHCS Medi-Cal Behavioral Health Demonstration Collaborative, an initiative around improving data integration and follow-up care.

4.3. Quality and Population Health Management Performance

CalOptima Health monitors performance across a comprehensive set of quality and population health management measures to assess how effectively the plan is meeting the clinical needs of its members, identifying gaps and driving targeted improvement. This section presents trending HEDIS performance data across medical and behavioral health measures, health disparities by race and ethnicity, and PHM key performance indicators, together providing a multidimensional view of where CalOptima Health is performing well and where focused investment is needed.

4.3.1. CalOptima Health Medi-Cal Medical HEDIS Rates

4.3.1.1. Overall (MCAS)

Medi-Cal Managed Care Accountability Set (MCAS) Measures	MY 2022	MY 2023	MY 2024	2024 Goal/50th Percentile	STATUS
Adults' Access to Preventive/Ambulatory Health Services (AAP)	64.05%	62.84%	62.94%	78.05%	NOT MET
Asthma Medication Ratio (AMR)*	74.16%	66.33%	66.08%	66.24%	NOT MET
Breast Cancer Screening (BCS-E)*	57.81%	58.39%	59.13%	52.68%	MET
Controlling High Blood Pressure (CBP)*	35.38%	43.54%	67.54%	64.48%	MET
Cervical Cancer Screening (CCS-E)*	57.73%	54.01%	57.86%	57.18%	MET
Chlamydia Screening in Women (CHL)*	72.11%	72.26%	76.66%	55.95%	MET
Childhood Immunization Status (CIS)					
*1. Combination 10 **	39.42%	35.45%	38.69%	27.49%	MET
Eye Exam for Patients with Diabetes (EED)	52.38%	54.09%	55.30%	56.39%	NOT MET
Glycemic Status Assessment for Patients With Diabetes (GSD)					
*1. HbA1c Poor Control (> 9%)+**	30.41%	29.34%	30.92%	33.33%	MET
Immunizations for Adolescents (IMA)					
*1. Combination 2**	51.82%	45.79%	46.21%	34.30%	MET
Kidney Health Evaluation for Patients With Diabetes (KED)	47.55%	44.40%	51.02%	42.13%	MET
Lead Screening in Children (LSC)	60.28%	63.83%	70.57%	69.96%	MET
Prenatal and Postpartum Care (PPC)					
*1. Timeliness of Prenatal Care**	81.60%	80.62%	88.15%	84.55%	MET
*2. Postpartum Care**	81.15%	74.41%	81.11%	80.23%	MET
Topical Fluoride for Children (TFL-CH)*	17.74%	23.25%	26.64%	19.00%	MET
Well-Child Visits in the First 30 Months of Life (W30)					
*1. 6+ Well-Child Visits in the First 15 Months**	55.78%	58.92%	70.28%	60.38%	MET
*2. 2+ Well-Child Visits for Age 15-30 Months**	71.20%	72.44%	74.40%	69.43%	MET
Child and Adolescent Well-Care Visits (WCV)*	51.49%	53.03%	55.46%	51.81%	MET

50th Percentile used is based on the MY2024 NCQA Quality Compass Benchmarks

** DHCS MY2024 MCAS Minimun Performance Level (MPL) for MCPs*

+ Lower rate indicates better performance

Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Analysis:

The table above presents MCAS measures based on HEDIS specifications for MY 2022–2024. Measures that did not meet the 2024 50th percentile goal include Adult Access to Preventive/Ambulatory Health Services (AAP), Asthma Medication Ratio (AMR), and Eye Exam for Patients with Diabetes (EED). Measures reflecting the greatest opportunities for improvement were identified as priority areas for 2025 and 2026 quality improvement initiatives.

Conclusion:
HEDIS performance reflects CalOptima Health's progress toward its strategic goal of achieving a 4-star Medi-Cal quality rating through NCQA. Measures showing improvement over the measurement year period demonstrate the value of sustained, coordinated quality improvement efforts across clinical programs, health networks and community partnerships. Measures that did not meet the 2024 goal represent priority areas for system improvements to enhance data capture and reporting and targeted member/provider interventions.

Activities/Resources to Address Gap:
CalOptima Health implements multimodal member outreach strategies to improve engagement and performance on key HEDIS measures, including text messaging, IVR calls, live telephonic outreach, targeted mailings, newsletters and mass media campaigns across social media, television and radio. The Member Health Rewards Program distributes gift card incentives to Medi-Cal members who complete preventive services, including breast and cervical cancer screenings, diabetes testing, prenatal and postpartum care, and lead screening. The 2026 QIHETP Work Plan includes deploying Cozeva, a real-time quality analytics platform, to enable automatic bidirectional data exchange with health network partners, integrating high-volume provider electronic medical record (EMR) systems to automatically extract quality data elements for care gap closure, and onboarding providers to the Cozeva user interface. In 2026, CalOptima Health also deployed an At-Home Lab Testing Program for colorectal cancer screening, HbA1c and kidney health testing with plans to expand at-home wellness visits to close additional quality gaps. The Quality Grant Program supports health networks in implementing measure-specific quality improvement initiatives. The Value-Based Payment Performance Program recognizes and rewards providers delivering high-quality care aligned with DHCS MCAS measures.

4.3.2. CalOptima Health Medi-Cal Behavioral Health HEDIS Rates

4.3.2.1. Overall (MCAS)

Medi-Cal Managed Care Accountability Set (MCAS) Measures	MY 2022	MY 2023	MY 2024	2024 Goal/50th Percentile	STATUS
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)					
1. Initiation Phase	42.37%	48.02%	50.35%	46.58%	MET
2. Continuation and Maintenance Phase	46.77%	52.55%	58.69%	55.07%	MET
Antidepressant Medication Management (AMM)					
1. Acute Phase Treatment	67.00%	68.09%	67.21%	64.36%	MET
2. Continuation Phase Treatment	48.62%	48.06%	50.64%	46.55%	MET
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
1. Blood Glucose and Cholesterol Monitoring Total	37.41%	36.76%	34.58%	37.93%	NOT MET
Follow-Up After ED Visit for Substance Abuse (FUA)					
1. Follow-up within 7 days	12.98%	11.23%	16.81%	26.89%	NOT MET
*2. Follow-up within 30 days**	24.05%	21.41%	28.63%	36.18%	NOT MET
Follow-Up After ED Visit for Mental Illness (FUM)					
1. Follow-up within 7 days	38.78%	21.38%	32.96%	41.52%	NOT MET
*2. Follow-up within 30 days**	58.83%	35.73%	52.33%	53.82%	NOT MET
Postpartum Depression Screening and Follow Up (PDS-E)					
1. Screening	8.08%	17.33%	9.24%	5.46%	MET
2. Follow-up	62.96%	56.84%	87.14%	69.10%	MET
Prenatal Depression Screening and Follow Up (PND-E)					
1. Screening	8.73%	14.52%	13.98%	9.54%	MET
2. Follow-up	45.16%	52.80%	77.53%	57.23%	MET
Pharmacotherapy for Opioid Use Disorder (POD)	20.77%	7.79%	4.93%	26.86%	NOT MET
Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications (SSD)	75.97%	74.96%	76.86%	82.83%	NOT MET

50th Percentile used is based on the MY2024 NCQA Quality Compass Benchmarks

** DHCS MY2024 MCAS Minimun Performance Level (MPL) for MCPs*

Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Analysis:

The table above presents behavioral health MCAS measures that use HEDIS specifications, for MY 2022–2024. Key measures that did not meet the 2024 50th percentile goal include Antidepressant Medication Management (AMM), Diabetes Screening for People with Schizophrenia/Bipolar Disorder Using Antipsychotic Medications (SSD), FUM, Follow-Up After ED Visit for Substance Abuse (FUA), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), and Pharmacotherapy for Opioid Use Disorder (POD). Follow-up-focused measures remain the most significant area for improvement.

Conclusion:

The performance data indicates that follow-up care remains a key area for improvement across behavioral health measures. Two key barriers to improving follow-up performance include challenges with data sharing and coordination with the HCA due to privacy laws, as well as limited capacity to outreach to all members who meet FUM and FUA criteria. Continued focus on engagement, care coordination, and member and provider education is essential to closing these gaps.

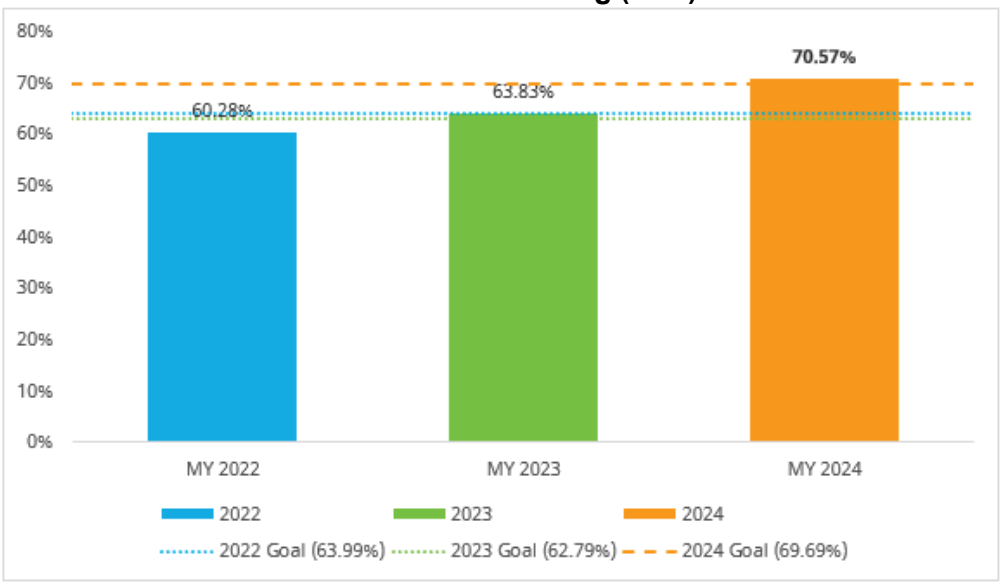
Activities/Resources to Address Gap:

CalOptima Health's BHI team increased education efforts for both members and providers through website improvements, provider office visits and the creation of member and provider materials to assist members in understanding how to gain access to needed behavioral health services. CalOptima Health maintains a yearly outreach and education plan that addresses gaps in care and areas that may need improvement. CalOptima Health's BHI team also

monitors behavioral health measures and advances member engagement strategies, including weekly text messages based on real-time ED visit data, and outreach through the National Alliance on Mental Illness (NAMI) By Your Side program to support members flagged in the daily ED data feed. In-person meetings with high-volume EDs are conducted to ensure members are connected to services before discharge, with partnerships reinforced with TeleMed2U and NAMI By Your Side for immediate member support. Health network Secure File Transfer Protocol (SFTP) data sharing facilitates timely follow-up coordination, and CalOptima Health Provider Portal enhancements include sharing BH Measures Reports and FUM/FUA daily ED reports to improve provider visibility and accountability. An active collaboration with DHCS/HCA through the Behavioral Health Collaboration Project supports improvement in FUA and FUM HEDIS outcomes. For prenatal and postpartum depression measures, CalOptima Health enhances tracking and documentation through collaborative efforts with HCA, targeted social media campaigns to promote depression screening, and partnerships with community-based organizations. Effective July 2026, CalOptima Health increased the postpartum member health reward from $25 to $50 for completing a postpartum checkup, which includes screening for postpartum depression.

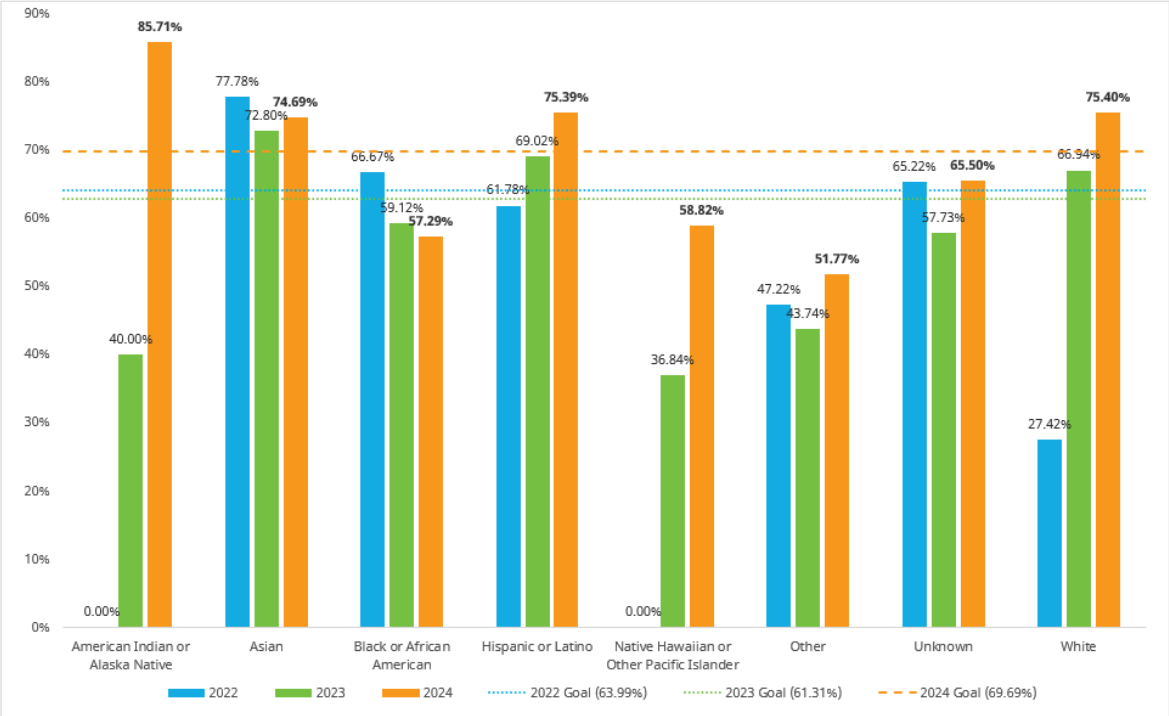
4.3.3. Health Disparities

4.3.3.1. Efforts to Support Blood Lead Screening Among Members



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Blood Lead Screening (LSC) by Race/Ethnicity



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Analysis:

Blood lead screening is a routine test that measures the level of lead in a child's blood at 12 and 24 months, enabling early identification and intervention before lead exposure causes irreversible developmental harm. The charts above display blood lead screening (LSC) trends from MY 2022 through 2024, including a breakdown by race and ethnicity. CalOptima Health met the goal for LSC in MY 2023 and 2024, demonstrating year-over-year improvements. As observed in prior years, screening rates vary by race and ethnicity, with certain populations, including Black or African American, Native Hawaiian or Other Pacific Islander, Unknown and Other falling below the goal, while American Indian or Alaska Native, Asian, Hispanic or Latino, and White members exceeded it.

Conclusion:

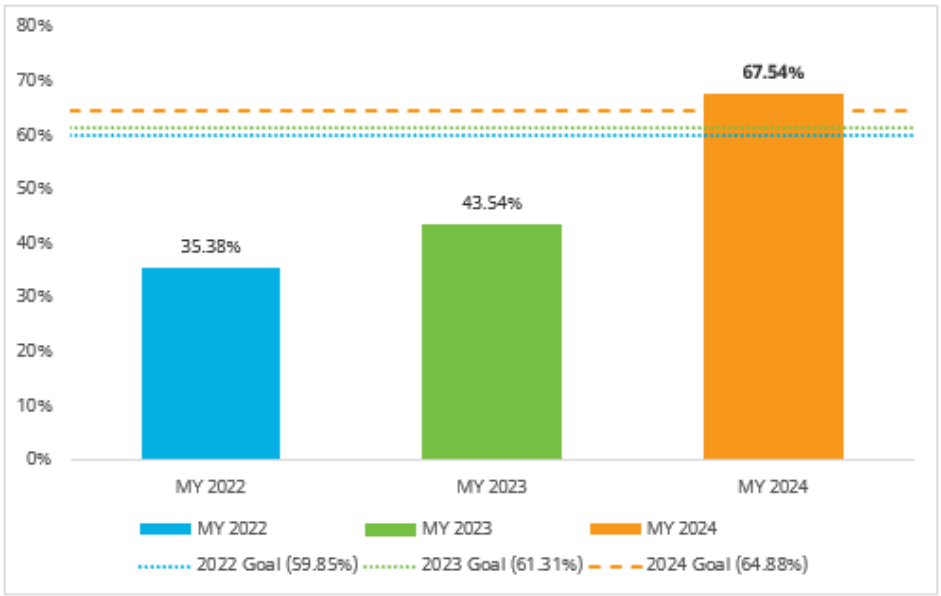
These screening disparities are particularly concerning when viewed alongside race-specific patterns in lead exposure. According to the California Department of Public Health, housing-related sources of lead are the most common exposure pathway among Black children (40%) and Hispanic children (36.6%), reflecting the disproportionate burden these communities bear from aging housing stock and residential lead-based paint hazards. In contrast, nonhousing sources like imported goods, traditional remedies or occupational take-home exposure account for the majority of lead exposure among Asian Indian children (63.6%) and Afghan children (76.5%). This divergence in exposure pathways underscores that lead risk is not uniform across racial and ethnic groups and that a single screening or outreach strategy will not serve all populations equitably.

Furthermore, geographic location amplifies these disparities. Children in high-poverty communities and neighborhoods with older housing built before 1978 face compounded environmental and economic risk factors that increase both the likelihood of lead exposure and barriers to timely screening.

Activities/Resources to Address Gap:

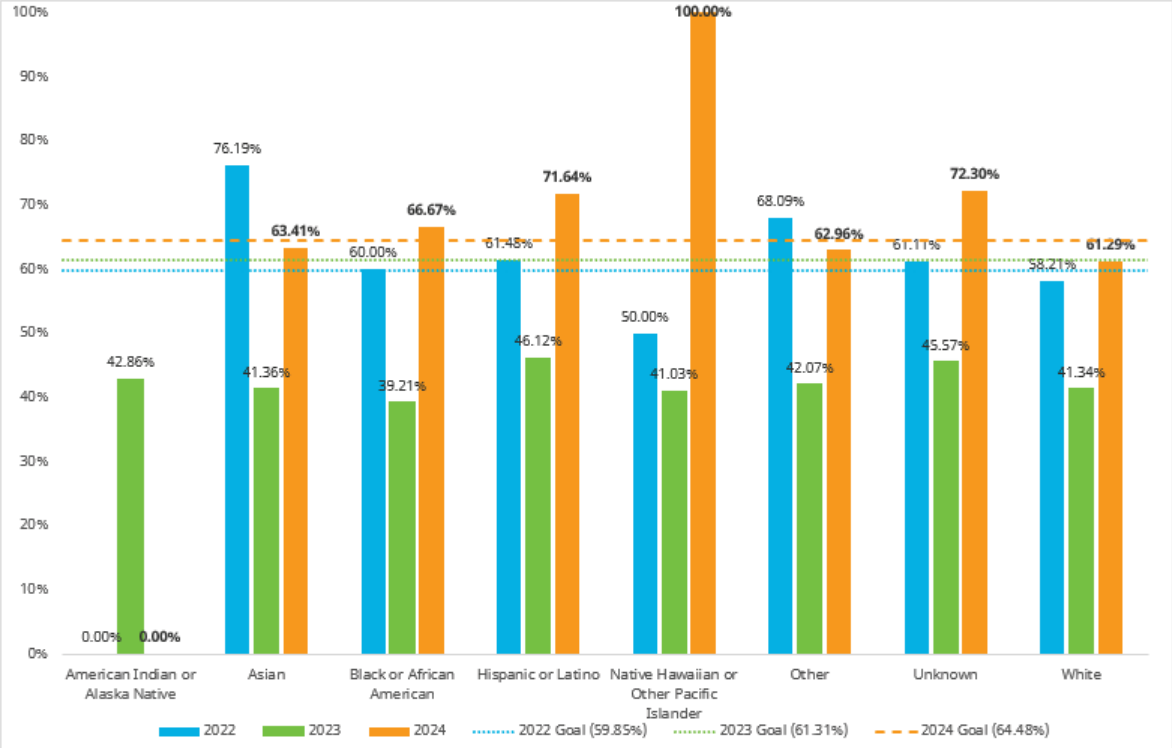
CalOptima Health monitors LSC performance as part of its disparities-reduction efforts. Targeted outreach focuses on populations with the lowest screening rates, using culturally and linguistically appropriate materials. Provider education, health network accountability and the Member Health Rewards Program all support improved screening completion. Members receive rewards for completing lead tests at 12 and 24 months. Text messaging campaigns promote pediatric wellness and blood lead reminders, and targeted mailings are sent to children approaching these milestones. Through the Quality Grant Program, health networks receive funding to implement point-of-care lead testing in high-volume clinics. In 2025, CalOptima Health collaborated with the HCA and Kaiser Permanente to reduce disparities in timely blood lead screening, including the development of a comprehensive dashboard and community profiles for high-need neighborhoods. These neighborhood profiles enable CalOptima Health and its providers to identify geographies where housing age and poverty converge to elevate lead risk and direct outreach resources accordingly. A communications toolkit and training for community health workers promoted the use of motivational interviewing to address concerns and barriers to lead testing, with messaging adapted to reflect the distinct exposure sources and contexts relevant to each community.

4.3.3.2. High Blood Pressure Control Among Members



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Controlling Blood Pressure (CBP) by Race/Ethnicity



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Analysis:

The charts above show CalOptima Health's CBP rates among Medi-Cal members overall and by race/ethnicity from MY 2022–2024. The rate demonstrated a significant leap from 43.54% in 2023 to 67.54% in 2024, meeting the overall goal for the first time during the three-year period. Additionally, Black, Hispanic and Native Hawaiian/Pacific Islander members exceeded the goal, while White and Asian members fell slightly below. Disparities across racial and ethnic groups continue to present opportunities for targeted intervention.

Conclusion:

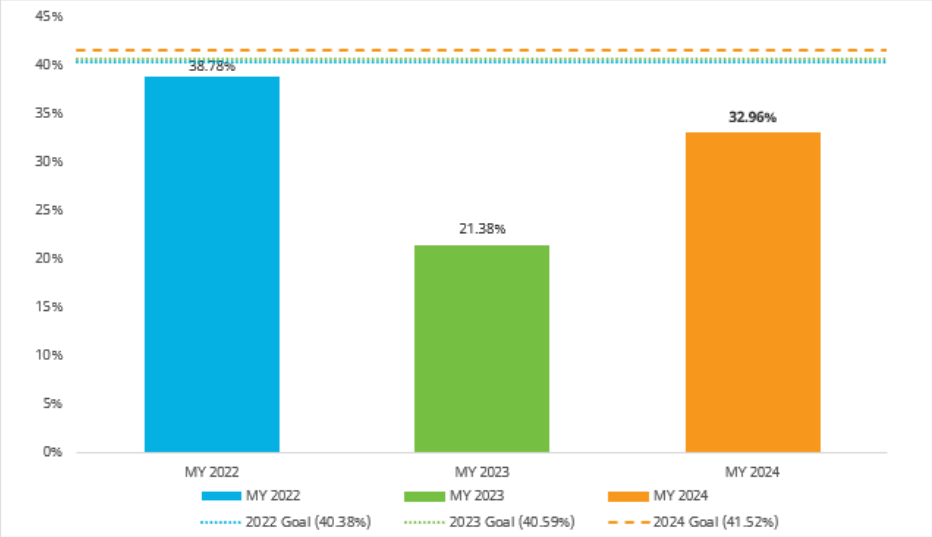
Strengthening hypertension management and improving CBP rates across the Medi-Cal population requires addressing disparities in blood pressure control across different racial and ethnic groups. Effective blood pressure management requires sustained, multilevel engagement with members, providers and community partners, including approaches that extend beyond clinical settings and into the communities where members live.

Activities/Resources to Address Gap:

CalOptima Health works on multifaceted interventions to improve hypertension control, including promoting access to home blood pressure monitoring devices for member self-management. Additional efforts, such as social media campaigns, community outreach events, newsletter articles, text messaging and telephonic health education, provide targeted education and self-management support for members with high blood pressure.

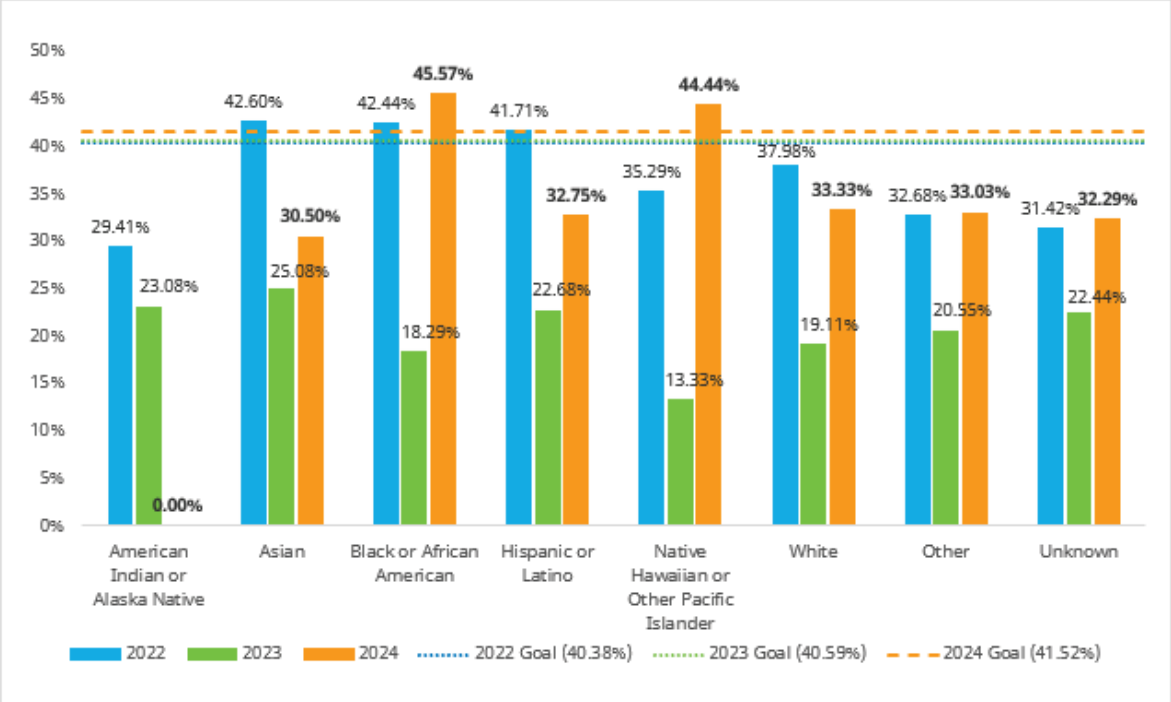
4.3.3.3. Efforts to Support Member Follow-up Care After Emergency Department Visit for Mental Illness

Follow-Up Within Seven Days (FUM)

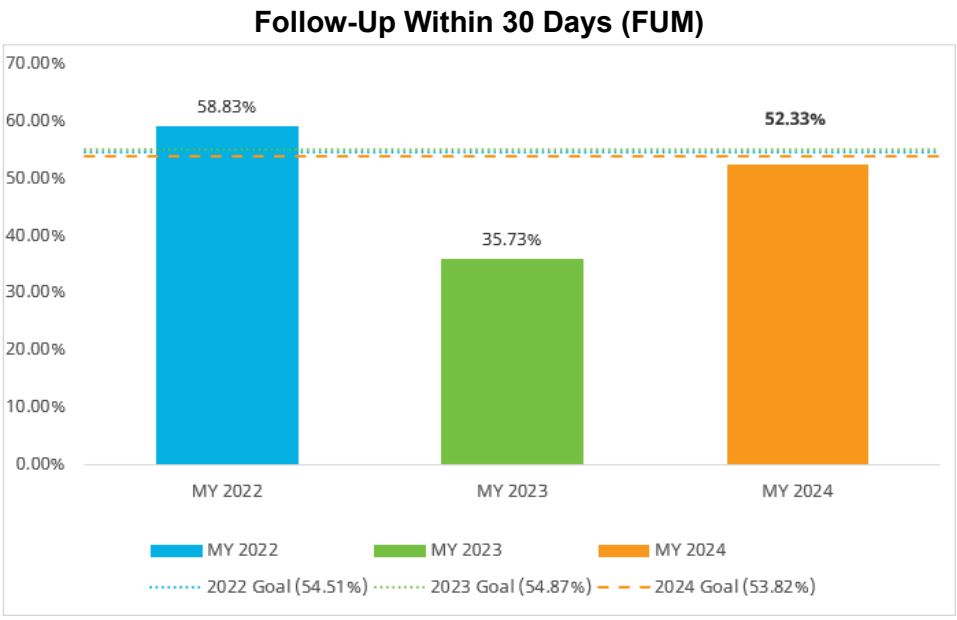


Data Source: MY 2022-2024 CalOptima Health HEDIS Results

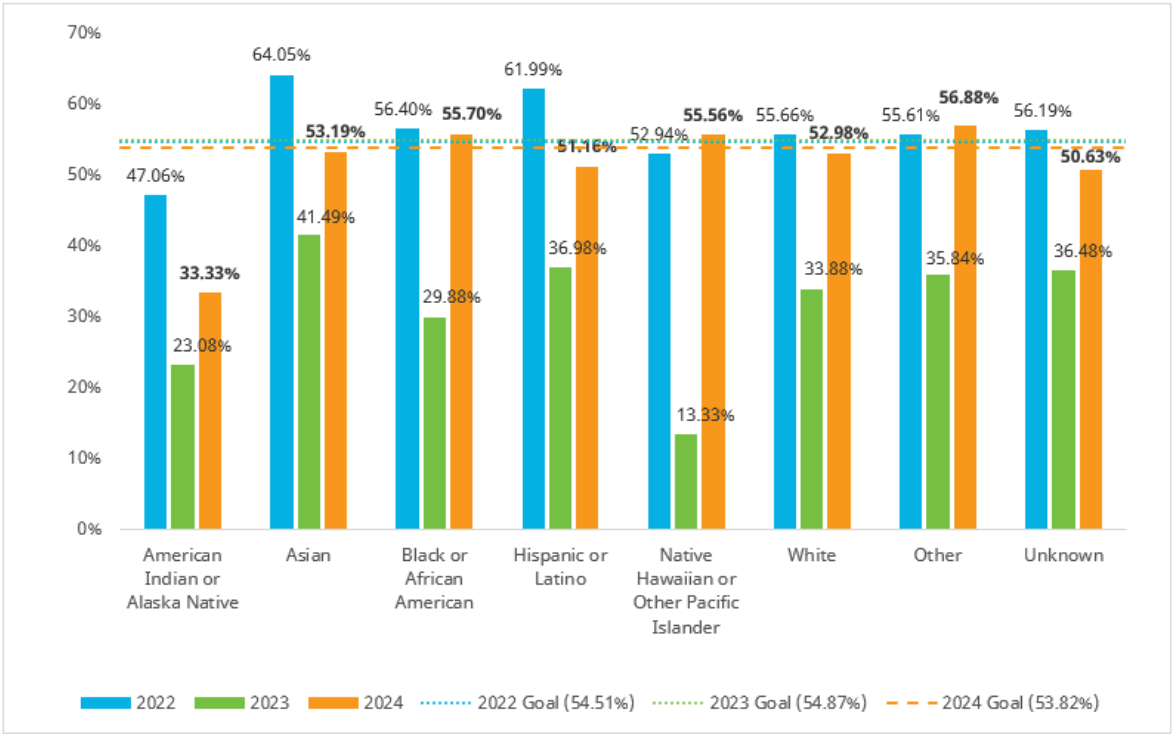
Follow-Up Within Seven Days (FUM) by Race/Ethnicity



Data Source: MY 2022–2024 CalOptima Health HEDIS Results



Data Source: MY 2022–2024 CalOptima Health HEDIS Results



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

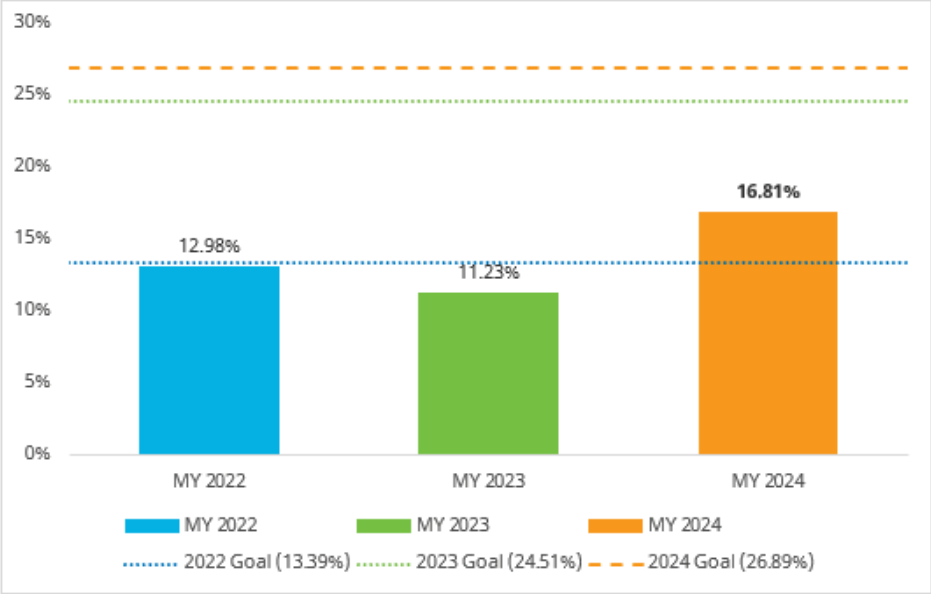
Analysis:
The tables above show follow-up rates after ED visits for mental illness (FUM) within seven and 30 days, broken down by race and ethnicity for MY 2022 through 2024. As observed in prior years, CalOptima Health's overall FUM rates remain below the goal for both seven- and 30-day follow-up. Racial and ethnic disparities in FUM performance persist, with most groups declining or showing limited improvement relative to prior measurement years.

Conclusion:
The failure to meet the goal for both seven- and 30-day FUM measures highlights the urgent need for continued focus on engaging members with mental illness, supporting providers and closing gaps in care. Key barriers include challenges with data sharing and coordination with HCA due to privacy laws, as well as limited capacity to outreach to all members who meet FUM criteria. Improvement in FUM is a direct organizational priority for CalOptima Health in 2026.

Activities/Resources to Address Gap:
CalOptima Health continues to prioritize improving FUM rates. Transitional Care Services (TCS) staff conduct outreach to members discharged from the ED after a behavioral health visit, including text outreach, which launched in October 2024. The BHI team coordinates with health networks and community behavioral health providers to facilitate timely follow-up, and CalOptima Health monitors FUM performance by network to implement targeted interventions where gaps are greatest. The BHI team deploys multiple strategies to address FUM gaps, including weekly text messages based on real-time ED data, outreach through the NAMI By Your Side program and partnerships with behavioral health telehealth vendor TeleMed2U to contact members identified through the daily ED feed. In 2026, CalOptima Health is conducting in-person meetings with high-volume EDs to strengthen warm handoffs before discharge, reinforcing partnerships with TeleMed2U and NAMI for immediate support. Provider portal updates now include BH Measures Reports and FUM daily ED reports to enhance provider visibility and accountability. Collaboration with HCA continues through the DHCS/HCA Behavioral Health Collaboration Project to address data sharing and coordination challenges with County BH. Health network engagement includes participation in HN Quality Meetings and a standardized process to engage providers in the behavioral health care continuum.

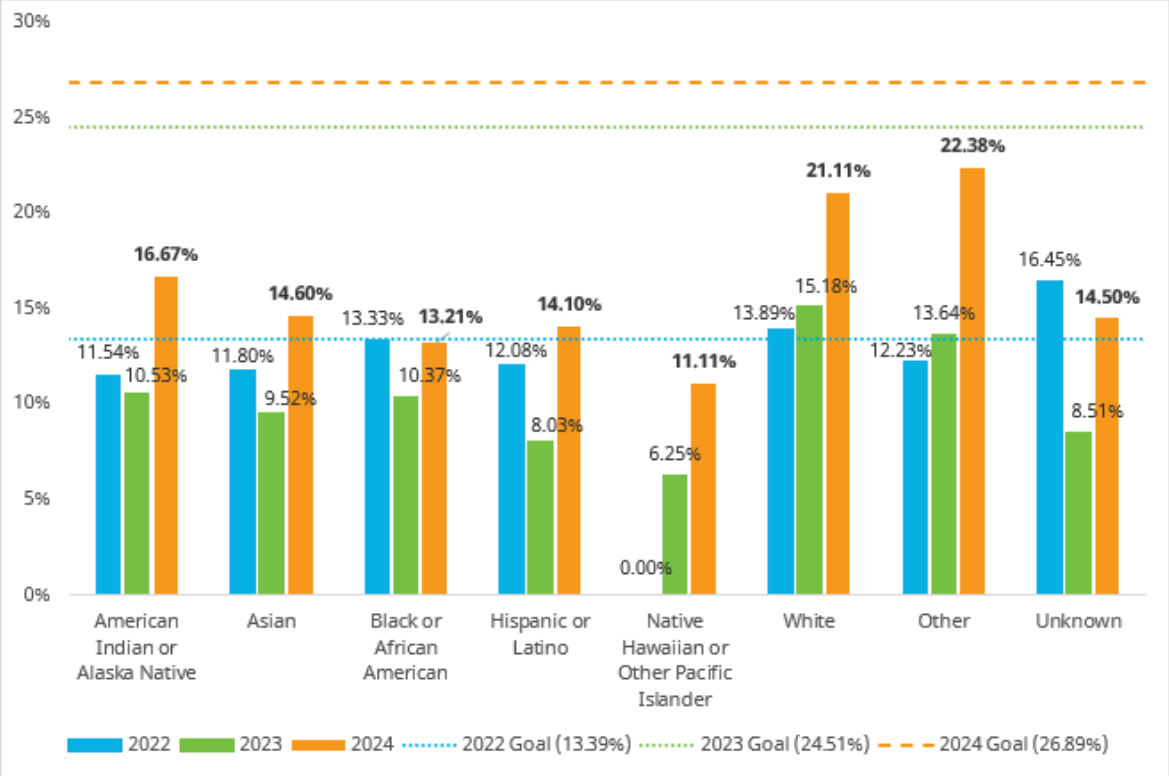
4.3.3.4. Efforts to Support Member Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Follow-Up Within Seven Days (FUA)



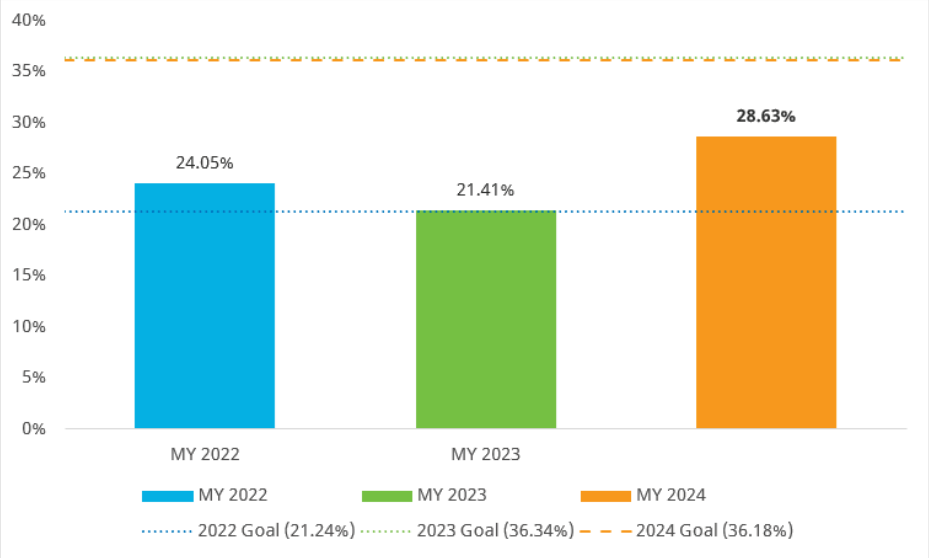
Data Source: MY 2022–-2024 CalOptima Health HEDIS Results

Follow-Up Within Seven Days (FUA) by Race/Ethnicity



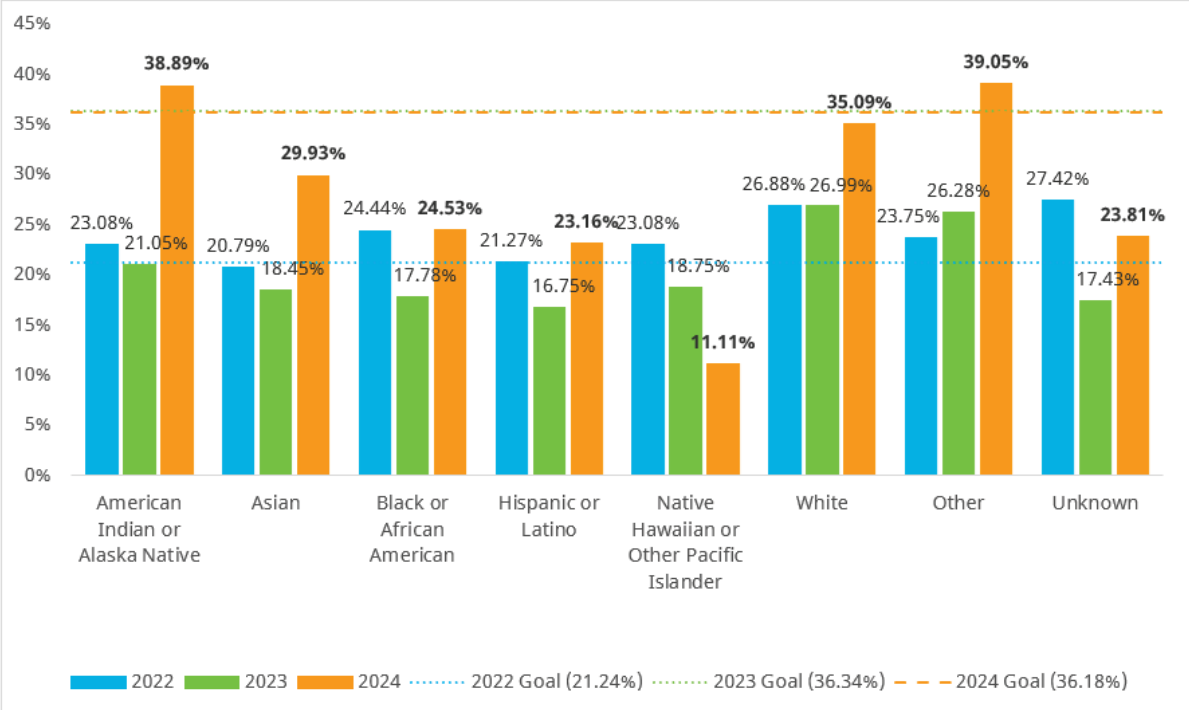
Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Follow-Up Within 30 Days (FUA)



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Follow-Up Within 30 Days (FUA) by Race/Ethnicity



Data Source: MY 2022–2024 CalOptima Health HEDIS Results

Analysis:

The charts above display CalOptima Health's follow-up rates after ED visits for substance use disorder (FUA) within seven and 30 days, broken down by race and ethnicity for MY 2022 through 2024. Although 2024 rates demonstrated improvement compared to 2023, both seven-day and 30-day FUA rates remain below the 2024 goal. Racial and ethnic variation is present across both rate periods, with most groups below the 2024 goal.

Conclusion:
Given ongoing gaps in follow-up care after substance use-related ED visits, CalOptima Health recognizes the continued importance of investing in outreach strategies and developing secure, streamlined data-sharing mechanisms with key partners such as HCA.

Activities/Resources to Address Gap:
CalOptima Health's BHI team coordinates with substance use treatment providers and the Orange County BHP to ensure timely follow-up after substance use-related ED visits. ECM is available to high-risk members with co-occurring substance use disorders and complex needs, and TCS supports follow-up after inpatient or ED discharge. CalOptima Health monitors FUA performance by health network and race/ethnicity as part of its efforts to reduce disparities. Real-time ED data is also shared with contracted health networks, including daily FUA ED reports to enhance provider visibility. BHI sends biweekly text reminders to promote follow-up care, and FUA services are highlighted in member newsletters. CalOptima Health also participates in the IHI/DHCS Behavioral Health Collaboration Project with HCA to support FUA improvement.

4.3.4. Population Health Management Key Performance Indicators

KPI	CalOptima Health	State Avg.	vs. State	Key Takeaway
Members with more ED than PCP visits (EDPC*)	**4.6%**	5.8%	**Above state average**	Favorable; lower is better. 26–34 year olds are the highest sub-group at 6.0%
Members with at least one PCP visit (ENPC)	**47.8%**	54.4%	**Below state average**	6.6 percentage points below state average. Young adults (21–25) at 32.1%, lowest of any age group.
PCP visit with assigned provider (ENPC-A)	**25.5%**	N/A	**Not available**	DHCS excluded statewide average due to data issues.
CCM enrollment — all eligible (CCME-A)	**68.8%**	10.2%	**Above state average**	Second highest in California; reflects strong CCM infrastructure.
Care management after discharge (CMHRD)	**27.7%**	20.7%	**Above state average**	7.0 percentage points above state average, reflecting TCS infrastructure.
Seven-day follow-up visit after hospitalization (FUAH)	**39.0%**	42.1%	**Below state average**	~750 additional members needed to reach state average

**ENPC-A excluded from statewide comparison. Data Source: DHCS PHM KPI Data submitted January 31, 2026, for Reporting Period:10/1/2024–9/30/2025*

Analysis:
Beginning in 2026, DHCS requires all Medi-Cal managed care plans (MCPs) to report PHM Key Performance Indicators (KPIs) on a quarterly basis. These measures assess how effectively plans support members in accessing appropriate care, including reducing avoidable ED utilization, connecting members to primary care and ensuring timely follow-up

after high-risk transitions. While formal performance benchmarks have not yet been established, reporting is standardized across all MCPs, enabling CalOptima Health to benchmark against statewide plans. For the January 31, 2026, report submission, CalOptima Health's Medi-Cal population was assessed across six KPIs, with performance above the statewide average on three measures.

Members with more ED visits than PCP visits (EDPC):
4.6% of members had more ED visits than primary care visits, compared to the statewide average of 5.8% (lower is better). ED utilization is highest among members ages 26–34 (6.0%) and 0–5 year-olds (5.3%), suggesting some parents may be using the ED for conditions manageable in primary or urgent care. Black/African American members have the highest EDPC rate at 7.8%, followed by Native Hawaiian/Other Pacific Islander (6.4%) and American Indian/Alaska Native (6.4%) members, indicating meaningful disparities in primary care access across racial groups.

Members with at least one PCP visit (ENPC):
47.8% of members had at least one primary care visit during the measurement period, compared to the statewide average of 54.4% (higher is better). At 6.6 percentage points below the state average, engagement in primary care is CalOptima Health's most significant performance challenge relative to other plans. Engagement is highest among the 0–5 age group (68.7%) but still lags the statewide rate of 76% for that group. Young adults ages 21–25 have the lowest engagement rate (32.1%), and the 18–34 age range consistently underperforms, warranting targeted outreach. American Indian/Alaska Native members have the lowest ENPC rate at 29.0%, nearly 19 percentage points below the population average, followed by Native Hawaiian/Other Pacific Islander (36.1%) and Black/African American (38.4%) members, while Asian (49.9%) and Hispanic/Latino (49.7%) members are the only identified groups performing above the overall rate.

Members with at least one PCP visit with their assigned provider (ENPC-A):
25.5% of members had at least one primary care visit with their assigned PCP. This measure is excluded from statewide comparison due to a DHCS data issue.

CCM enrollment (CCME-A):
68.8% of members eligible for CCM were enrolled, compared to a statewide average of 10.2% (higher is better). CalOptima Health ranks second among all Medi-Cal MCPs on this measure, reflecting strong infrastructure for high-risk member identification and care management engagement. CalOptima Health's CCM enrollment rates are lower among Asian members (59.4%) compared to Hispanic/Latino (72.0%) and White (69.5%) members.

Care management for high-risk members after discharge (CMHRD):
27.7% of high-risk member discharges were followed by a care management interaction within seven days, compared to the statewide average of 20.7% (higher is better). While CalOptima Health performs above average, the 26–34 age group, which accounts for the highest volume of discharges (5,525), has the lowest follow-up rate at 20.2%.

Follow-Up Ambulatory Visit After Hospitalization – Seven Days (FUAH):

39.0% of hospital discharges were followed by an ambulatory visit within seven days, compared to the statewide average of 42.1% (higher is better). Closing the gap to the statewide average would require securing follow-up for approximately 750 additional discharged members per year. Follow-up rates are highest for the 0–5 age group (60.0%) and lowest among members ages 26–34 (27.6%). The 35–64 age band represents the largest share of discharges and performs below the plan average, making it a high-impact target.

Conclusion:

CalOptima Health's PHM KPI results reflect both strengths and opportunities. CCM enrollment is a clear organizational strength, with CalOptima Health ranking second in the state, and EDPC performance is positive relative to peers. However, ENPC represents the plan's most significant opportunity, with a 6.6 percentage point gap below the statewide average, driven largely by low engagement among young adults ages 18–34. While age 0–5 ENPC (68.7%) is the highest pediatric rate, it lags behind the statewide average of 76%. Conversely, the 0–5 group has the highest EDPC among pediatric age groups (5.3%), suggesting some parents are using the ED for conditions that may be better addressed in primary or urgent care. FUAH is similarly below the state average, particularly for working-age adults ages 35–64, who account for the greatest share of discharges.

Across measures, young adults ages 18–34 consistently underperform and disparities by race and ethnicity persist: Black/African American, Native Hawaiian/Other Pacific Islander and American Indian/Alaska Native members have substantially higher EDPC rates, while Asian members show lower CCM enrollment. These patterns will inform targeted interventions in future organizational PHM efforts to close gaps and reduce disparities.

Activities/Resources to Address Gap:

Opportunities for improvement include expanded primary care outreach and engagement strategies targeting young adults ages 18–34, increased appointment availability and member education on the appropriate use of emergency, urgent and primary care settings. Promoting the Nurse Advice Line, particularly for caregivers of young children, represents an opportunity to support timely triage and reduce avoidable ED utilization among the 0–5 age group. Improvements to how newly enrolled members are assigned to a PCP and informed of their provider may also drive gains in primary care engagement over time.

To address gaps in post-hospitalization follow-up, CalOptima Health is enhancing its ability to engage high-risk members through real-time dashboards that identify opportunities for targeted outreach within seven days of transitions. System enhancements will automate TCS activity creation, increasing visibility into member inpatient admissions and supporting timely follow-up. Standardized, disease-specific question templates are also being implemented to ensure a consistent approach to disease management across the care management team. TCS outreach snapshots are being cascaded to delegated health networks to promote communication, alignment and shared awareness of transition activity at the health network level.

To support improvement on the FUAH measure, CalOptima Health has expanded access to PCP gap visits through a partnership with an urgent care provider that can see members who are not yet assigned to a PCP, as well as members needing follow-up within seven days of discharge. This partnership includes availability after 5 p.m. and on weekends, creating additional opportunities for timely follow-up across multiple locations. CalOptima Health is

encouraging the use of urgent care gap visit scheduling with hospital and skilled nursing facility partners and shares ambulatory follow-up rates with delegated health networks and hospitals during joint operations meetings to drive shared awareness and identify opportunities to improve discharge appointment scheduling.

CalOptima Health will also explore opportunities to strengthen care management at discharge and expand outreach to the maternal health population and working-age adults, who account for the disproportionately low post-discharge follow-up rates. Across all measures, race- and ethnicity-stratified performance will be monitored quarterly to identify emerging disparities and inform targeted interventions, alongside ongoing efforts to improve data completeness in discharge-related reporting.

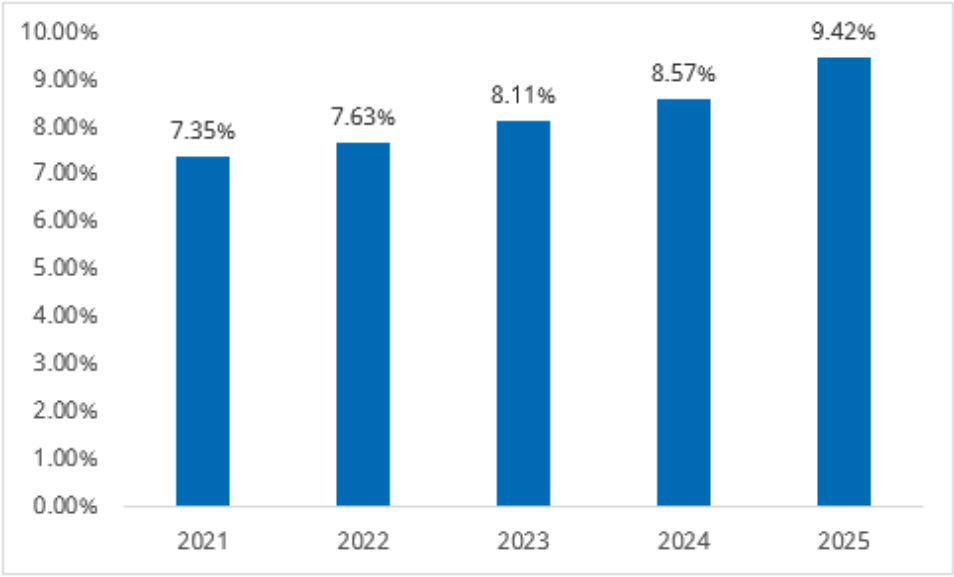
4.4. Subpopulations

Certain groups within CalOptima Health's Medi-Cal membership carry a disproportionate share of complexity and unmet need. This section examines three priority subpopulations: members with diabetes, members in the maternal health population and members with co-occurring behavioral health and substance use disorders. For each subpopulation, the assessment presents demographic profiles, clinical data and an overview of the program and strategies CalOptima Health has in place to improve outcomes.

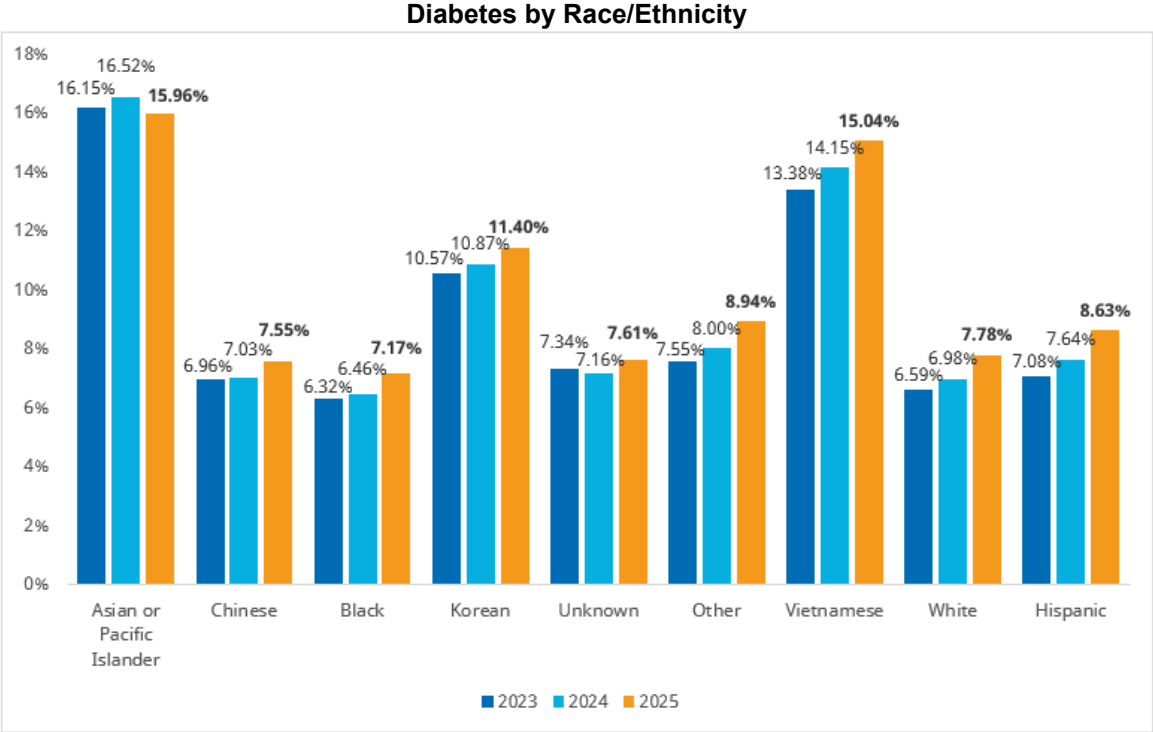
4.4.1. Diabetes

Diabetes is one of the most prevalent and clinically significant chronic conditions among CalOptima Health's Medi-Cal membership, disproportionately affecting communities of color and members facing the compounding challenges of poverty, food insecurity and chronic stress. The emergence of GLP-1 medications reflects a significant advancement in diabetes management, offering the potential to meaningfully improve outcomes for members who can access and sustain this treatment. CalOptima Health is committed to addressing diabetes through a comprehensive continuum of education, disease management, provider engagement and ongoing improvement strategies that meet members where they are and support the highest quality of care.

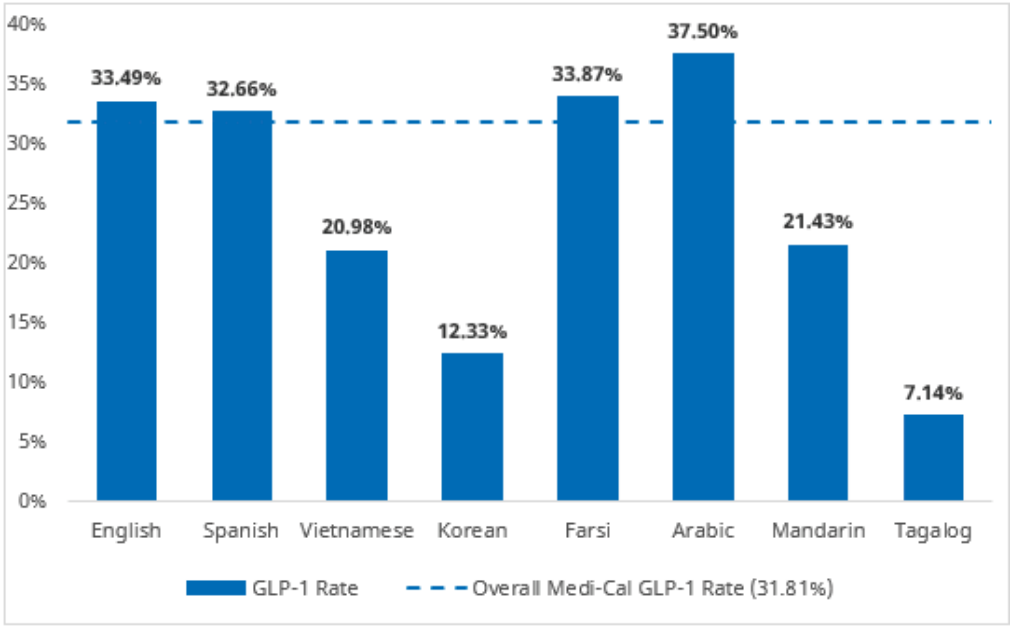
Diabetes Prevalence Among Medi-Cal Membership



Data Source: CalOptima Health (2021–2025). CMS Chronic Conditions Tableau Dashboard. Accessed April 2026.

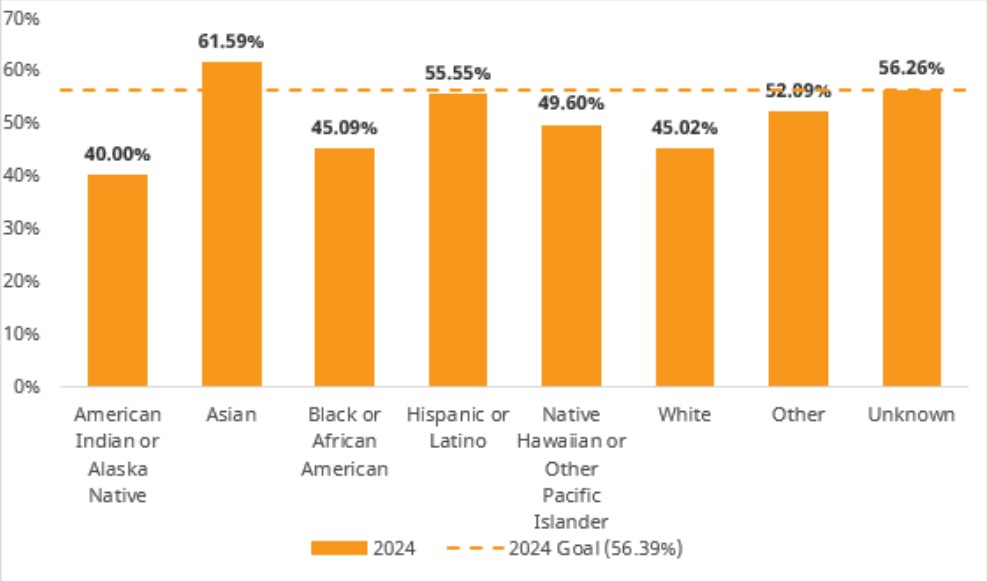


Data Source: CalOptima Health (2023–2025). CMS Chronic Conditions Tableau Dashboard. Accessed April 2026.



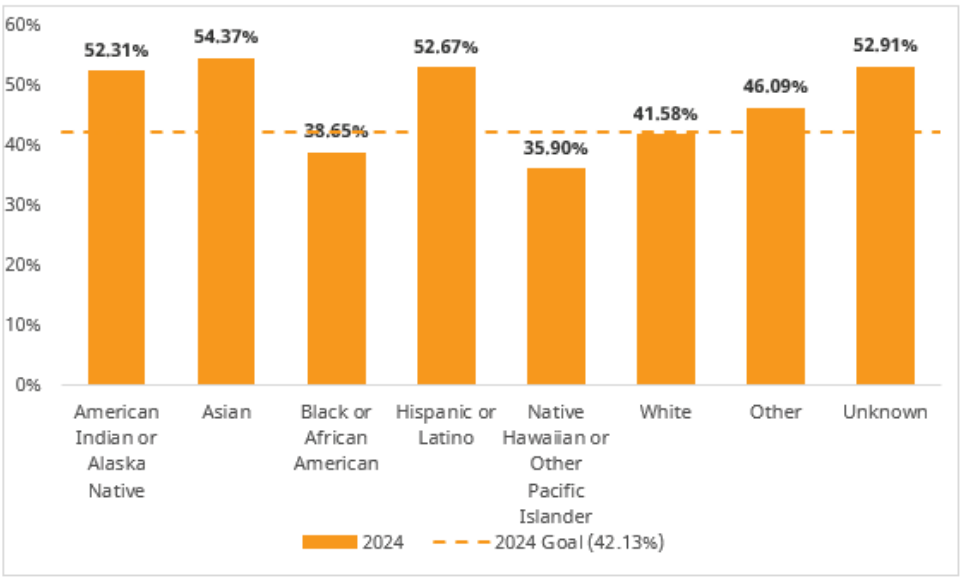
Data Source: Ad-hoc GLP-1 utilization report of members with diabetes and an A1c ≥9%. CalOptima Health claims and encounters from CAL_DIM. Accessed February 2026.

Eye Exam for Patients with Diabetes (EED)



Data Source: MY 2024 CalOptima Health HEDIS Results

Kidney Health Evaluation for Patient with Diabetes (KED)



Data Source: MY 2024 CalOptima Health HEDIS Results

Analysis:

Diabetes remains one of the most prevalent and clinically significant chronic conditions among CalOptima Health's Medi-Cal membership. Trending data from 2021 through 2025 shows a sustained increase in diabetes prevalence over the five-year period, reflecting broader national trends in Type 2 diabetes driven by rising rates of obesity, sedentary behavior and food insecurity. Approximately 79,000 Medi-Cal members were living with diabetes in 2025, with more than 113,000 additional members at risk based on either a diagnosis of prediabetes or obesity.

When examined by race and ethnicity, diabetes prevalence is not evenly distributed across the membership. Hispanic members, who represent the largest share of CalOptima Health's Medi-Cal enrollment, show elevated rates of diabetes relative to other groups, consistent with well-documented national disparities in diabetes burden among Latino populations. Vietnamese members also show elevated rates, reinforcing the need for culturally targeted disease management and outreach strategies. Trending data from 2023 through 2025 indicates continued growth in diabetes prevalence across most racial and ethnic groups. Analysis of GLP-1 medication utilization by spoken language reveals meaningful variation in how members across language groups engage with this emerging class of diabetes and obesity treatment. Variation in adherence by language group suggests that language access and culturally appropriate health education are important factors in medication engagement. Performance on diabetes-related HEDIS quality measures reflects ongoing care gaps. The Eye Exam for Patients with Diabetes (EED) and Kidney Health Evaluation for Patients with Diabetes (KED) rates have shown mixed trends across MY 2022–2024, with both measures reflecting continued opportunities to close gaps in preventive monitoring. Diabetic retinopathy and chronic kidney disease are largely preventable with timely screening and intervention, making performance on these measures a direct indicator of care quality for this subpopulation.

Conclusion:

Slowing the trajectory of diabetes within CalOptima Health's membership requires equal investment in prevention and management, including identifying at-risk members early, connecting them to evidence-based interventions, and addressing the social and structural conditions that make healthy choices difficult for many Medi-Cal members.

Furthermore, the sustained prevalence of diabetes across CalOptima Health's Medi-Cal membership, combined with persistent gaps in HEDIS quality performance for EED and KED, underscores the urgent need for a comprehensive, integrated approach to diabetes management. Racial and ethnic disparities in diabetes prevalence highlight that this condition disproportionately affects Hispanic and other communities of color within the membership. Variation in GLP-1 utilization by spoken language further signals that clinical access alone is insufficient; members require linguistically appropriate education and engagement to benefit fully from available treatments. As the policy environment around GLP-1 coverage evolves, CalOptima Health must remain proactive in ensuring members retain access to medications that support both diabetes and obesity management. Unmanaged diabetes drives ED utilization, accelerates progression to chronic kidney disease and cardiovascular complications, and reduces quality of life, making this subpopulation a continued priority for targeted investment.

Activities/Resources to Address Gap:

In recognition of the significant proportion of members at risk for developing Type 2 diabetes, CalOptima Health is expanding access to the Diabetes Prevention Program (DPP), an evidence-based lifestyle change program proven to reduce the risk of Type 2 diabetes in adults. The program supports at-risk members in making sustainable changes to nutrition, physical activity and weight management through structured group coaching delivered by lifestyle coaches. CalOptima Health employs a multifaceted approach to diabetes management through its Disease Management (DM) Program, which provides tailored diabetes self-management education led by health coaches with deep experience providing

health education to individuals with chronic conditions. Health coaching services are available to members with diabetes to support lifestyle modification, medication adherence and care navigation.

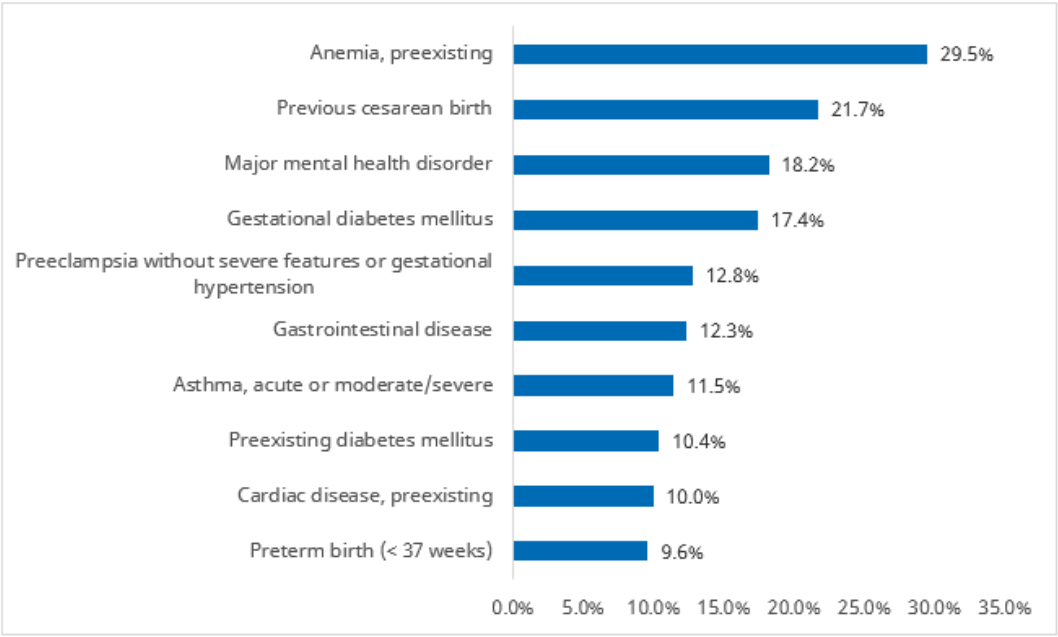
In 2025, CalOptima Health launched a structured outreach initiative targeting members with elevated hemoglobin A1c levels (≥11%), using stratified member lists and a tiered risk-based outreach cadence across health networks. This initiative includes monthly reporting expectations for health networks and a dedicated outreach reporting tool to drive accountability and track progress. A specialty telehealth referral pilot in partnership with Telemed2U is also underway, connecting members with elevated A1c to health coaches to support intensive engagement and clinical follow-up.

To further address gaps in diabetes quality measures, CalOptima Health has implemented multimodal member outreach, including text, IVR and mailed education materials, to encourage completion of EED and KED screenings. Additional targeted efforts include telehealth specialty care, home visits for individuals needing an annual wellness visit and home test kits for A1c and kidney screenings. Health networks receive regular performance reporting on EED and KED rates to support targeted provider-level interventions. The GLP-1 member outreach initiative supports medication access and adherence for members managing diabetes and obesity, with dashboards shared with health networks to monitor engagement and identify members at risk of care gaps.

4.4.2. Maternal Health

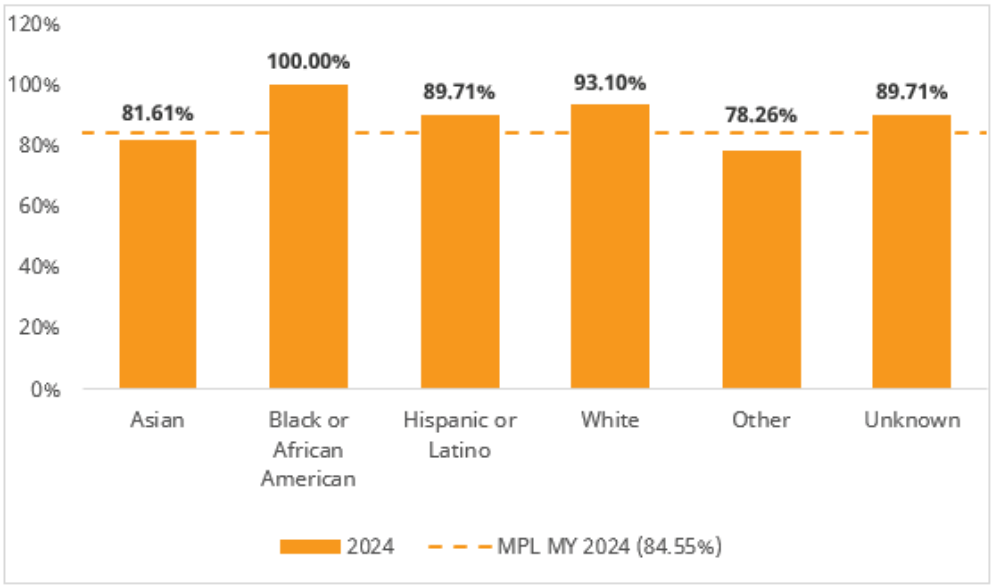
Maternal health is a priority subpopulation for CalOptima Health, reflecting the plan's commitment to supporting members through one of the most critical and consequential periods of their health journey. CalOptima Health's birthing population is predominantly Hispanic with a significant number of Spanish-speakers, reflecting the diversity of Orange County's Medi-Cal community and driving the plan's commitment to delivering coordinated, culturally responsive care that meets members where they are, regardless of language, culture or clinical needs.

Most Prevalent Obstetric (OB) Comorbidities

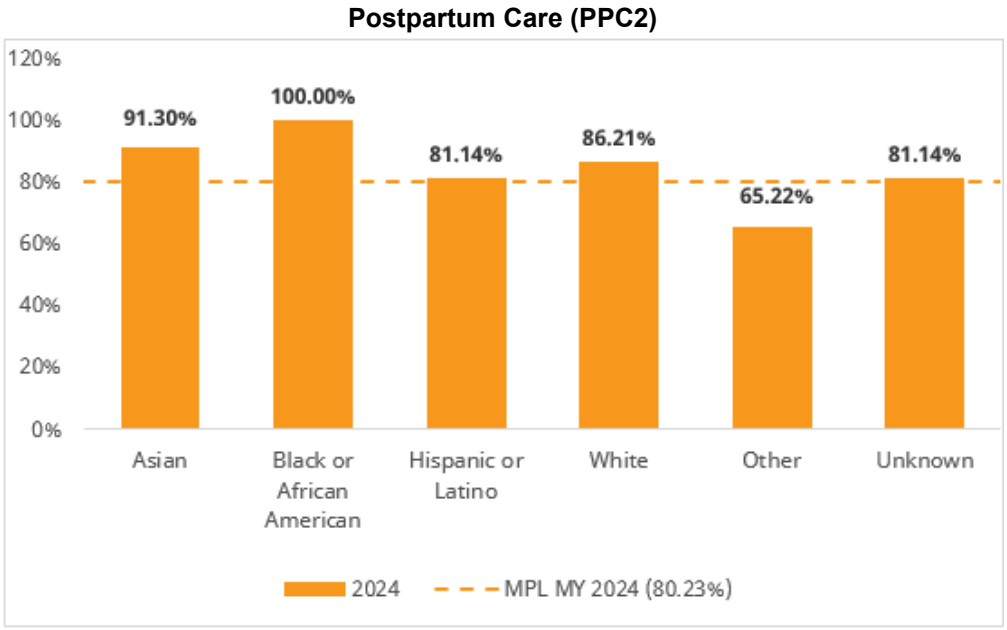


Data Source: Ad-hoc claims and encounter data reflecting CalOptima Health Medi-Cal member hospital-based deliveries between July 1, 2024, and June 30, 2025, using conditions included in the Obstetric Comorbidity Index

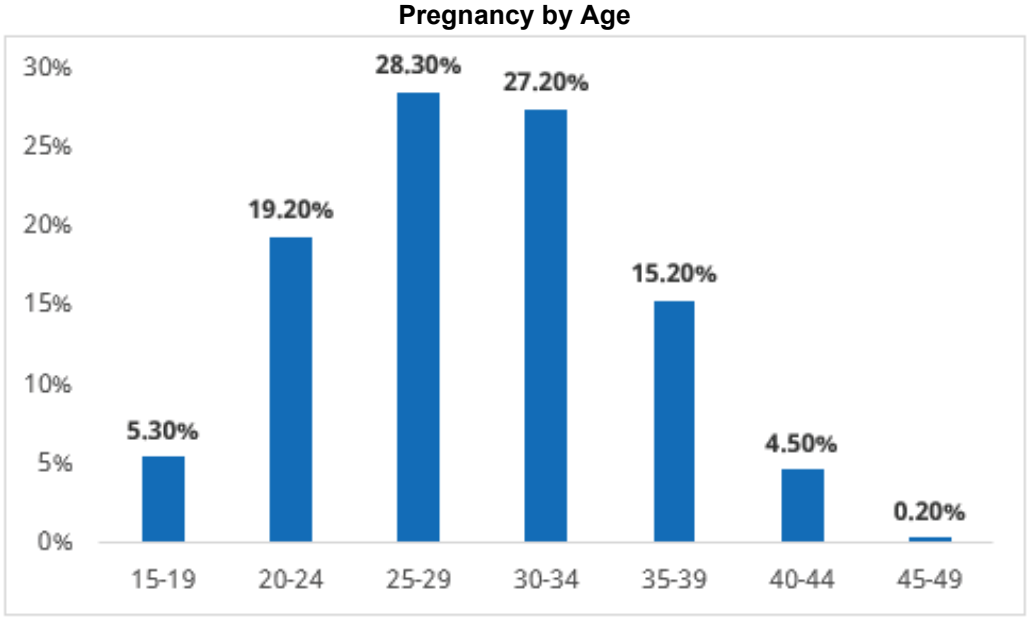
Prenatal Care (PPC1)



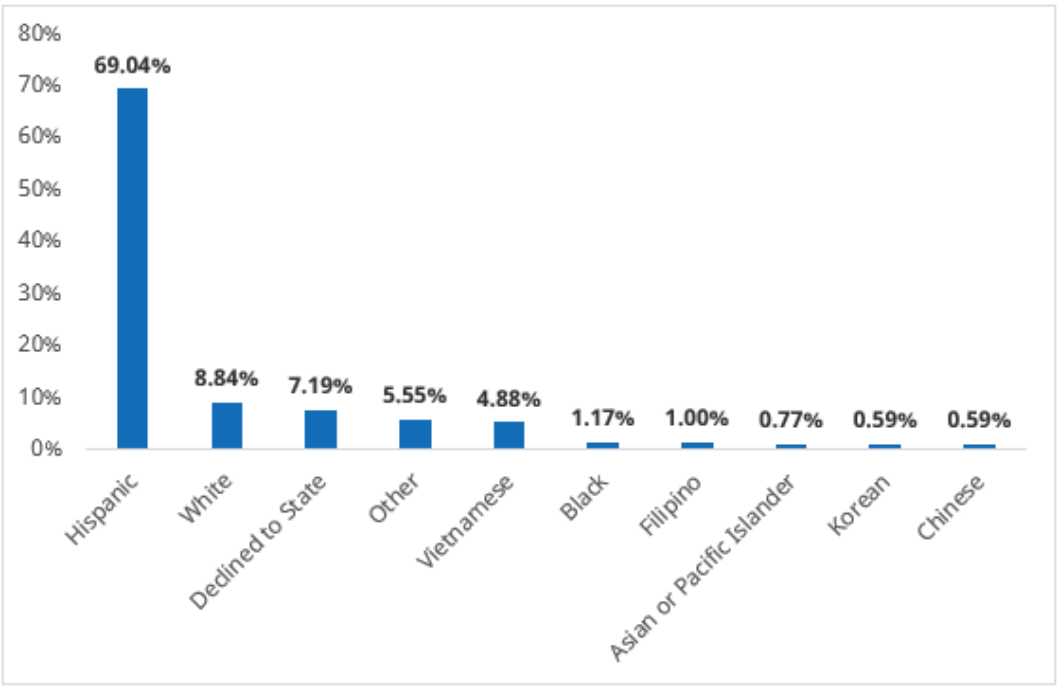
Data Source: MY 2024 CalOptima Health HEDIS Results



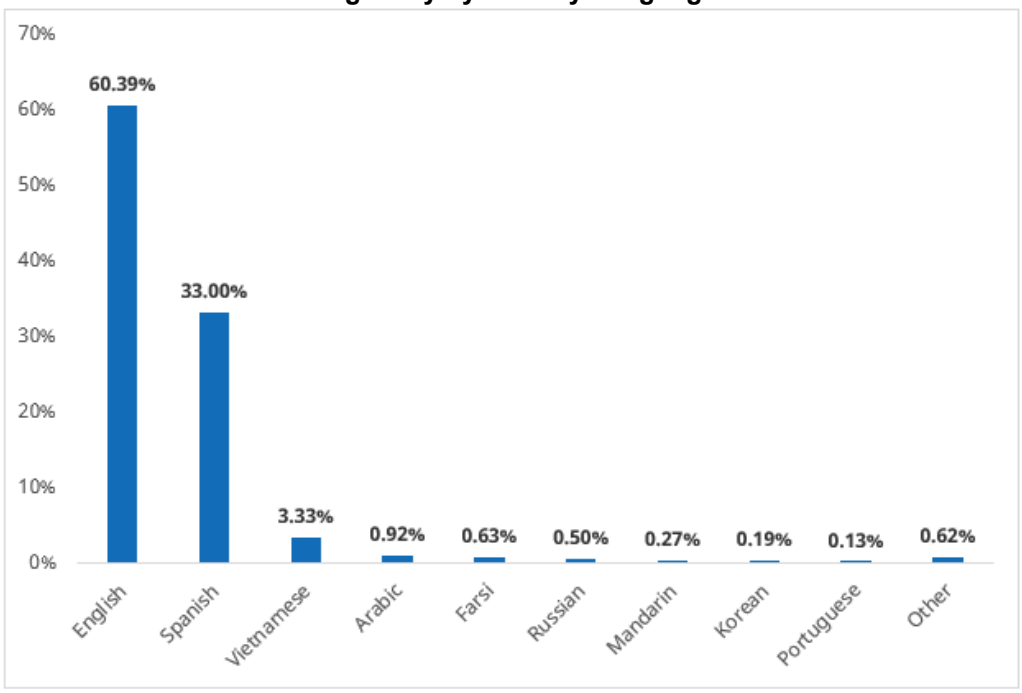
Data Source: MY 2024 CalOptima Health HEDIS Results



Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.



Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.



Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Analysis:
CalOptima Health's maternal population is predominantly Hispanic (69.04%), followed by White (8.84%), members who declined to state (7.19%), Vietnamese (4.88%) and Black (1.17%). This racial and ethnic composition reflects broader membership trends and reinforces the importance of culturally and linguistically responsive prenatal and postpartum services. English (60.39%) and Spanish (33.00%) are the predominant spoken languages among pregnant members, with Vietnamese representing the next largest group at 3.33%. These patterns are consistent with the overall membership and underscore the continued need for language access supports across the care continuum.

Pregnancies are most concentrated among members ages 25–29 (28.30%) and 30–34 (27.20%), with a meaningful proportion occurring among members ages 20–24 (19.20%). Adolescent pregnancies among members ages 15–19 represent 5.30% of total pregnancies, signaling a continued need for age-appropriate prenatal support and early engagement strategies for younger members. Advanced maternal age pregnancies (age 35 and older) represent 19.9% of cases, a population associated with elevated clinical risk.

Obstetric comorbidities are common among CalOptima Health's maternal population and contribute to clinical complexity across the perinatal continuum. Across hospital-based deliveries between July 1, 2024, and June 30, 2025, notable conditions include a history of previous cesarean birth (21.7%), mental health conditions (18.2%), gestational diabetes (17.4%), preeclampsia without severe features or gestational hypertension (12.8%), preexisting diabetes (10.4%), preexisting cardiac disease (10.0%), preterm birth (defined as less than 37 weeks) (9.6%), and substance use disorder (7.3%).

Prenatal and postpartum care quality data from MY 2024 reveal meaningful variation by race and ethnicity. For Prenatal Care (PPC1), the DHCS MPL was 84.55%. Hispanic or Latino members achieved 89.71% (above the MPL) while Asian members fell below at 81.61% and members in the Other racial category showed the greatest gap at 78.26%. Black or African American members achieved 100%, and White members performed above the MPL at 93.10%. For Postpartum Care (PPC2), the MPL was 80.23%. Asian (91.30%), Black or African American (100%), White (86.21%), and Hispanic or Latino members (81.14%) exceeded the MPL, while members in the Other category showed a notable gap at 65.22%. These disparities signal that postpartum engagement, particularly for members in the Other race/ethnicity category, remains a priority area requiring targeted outreach and follow-up.

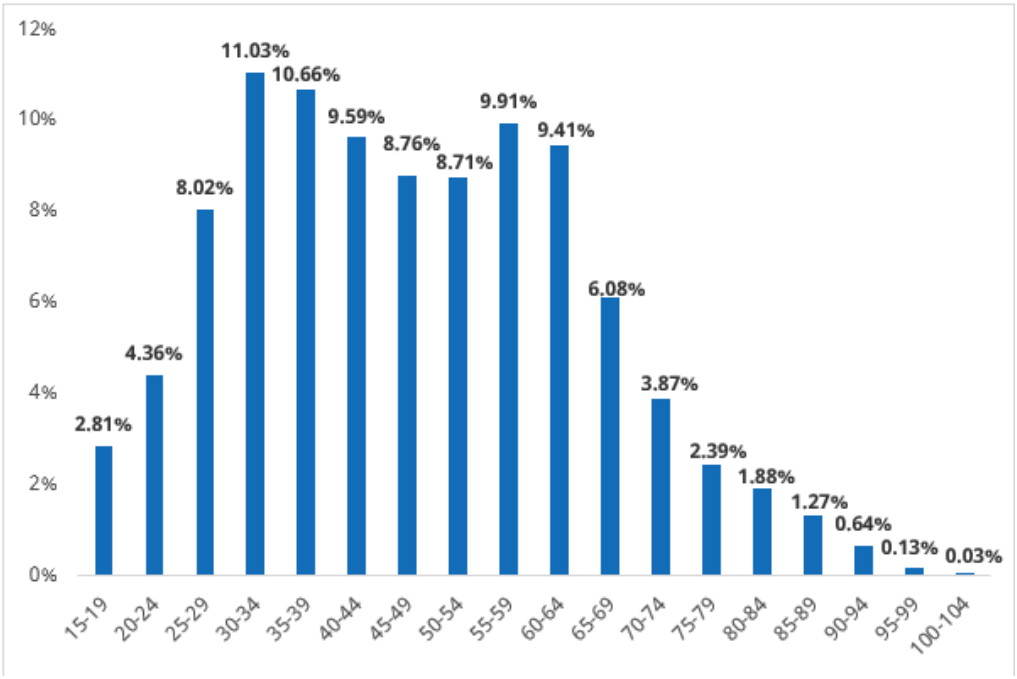
Conclusion:
The maternal health data collectively reflect a predominantly Hispanic, Spanish- and English-speaking population with elevated rates of medical and behavioral health comorbidities that require coordinated, culturally responsive care across the prenatal and postpartum continuum. The prevalence of mental health conditions among nearly one in five obstetric members represents a particularly urgent opportunity for integrated intervention, as untreated perinatal depression and anxiety are associated with adverse outcomes for both mother and infant. Postpartum care disparities, especially for members in the Other race/ethnicity category, signal a need for more targeted engagement strategies following delivery, when members are most at risk of disengaging from care. CalOptima Health's ability to identify high-risk pregnancies early, provide coordinated case management and sustain engagement

through the postpartum period is central to improving maternal and infant outcomes and reducing health disparities across the membership.
Activities/Resources to Address Gap: CalOptima Health's Maternal Health Program provides comprehensive support to members throughout pregnancy and the postpartum period, including telephonic outreach, prenatal and postpartum health education, nutrition counseling, and connection to community-based support services. Pregnancy notification by providers enables CalOptima Health to initiate outreach early in the prenatal period, with trimester-specific and postpartum follow-up to support continuity of care and health outcomes for both mothers and newborns. For members with high-risk pregnancies or complex comorbidities, including those with preexisting diabetes, cardiac disease, hypertensive disorders or major mental health conditions, CCM and ECM are available to provide intensive, coordinated support across clinical and social service domains. Behavioral health services, including perinatal mental health screening and referral, are integrated into the maternal health workflow to identify and address conditions such as perinatal depression and anxiety. In 2026, CalOptima Health enhanced the tracking and documentation of prenatal and postpartum depression measures through collaborative efforts with HCA, targeted social media campaigns for depression screening and partnerships with community-based organizations. To drive improvement in PPC quality measures, CalOptima Health implements multimodal member outreach strategies, including text messaging, IVR calls, targeted mailings, newsletters and mass media campaigns. The Member Health Rewards Program provides gift card incentives for completing prenatal and postpartum visits; effective July 2026, CalOptima Health increased the postpartum member health reward from $25 to $50 to strengthen engagement with postpartum care.

4.4.3. Behavioral Health and Substance Use Disorder

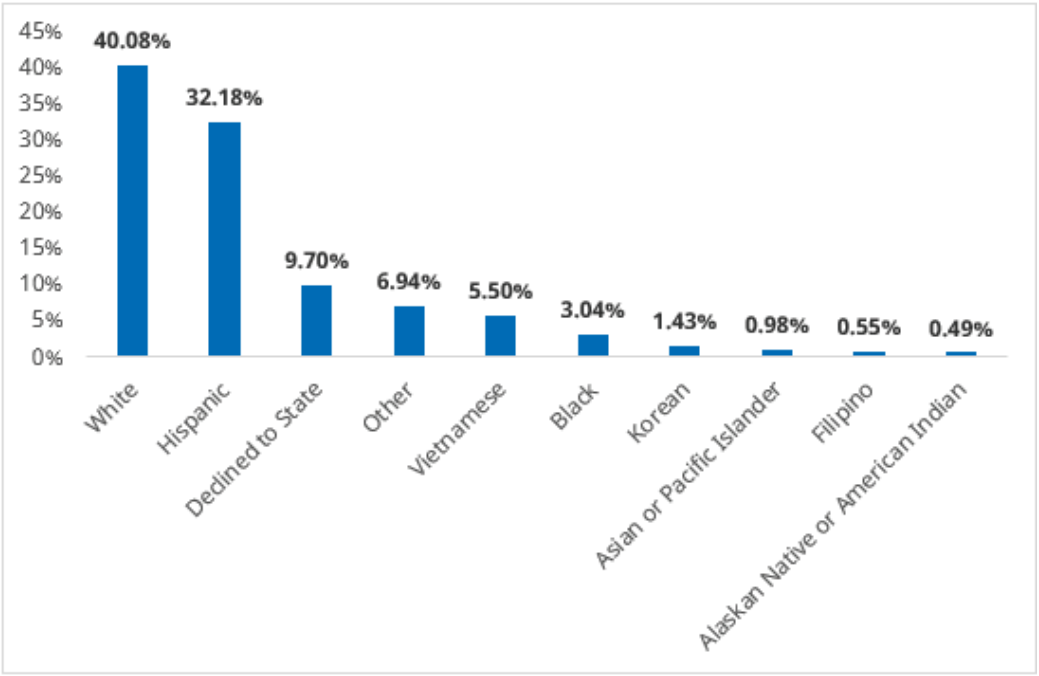
Members with co-occurring behavioral health and substance use disorders (BH+SUD) represent one of CalOptima Health's most clinically complex and high-need subpopulations. The following data describes the demographic profile and health care utilization patterns of this group in 2025, compared against the broader adult Medi-Cal membership, to inform program planning and investment. For the purposes of this analysis, the BH+SUD subpopulation is defined using the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Categories and includes members with at least one qualifying behavioral health condition — such as anxiety disorder, bipolar disorder, depression, schizophrenia, personality disorders or PTSD — and at least one co-occurring substance use disorder, including alcohol use disorder, drug use disorder, opioid use disorder or documented utilization of medication-assisted treatment.

Behavioral Health and Substance Use Subpopulation by Age



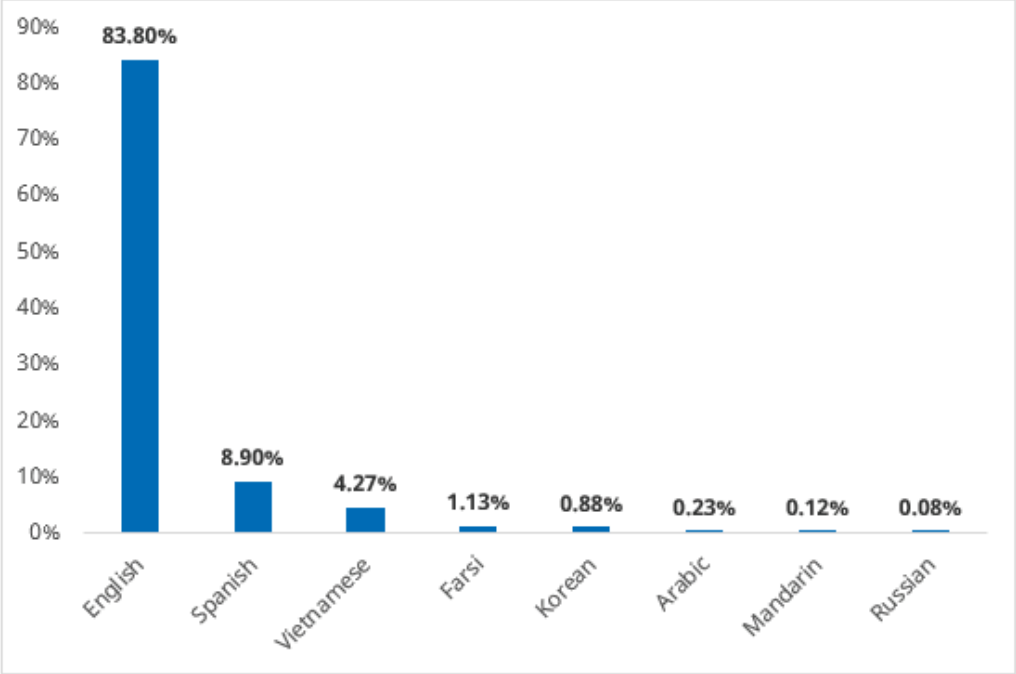
Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Behavioral Health and Substance Use Subpopulation by Ethnicity



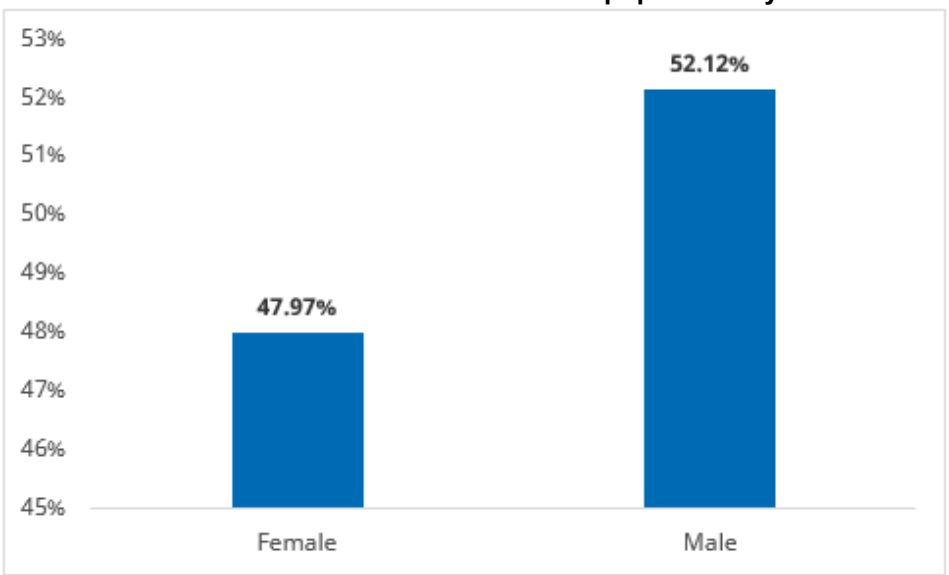
Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Behavioral Health and Substance Use Subpopulation by Language



Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Behavioral Health and Substance Use Subpopulation by Gender



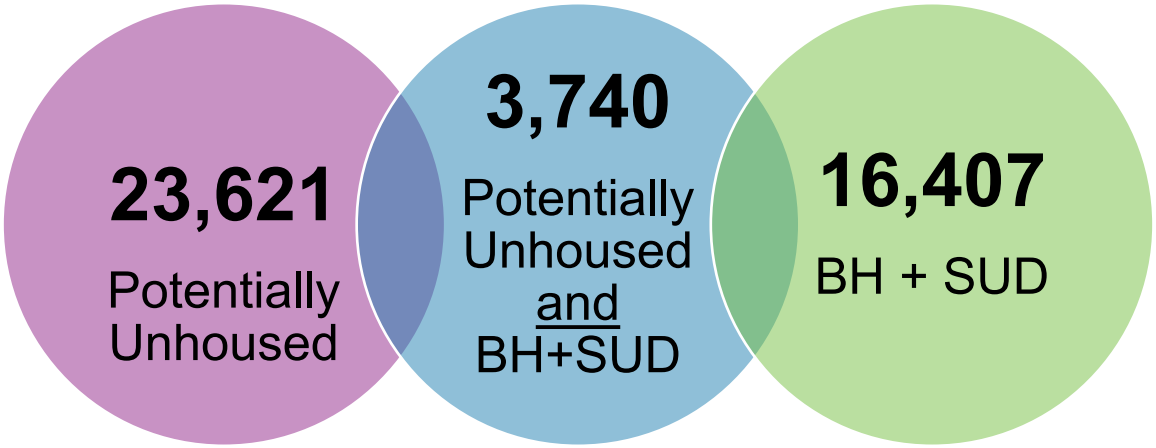
Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Top Chronic Medical Conditions Among Behavioral Health and Substance Use Subpopulation and Comparison to Overall Medi-Cal Population

Chronic Condition	Prevalence in BH+SUD Subpopulation	Prevalence Among Medi-Cal Population
Hypertension	46.6%	14.15%
Tobacco Use	41.8%	5.29%
Hyperlipidemia	41.0%	18.13%
Fibromyalgia and Chronic Pain and Fatigue	33.1%	5.85%
Obesity	28.2%	10.71%
Anemia	27.0%	6.21%
Rheumatoid Arthritis/Osteoarthritis	25.3%	5.82%
Diabetes	22.9%	9.41%
Liver Disease, Cirrhosis, and Other Liver Conditions (except Viral Hepatitis)	18.1%	3.14%
Chronic Obstructive Pulmonary Disease	14.2%	1.71%

Data Source: CalOptima Health (2025). CMS Chronic Conditions, Ad-Hoc Data Pull and Tableau Dashboard. Data from December 2025, Accessed February 2026.

Homelessness and Behavioral Health and Substance Use Subpopulation



Data Source: CalOptima Health (2025). Cost & Utilization Membership Tableau Dashboard. Accessed April 2026.

Utilization Rates by BH+SUD Subgroup

Utilization Metric	All Medi-Cal Adults 18+	Members with BH + SUD Diagnosis	Ratio
Inpatient Utilization *(Admits per Member per Year)*	69.70	478.06	6.9x higher
Emergency Department *(Visits per 1,000 Members per Year)*	330.20	1,949.30	5.9x higher
Authorized for ECM *(% of membership)*	0.80%	7.91%	9.9x higher
Office/Outpatient Services *(Visits per 1,000 Members per Year)*	3,171.80	7,997.60	2.5x higher

Data Source: CalOptima Health (2025). Cost & Utilization Claims and Encounters Tableau Dashboard. Cost & Utilization IP Acute Claims Tableau Dashboard. Membership Tableau Dashboard. Accessed April 2026.

Analysis:

Age

The BH+SUD population is concentrated in working-age adults, with the highest representation in the 30–34 (11.03%) and 35–39 (10.66%) age bands and with sustained prevalence through the 40–64 range. Members under age 20 account for a much smaller share of the BH+SUD population, a contrast to the overall Medi-Cal membership, where children and adolescents comprise approximately 30.85% of enrollment.

Race/Ethnicity

The ethnic composition of the BH+SUD subpopulation differs from CalOptima Health's overall Medi-Cal membership. White members represent 40.08% of the members with BH+SUD diagnoses, nearly three times their 14.08% share of overall membership. Conversely, Hispanic members represent 32.18% of members with BH+SUD diagnoses, below their 48.39% share of total membership. A similarly notable underrepresentation is for Vietnamese members, who represent 5.50% of the BH+SUD population compared to 11.97% of overall membership. Black members represent 3.04% of the BH+SUD population, compared with 1.57% of total membership, suggesting a higher proportional prevalence.

Primary Language

The language distribution of the BH+SUD population reinforces the ethnicity findings. English-speaking members account for 83.80% of the BH+SUD population, exceeding their 56.02% share of overall membership. Spanish-speaking members represent just 8.90% of members in the BH+SUD subpopulation, despite comprising 28.88% of total membership, and Vietnamese-speaking members represent 4.27% compared to 9.12% overall membership.

Gender

The gender distribution of the BH+SUD population is noticeably inverted relative to overall membership. Male members represent 52.12% of the BH+SUD population, compared to 46.75% in the overall Medi-Cal membership. Female members represent 47.97% of BH+SUD members, compared to 53.25% overall membership.

Chronic Medical Conditions

Members in the BH+SUD population carry a substantially higher burden of chronic physical conditions compared to the overall Medi-Cal membership, confirming that behavioral health and substance use disorders rarely occur in isolation. Hypertension is the most prevalent co-occurring condition at 46.6% — more than three times the rate among all Medi-Cal members. Tobacco use (41.8%), hyperlipidemia (41.0%) and fibromyalgia and chronic pain and fatigue (33.1%) are also notably elevated, reflecting the compounding physical toll of untreated or undertreated behavioral health conditions.

Potentially Unhoused

CalOptima Health's 2025 data reveals a significant overlap between members potentially experiencing housing instability and behavioral health conditions within the Medi-Cal population. Of the approximately 23,621 members identified as potentially unhoused, 3,740 (approximately 16%) also carry a diagnosis of BH+SUD.

Utilization Rates

Among Medi-Cal adults ages 18 and older, members with co-occurring BH+SUD utilize health care services at higher rates than the general adult Medi-Cal population. Both comparison groups were restricted to adults 18 and older to control for age as a confounding factor, given that, at an average of 47.6 years, the BH+SUD subpopulation skews older than the overall Medi-Cal membership of 35.5 years.

In Calendar Year (CY) 2025, adult members in the BH+SUD subpopulation were hospitalized at nearly seven times the rate of all Medi-Cal adults 18+ (478 versus 70 inpatient admits per member per year) and used the emergency room at nearly six times the rate (1,949 versus 330 visits per 1,000).

Importantly, adult members in the BH+SUD subpopulation also engage with appropriate, community-based care at higher rates. Office-based outpatient services were two and a half times higher among BH+SUD adults compared to the general adult population (7,998 versus 3,172 per 1,000), and those authorized for ECM were 10 times higher (0.80% vs. 7.91% of membership).

Conclusion:

The age distribution of members with BH+SUD diagnoses is consistent with established patterns for both behavioral health and substance use conditions, which typically emerge or are diagnosed in early-to-middle adulthood and grow in complexity over time. Interpretation of disparities in race/ethnicity and language requires consideration of multiple overlapping factors. For Hispanic and Vietnamese members, lower representation in the BH+SUD subpopulation may reflect protective factors, including family support networks and cultural or religious beliefs that discourage substance use. At the same time, stigma around behavioral

health and substance use disclosure, limited availability of culturally or linguistically behavioral health providers, and differences in screening practices may contribute to lower rates of diagnosis and treatment. The data on BH+SUD diagnoses by gender is consistent with national data showing that men have higher rates of substance use disorder than women, although research also demonstrates that women may be underdiagnosed, as provider screening practices and stigma may suppress identification of substance use disorders in female patients[5].

The disproportionate prevalence of chronic physical conditions among members with BH+SUD diagnoses underscores the limitations of treating behavioral health and physical health as separate domains. Effective care for this population requires a truly integrated approach, one that addresses cardiovascular risk, pain, metabolic conditions and substance use simultaneously rather than sequentially. The patterns of elevated emergency and inpatient utilization reflect the significant clinical and social complexity of members managing co-occurring conditions and underscore the need for sustained intensive care intervention. Furthermore, elevated rates of ECM utilization and outpatient care reflect the care system responding to member needs, connecting high-complexity individuals to longitudinal primary care, behavioral health and substance use services, and intensive care management support. Sustained investment in ECM and outpatient engagement for this population is consistent with a high-value care strategy that prioritizes the right care in the right place and aims to reduce preventable acute events over time. The concentration of potentially unhoused members with co-occurring behavioral health and substance use conditions represents one of the most complex challenges facing CalOptima Health, and one where investment in whole-person, community-based intervention has the greatest potential to reduce crisis utilization and improve quality of life.

Activities/Resources to Address Gap:

In California, behavioral health services for Medi-Cal members are organized through a carved-out delivery system. Specialty Mental Health Services for members with serious mental illness and Drug Medi-Cal Organized Delivery System services for members with moderate-to-severe substance use disorders are provided through the Orange County BHP, not through CalOptima Health. CalOptima Health retains responsibility for NSMHS, including outpatient therapy, psychiatric consultation and medication management for members with lower acuity behavioral health needs. Coordination between CalOptima Health and HCA is governed by a formal memorandum of understanding to ensure continuity of care and warm handoffs for members transitioning between systems.

For members not receiving services through the county, CalOptima Health's ECM services are a critical resource for members with lower-acuity BH+SUD diagnoses, providing intensive, person-centered care coordination that spans physical health, behavioral health, substance use, social services and housing. ECM connects the highest-complexity members with a dedicated lead care manager who coordinates care across the full delivery system, meeting members where they are: in the community, in shelters or in clinical settings.

[5] https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

In addition to ECM, CalAIM Community Supports provide a range of services relevant to members with BH+SUD needs, including:

- Sobering centers as an alternative to unnecessary ED visits for members under the influence of substances.
- Recuperative care for members transitioning out of inpatient behavioral health or substance use treatment facilities.
- Housing programs for those experiencing homelessness, including Housing Navigation, Housing Deposits, and Housing Tenancy and Sustaining Services.

Additionally, CalOptima Health providers offer virtual behavioral health services, enabling members to access outpatient psychiatric care and psychotherapy with reduced barriers related to transportation, scheduling and stigma. This serves as an important point of entry for members who may not otherwise engage with the traditional behavioral health system.

CalOptima Health actively monitors FUM and FUA performance as part of its quality improvement strategy. Improvement efforts include real-time ED data sharing with health networks, member text messaging following ED visits and ongoing provider education.

CalOptima Health has made significant investments to expand the capacity, diversity and reach of Orange County's behavioral health system. This includes grant funding for behavioral health workforce development through the Provider Workforce Development Initiative and support for youth-focused mental health and substance use services established through SBHIP.